

**SELECT COMMITTEE ON THE
LONG-TERM SUSTAINABILITY OF THE NHS
Oral evidence**

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Department of Health and Department for Communities and Local Government – Oral evidence (QQ 1-21)

Evidence Session No. 1

Heard in Public

Questions 1 - 21

Tuesday 12 July 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Andrew Baigent, Director of Finance, Department of Health, Dr Edward Scully, Deputy Director, Integrated Care, Department of Health, Gavin Larner, Director of Workforce, Department of Health, Tim Donohoe, Director, Informatics Delivery Management, Department of Health, Mark Davies, Director, Health and Wellbeing, Department of Health, and Graham Duncan, Deputy Director for Care and Reform, Department for Communities and Local Government.

Q1 **The Chairman:** Good morning. Thank you for coming to give evidence today at our first session. Before we start, may I say that this session is being broadcast and recorded? Whatever you say will be recorded, but it will also be broadcast. Therefore, it is important for both Committee members and you to know that any private conversation that you have will be picked up, because the microphones are rather sensitive. It will also be recorded and heard on the broadcast media, including the web. I see that there is one seat empty.

Andrew Baigent: Ed has gone for a quick comfort break. I am sure he will be with us in a few seconds.

The Chairman: Okay. Would you like to introduce yourselves? You may start, Mr Baigent.

Andrew Baigent: Of course. I am Andrew Baigent. I am the director of finance at the Department of Health.

Gavin Larner: I am Gavin Larner. I have been the director of workforce at the Department of Health for four weeks.

The Chairman: Mr Scully, do you want to introduce yourself?

Dr Edward Scully: I am Edward Scully. I am the deputy director at the Department of Health, responsible for the integration of health and social care.

Tim Donohoe: I am Tim Donohoe. I am the director of informatics delivery management, responsible for overseeing or deployment of

technology and the programme portfolio, delivering that technology into health and social care.

Mark Davies: I am Mark Davies. I am the director of population health at the Department of Health, covering the public health system, healthy behaviours and prevention.

Graham Duncan: I am Graham Duncan. I am from the Department for Communities and Local Government. I am the deputy director for care and reform, which means that I am responsible for DCLG's interests in adult social care and public health, in particular, and in health and social care integration.

The Chairman: Thank you very much. I assume one of you will make sure that the right person answers the question.

Andrew Baigent: It will be down to me to do that.

The Chairman: Okay. Do you have an opening statement to make?

Andrew Baigent: I thought that I would make a few remarks, just to open up.

The Chairman: Before you do that, I will reiterate some information that we have given you. Remember that this inquiry is about long-term sustainability. We are looking at how the health service, including social care and prevention, could be sustainable after 2025, to 2030 and beyond.

Andrew Baigent: I am glad you have said that, because that is exactly what I hope I will do in the next couple of minutes.

I want to open by saying briefly that the department's role changed in 2013. We devolved a lot of the operational delivery of the health service to our arm's-length bodies—NHS England, Public Health England and others. To some extent, that has freed us up to look at some of the longer-term issues within the department. However, as you would expect, quite a lot of the work we do is focused on the short term and the medium term. In the short term, we focus on managing the arm's-length bodies and holding them to account for delivery of performance in the NHS and the broader health and social care system, and on making sure that we can do that within the funding that we have. We will not talk too much about that today, and I will not dwell on it. In the medium term, the NHS came up with a five-year forward view, which the Government have fully funded. A lot of our efforts in the department are in holding the ALBs accountable for delivering that forward view.

However, today we are talking about the longer-term stuff. My colleagues have already introduced themselves. Gavin can take us through some of the issues around workforce strategy and the long-term nature of that. Tim Donohoe can talk about how we are trying to advance our infrastructure and IT infrastructure base, to get IT fully integrated with the delivery of health and social care. I can talk a little about shorter-term efficiency and how we are setting up that basis. I suspect that we will not dwell too much on that, as we are looking over the longer term. Mark will be able to talk about population health and some of the prevention work

that we are doing. Ed and Graham will be able to talk about social care. However, you know that already.

Q2 **The Chairman:** The key questions have been submitted to you. No doubt Committee members will have lots of supplementary questions. Might I make a start? You said that you are involved in some long-term strategic thinking. Would you like to tell us what long-term thinking is taking place in government bodies on the sustainability of the NHS beyond the next 15 to 20 years?

Andrew Baigent: It is probably best to break it down into each of the areas we have talked about: workforce, IT and integration.

The Chairman: We have questions related to all those. Could you stick to finance first?

Andrew Baigent: I can talk briefly about finance. As always happens in these things, we have a five-year settlement in the spending review. The funding of the NHS is planned in the five-year forward view to meet that settlement. At the moment, most of our focus with the finances is on being able to deliver within that envelope and emerging at the end of it in a position to carry on, with roughly the same envelope.

The Government have been quite clear that they see spending as being taxpayer funded. At the moment, we are not exploring any particular avenues of longer-term thinking about charging. That is the policy Lord Prior has talked about in front of Members of the House of Lords at various points. To some extent, it is about looking at the underlying pressures in the system and how we can model those and approach the delivery of healthcare in a different way, building on the forward view. While the finance is a governing factor in being able to deliver the service, to some extent, it has to be completely responsive to the underlying pressures. As you will know, those pressures are the cost of the workforce, the cost of the drugs and how we do that, the cost of the infrastructure, the way in which we deliver services and the balance between primary care, secondary care and emergency non-elective care, when that comes through the door into the acute sector.

The Chairman: You said that, in your thinking, you have come to the conclusion that in the long term you will still be looking at a taxpayer-funded NHS. Have you ruled out the possibility of any charges? Do you think that a service free at the point of need is sustainable?

Andrew Baigent: That is current policy, and that is the way we are thinking. As you know, we have done some work around eligibility. Migrant access charges and charging for overseas visitors are coming in, so there is some charging. There are always considerations around prescription charging and how that is taken forward, but those are all issues of what we should charge for services that are being charged for at the moment. We have done no thinking beyond that about charging, under current policy.

Q3 **Lord Willis of Knaresborough:** Thank you for that. I find it somewhat incredible, given that, with every modern healthcare system, we are facing issues of long-term sustainability, and given that you have to

integrate health and social care into a single package, that you are doing absolutely no thinking about whether there are any items in both health and social care that we could remove from being free at the point of delivery and put on to a pay list. Is none of that thinking going on? If not, could we have your personal view as to whether we should be doing it?

Andrew Baigent: On the broader strategic issue of whether there are large clumps of things where we are looking at charging and different charging mechanisms, there is no thinking going on that has gone beyond very early thoughts. As a Civil Service, clearly we think about some of these things, in case Ministers wish to take them forward, but at the moment that is not there.

NHS England is looking at low-value procedures. There is some work going on around whether there are certain low-value procedures that should be taken out. That is a matter on which I need to defer to NHS England, because it is doing the thinking. Personally, I would think of that not as strategic thinking but as short-term tactical thinking that will make a difference around the margins. If you look at the figures that NHS England has provided in the past around the five year forward view and the efficiency challenge—the £22 billion, which you will be aware of there—an element of that is about not offering certain low-value procedures.

Lord Willis of Knaresborough: So we have nothing beyond five years. Mr Duncan, I wonder whether you could comment here. You have the issue of large swathes of social care and, indeed, public health that are now involved with local government. Surely you are doing this work, looking ahead and saying, “Come on. Are there areas that could be taken off ‘free at the point of delivery’, to release funds for greater integrated care?” Are you not doing that either?

Graham Duncan: Our main interest is in how you shift money from one part of the system to the other. The long-term strategic story is about shifting from a system that targeted disease in hospitals to one that looks at long-term conditions—particularly for older people, but also for people with learning disabilities. Over the last decades, we have gradually been on a journey to make that shift. Community care is a good example from 20 to 30 years ago, but it is a long-term journey. We need to go further on that. Our focus and interest are in how you shift activity and resources from acute to community settings.

Lord Willis of Knaresborough: Whether they are in acute or in the community, they still need paying for. How do we release more resource to pay for the whole package unless you look at the core issue of what is free at the point of delivery?

Graham Duncan: All I would say is that that is not our focus. Our focus is on how you make the money that will be in the system work. In the end, Governments will have to make a decision about how much they put into the system. What we need to think about is how you best use the resources that are likely to be available to get better outcomes for the people for the same amount.

Lord Mawhinney: We were set up to look at the long-term sustainability of the NHS. You are doing no thinking about the long-term sustainability

of the NHS. How would you want to convince us that you are fit for purpose?

Andrew Baigent: The question was very directly against the finances. As colleagues and I have said, we are working within an envelope that the Government have decided and within a set of instructions around how that will be funded.

Lord Mawhinney: I understand all that, as do my colleagues. My question is an entirely different one. We are supposed to be looking at sustainability. You have told us that you are not doing any work on sustainability. Why should we conclude in our report that you are fit for purpose?

Andrew Baigent: On sustainability, we are looking at each of the cost drivers—the demand for the service, for treatment and for social care. We are looking at how we will have the right workforce to deliver. That work is fairly long-term and goes 15 or 20 years into the future. That is important as well. We are looking at how we get efficiencies out of the service. Those will continue, of course. If we get them in place in the next two, three or four years, they will underlie the operation of the health and care service going forward. We need to look for as many opportunities as we can to do that, within the envelope that we have been given.

Lord Mawhinney: Forgive me, but some of us have been listening to this for 30 years. We have listened to people saying, “We will improve the efficiency, Minister. We are looking at how we can constrain demand”. Demand is increasing all the time. Efficiencies, such as they are, are not remotely staying in line with demand. Sustainability will be even worse in the future than it is now, according to what you have just told us, because you cannot control the demand. I ask you for the third time, if you cannot control the demand, sustainability is going to get worse and you are not doing any thinking about sustainability, can you understand why we, as a Select Committee that is looking at sustainability, might come to the conclusion that you are not fit for purpose?

Andrew Baigent: I certainly understand where you are coming from on that; you make it very clear. I come back to the point that you have just made on demand. We have not yet explored the work that is being done on demand. Of course, you will also talk to NHS England about that, as the inquiry continues. Demand for the services that are offered currently is increasing. How we deliver those services—whether we can do them in a more efficient way, closer to home, in different care settings—is very much the focus of what we are doing within the department and with colleagues in CLG. That is the plan—to work out how we can deliver that. You used the term “efficiency”. That is right, but it is also about what we are delivering and how we are delivering it, to meet local demand.

The Chairman: Through your answers, you have excited so many different Committee members that we are stuck on the first set of questions. I will take a quick question from Lord Scriven, who will be followed by Baroness Blackstone, Baroness Redfern, Lord Turnberg, Lord Warner and the Bishop of Carlisle.

Q4 **Lord Scriven:** I get the message that you have been asked to work

within a policy framework of “free at the point of use”. You do not have operational responsibility, so you are forward planning. Based on projections that you have done about sustainability of the NHS free at the point of use, what are the implications for 10 or 15 years’ time as regards demand, core service delivery, et cetera?

Andrew Baigent: As we look forward on demand, most of the modelling has been done for the five-year forward view. We are now turning our attention to looking beyond that. I cannot tell you today where that is in respect of modelling going forward. What I can do is talk briefly about the efficiency side of things, which we have looked at very carefully. The five year forward view talks about a two percent-year year-on-year efficiency—

Lord Scriven: May I stop you? Have you done nothing beyond five years? Is that what you are telling us? There is no work beyond five years about a service free at the point of use, as regards core provision and the implications, particularly given that planning in the NHS takes more than a couple of years to implement.

Gavin Larner: On workforce, we have a much longer-term timeframe. The bulk of health and care costs are tied up in the cost of employing people. There are two main strands of work. The first is by Health Education England, to inform its commissioning strategy, particularly for medicine. The timeframe for new consultants is 14 or 15 years ahead, so you need to imagine the world in 2030. Last year, it published an updated version of the 15-year strategy, which takes three key focuses. The first is global drivers of change in health and social care around population demographics, to do with the ageing population and the shape of the employable workforce—factors such as the attitudes of millennials and when people work past 60, for the supply side.

Lord Scriven: You say that it has done this work. What are the answers?

Gavin Larner: The key conclusion is that the thing you can predict most is that the future is quite unpredictable 15 or 20 years hence, as regards what skill sets you need. The kind of health professionals we need to start training now, particularly the higher-cost ones, are people who are not just specialist surgeons—I know that there are many around here—but who can flex quickly, adapt to meet new technologies and circumstances, and jump on new opportunities to make the service more sustainable. Some really important work needs to be done over the next few years, particularly in medicine, on how we can adapt. I am quite optimistic on that front. If you look at the way in which doctors and surgeons have adapted to new pharma and new technology over the past 15 or 20 years, you see that they have been pretty adaptable, flexible and agile. The challenges for the future are—

The Chairman: I am sorry to stop you, but time is important. I can summarise what you are saying. If I ask what workforce numbers planning has been done for 2025, there are thoughts given, but no answer.

Gavin Larner: There is a second piece of work, which we commissioned from the Centre for Workforce Intelligence, called *Horizon 2035*. It has been trying to extend the global factors I talked about, to see what the

position will look like in the mid-2030s. A team of economists has been looking quite carefully at the evidence base. It concludes that, with the ageing population and the further spread of chronic disease through all age groups—beyond just older age groups—an estimated 3 billion extra care hours will be needed by 2035 and demand for care could rise twice as fast as population by that time. Its conclusion based on that is that you will need a lot more capacity at bands 1 to 4 of agenda for change than we currently have, to cope with that non-specialist, caring social care-health care border, where you have a big population to look after.

Q5 **Baroness Blackstone:** Notwithstanding the very valid questions asked by Lord Mawhinney and other members of the Committee about long-term sustainability, I want to come back to the current position. As you all know, NHS providers had a deficit of nearly £2.5 billion last year. That is an enormous deficit. It is unclear—the NAO has commented on this—how you will close the gap between the resources available and patients' needs. Can you tell us a little about how far you think the current healthcare funding envelope is realistic? If you do not think that it is realistic, what are you going to do about it?

Andrew Baigent: I think that the current funding envelope for the period of the five year forward view is realistic, but it is challenging. I do not underestimate that challenge. Quite rightly, you said that the NHS will exit the year with a deficit of about £2.5 billion. Going into the new year, we have made available a considerable amount of additional money: £3.8 billion, against the £10 billion of the five year forward view, will come in year one. Of that, £1.8 billion will go into a sustainability and transformation fund, which is available principally to providers of emergency care. That will help to put in what Jim Mackey has described as a "firebreak" and give providers an opportunity to get themselves on to a more even keel. I understand that £1.8 billion is not £2.5 billion. We expect the NHS to come into balance in 2016-17—

Baroness Blackstone: May I interrupt? You say that you expect it to come into balance. Expectation is fine, but what will you do in reality to make that happen? What funding models are you considering that are different from what exists at the moment? There is no point in just giving us the figures. We need to have some understanding of what your underlying thinking is to create the balance that is obviously needed.

Andrew Baigent: In the short term—in 2016-17—it is a relatively crude fund to bring providers on to an even keel. The changes to the funding mechanism are around that. We will talk about that later in the week, with an announcement at that point.

Baroness Blackstone: You cannot tell us now.

Andrew Baigent: I cannot, I am afraid.

The Chairman: Could you send us the details, once it has been announced?

Andrew Baigent: Of course. That will be around what we think that we can achieve this year, through a combination of accelerating some of the Carter work that is going on, using the £1.8 million sustainability fund, looking very carefully at the various investment plans and some detailed

work around the level of cost increase within individual providers and the support that will be given to them. It is a detailed but very micro-level plan that I would not want to claim was strategic, in the sense of doing anything other than provide this firebreak.

Baroness Blackstone: May I ask one supplementary? I realise that, to some extent, this is a political question. Nevertheless, you must all have a view on it. Do you think that the NHS is sustainable with 9% of GDP going on healthcare, when the European average is 12%? That is a very big gap between us and the rest of Europe.

Andrew Baigent: I believe that I have the figures right when I say that, according to the OECD, we are at or about the European average. It re-did the figures fairly recently and included more of our private payment as part of GDP. When it comes to the European average, we are there or thereabouts. Do I believe that it is deliverable? Yes. The Commonwealth Fund has said that we have the No. 1 health service in the organisation—

The Chairman: That comment is often made. It is based on access and, maybe, even some comparable models in expenditure, but it is not based on outcomes. Are we sacrificing better outcomes for lower financing?

Andrew Baigent: I do not believe so.

The Chairman: But you would agree that the Commonwealth Fund puts us pretty low down—at the bottom—on outcomes.

Andrew Baigent: On population health, yes.

The Chairman: That is health outcomes—or are you trying to fudge the definition?

Andrew Baigent: No.

Lord Lipsey: The OECD league table shows a different picture, does it not?

The Chairman: Yes, silence is perhaps a good answer.

Q6 **Baroness Redfern:** You have spoken about the financial envelope. I have a local authority background. Mr Duncan, I would like to know a bit more about how you are bringing together health and social care in the very short term—how local authorities can work together very closely, as we link health and social care.

Graham Duncan: We work on this jointly with the Department of Health, NHS England, the Local Government Association and the Association of Directors of Adult Social Services. At national level, they feel like the right people to be involved. That cascades down to local level. I said earlier that we had been on a journey for quite a while. I am sure that you will have experienced this yourself with community care issues.

Baroness Redfern: We never seem to get to the end of it, though.

Graham Duncan: I know. I will say what I think is different now, because I agree with you. A couple of years ago, I was looking at some papers from my mother's trunks. She was a geriatric social worker in the late 1980s. The rhetoric around health and social care integration in the

papers that I read there looked very similar to what we are saying now, so I accept the challenge. We have been trying to do this for a long time.

There are two things that are different now. We have never before had a Government who have tried to make this happen comprehensively across the country. The better care fund, which was introduced last year, is the first real attempt to do this across the system, in every area. It is not a perfect solution. However, if you look at what is happening in local areas, you will see that there have been real changes over the last couple of years already. All of a sudden, in every area—not just in those areas where there was already enthusiasm—there are conversations between health and social care professionals that did not happen in the past. In some areas, they definitely did; in others, they definitely did not. You get conversations between GPs about options that are not within their normal toolkit, because social care professionals can direct them towards those.

Baroness Redfern: That is fine. A conversation is a conversation. It is about action and really working together. Do you know what I mean?

The Chairman: Briefly.

Graham Duncan: I would challenge that slightly. Our work shows that relationships are critical to making this work. You can have systems, mechanisms, boards and structures, but if you do not have strong working relationships it will not work. Conversations are important.

The Chairman: I am managing this badly. We are still on the first question, and we have six more to get through. I ask you to make the answers succinct and my colleagues to do the same with questions. I have four more requests for supplementaries, from Lord Warner, Lord Turnberg, the Bishop of Carlisle and Lord Bradley.

Q7 **Lord Warner:** May I take you back to demand management and the five-year plan? The five year forward view, which will be two years old in October, was based on a set of assumptions. You would have to be a heroic optimist to believe that those assumptions are working in support of the five year forward view at the moment. There is also the issue that you sound a bit like someone who will be relieved, like a slightly beached whale, when you get to 2020, as it will all be done. What comes after the five year forward view? How will you reappraise the five year forward view if it is going off course? Do you have no contingency plans or mechanisms for dealing with that? If you do, please share them with us.

Andrew Baigent: If we look at the assumptions in the five year forward view and take the one for demand, we are not a million miles away from where the plan was. In the period so far, there has been weighted average cost growth of about 2%. We are keeping each of the elements under very active review. There is a detailed plan that is monitoring each element of how we meet the £30 billion challenge of reducing the cost increase in the service and checking their progress as we go through. We have a plan that is monitoring each of those lines and items at a fairly granular level. As things go off track, we will take intervention—

Lord Warner: The other assumptions were that social care was properly funded and that there was a prevention strategy. Those are quite key to delivering the five year forward view. Where are you taking and

evaluating that?

Andrew Baigent: I will defer to colleagues on those two points.

Mark Davies: On the prevention element of the five year forward view, we have a prevention board, which is chaired by Duncan Selbie, the chief executive of Public Health England, and brings together all the key players. It is looking at all the elements of prevention. Within the efficiency savings, £500 million is attributed to prevention. We are tracking that very closely. We will look closely at the sustainability of transformation plans when they come in to see how far they deliver those numbers on prevention. The majority of them—in fact, 43 out of 44—put prevention as one of their key priorities. They are still being worked on; they are not yet finalised. We think that the prevention elements of the five year forward view are in place. Of course, prevention goes much beyond the five years. Most of the key elements and key work that we are doing on prevention look beyond 2020 and into the next decade.

Lord Turnberg: You may have got the hint that the Committee is a little surprised that there is not a plan beyond five years. I wonder why that is the case. You are all intelligent civil servants, yet there has not been much thinking beyond that. It seems to me that it must be because you have been prevented from taking forward those sorts of ideas. Is it the Treasury? Are Ministers saying, “Do not think beyond five years”? You may wish to nod, if this is a politically loaded question.

Andrew Baigent: Colleagues will butt in. As I said, we are doing long-term thinking on each of the elements—on workforce, on the delivery of care, on how it is delivered and on integration. We are doing the work in those areas and are looking through them.

The Chairman: When can you send us the work that you are doing beyond the next 10 years?

Gavin Larnner: I am happy to send you the two strategic reviews that we have done on workforce—

The Chairman: Are you able to write to us about this next week?

Gavin Larnner: Yes. I can send them to you tomorrow.

The Chairman: So why can you not answer the question today, instead of just saying that you are doing some work?

Gavin Larnner: I was speaking specifically about workforce needs and how we think those will look. We have done a quite thorough piece of work, which is ongoing. I can send you the two main reports we have got to on that. They are a good, thorough take, based on the evidence that we have, on what we think the workforce needs will be, in so far as we can predict them.

The Chairman: This is the report that you have produced entitled *Future demand for skills: Initial results*.

Gavin Larnner: Yes.

Lord Turnberg: Have you costed that?

Gavin Larnner: No.

Bishop of Carlisle: I go back to the initial question about the sustainability of the NHS over the next 15 years. You made it clear at the beginning that you have handed over a certain amount of the operational work to people like NHS England, so that you can do more thinking yourselves. As we have heard, you are not thinking much beyond five years, except in those areas that you have mentioned. Do you know whether anybody, apart from us, is doing that thinking?

The Chairman: Silence is another answer, I guess.

Lord Bradley: I want briefly to pick up two issues that have been raised. First, on the relationship between finance and quality outcomes, control totals are now set for provider organisations. Are you able to explain to me how those control totals are calculated for 2016-17? Secondly, within the five year forward view, there is another dynamic, under the broad banner of parity of esteem between physical and mental health—the requirement to invest more in mental health, away from the current balance of 87% for physical and 13% for mental. Do you think that you can achieve that within the five-year plan? If not, what are your longer-term plans for the sustainability of mental and physical health services going forward?

Andrew Baigent: I can answer the first question, on the details of the calculation. The calculation is done by NHS Improvement. I cannot answer on the precise methodology on a case-by-case basis. What I can say—

Lord Bradley: Can you provide me with it?

Andrew Baigent: I am sure that we can. I believe that you will see NHS Improvement next week, so I can give you an outline.

Lord Bradley: It would be very helpful to have that.

Andrew Baigent: In effect, it is based partly on outturn from previous years and partly on looking at some of the fundamental cost increases, the demand increases that they have had over the last year and their projections going forward. It looks particularly at labour costs and how they have moved.

Lord Bradley: What about the second part?

Andrew Baigent: Your question was about mental health. Mental health funding has gone into the mandate, as part of the written side of that. It includes parity of esteem. That is probably a question of detail that is best directed to NHS England when you see it next week.

The Chairman: Baroness Blackstone, you have covered question 2, but you may have a supplementary.

Q8 **Baroness Blackstone:** I want to pick up something about switching funding from one area to another. You are concerned about social care, but how will the rest of the NHS survive if you topslice it to provide social care funding—which, of course, is desperately needed—when NHS providers are already running a big deficit? Surely there has to be some other way through this. That is why we need some other models for how this relationship will work and how, over a rather shorter timescale of five

to 10 years, you will have a system that does not run into these huge deficits every year. Surely that in itself is unsustainable.

Graham Duncan: I will answer that from the social care point of view. This is already happening in areas. If you can spend money on care at home, rather than in hospital or even in residential care, that is not just cheaper but—assuming that the circumstances are right—better for the person involved. There is a win-win here. It is not easy, but it is happening in areas right now. It is not just an aspiration. The challenge is to make it happen more widely.

The Chairman: What are the challenges?

Graham Duncan: There is a challenge in taking someone out of a hospital bed and putting them at home. That is great for the person, but a hospital bed is still there, so you do not make a full cost saving. People often have a binary conversation about this, which goes, “The hospital is still there, so you have not saved the money”. Actually, there is something about what you are spending in relation to that bed and whether you can shut down a ward for a while. I am straying slightly far from my territory here, but there are things that you can do to mitigate those challenges. There is a danger of being too defeatist about it.

The Chairman: You did not answer the question, but I dropped you in that. Baroness Redfern, do you have a supplementary to question 2?

Baroness Redfern: Yes. It is directed to Mark Davies and is particularly about funding for mental health. I wonder whether you have looked into that, to see where you can target some extra financial support.

Mark Davies: Mental health is not part of my remit. I am not sure whether there is anyone here today who can answer that.

Baroness Redfern: I read in the brief that you had been involved with that.

Mark Davies: Previously, but not at the moment.

Baroness Redfern: You have moved on.

Lord Mawhinney: What is the budget for the NHS for 2016-17? What would that budget need to be if the NHS and social care were fully integrated?

Dr Edward Scully: You could fully integrate them and have the same budget. Are you talking about changing access and entitlements to social care—

Lord Mawhinney: I am talking about getting rid of a government department and going back to where we were 25 or 30 years ago, with one organisation responsible for healthcare and all social care. What would the budget be in 2016-17? Remind us what it is for health and tell us what it would be if you integrated the whole lot.

Andrew Baigent: The budget for health in 2016-17 is £115,611,000,000. I cannot answer the second part of the question.

Graham Duncan: For social care, it is about £15 billion this year. There is one department responsible for health policy and adult social care policy. That is the Department of Health.

Baroness Blackstone: May I ask a very simple question? Will next year's budget for the NHS deal with the predicted funding gap or not?

Andrew Baigent: I believe that it will.

Baroness Blackstone: What about the year after and the year after that?

Andrew Baigent: I believe that, as a whole, we will balance in 2016-17.

Baroness Blackstone: You believe that, but you are not sure.

Andrew Baigent: No, I am confident.

The Chairman: Lord Warner, can we move on to the next question?

Q9 **Lord Warner:** Can I move away from the big picture to a bit more detail about how people get paid in this great and glorious system? What work and analysis have the Government done on different pricing structures and financial payment systems to help to improve how money is spent?

Andrew Baigent: I return to the five year forward view. We have been looking at different models of delivering healthcare. MCPs—multi-specialty community providers—and the primary and acute care systems or PACS are looking at different ways of funding healthcare, based on a whole local health economy. We believe that that is a good way to do some pilots, to see whether it works and is more effective. While that is evaluated, we will be able to see whether it works going forward and whether it is a better way of funding.

Lord Warner: How quickly will that happen? For most of the five year forward view, will you just stick with payment by results and local commissioning?

Andrew Baigent: Those areas are being implemented now. As we go through, it will happen fairly quickly and we will evaluate it and take it forward. At the moment, we are sticking with payment by results for the majority of the NHS, but that is not written in stone. It continues to be looked at from year to year.

Lord Warner: Most of your deficits are in acute hospitals. Many outside experts would say that what you have is supplier-induced demand. What are you doing about that? Supplier-induced demand could blow the five year forward view out of the water. What are you doing in the here and now to change the system rapidly? I do not get a sense of urgency about any of this.

Andrew Baigent: NHS England is looking at the local sustainability and transformation plans, which are regionally based. We are quite far on in the process of those initial plans coming in. They look at the local health economy as a whole. I do not have the detail, because that work is being led by NHS England.

Lord Warner: At the end of the day, it will be your political boss who takes the rap for the budget being out of control. I know that, because I had the painful experience of having to deal with it. The Department of Health cannot say that this is all down to NHS England. We as a Committee need to know what the Health Secretary's department is doing about improving the payment systems. Where are you? Personally, I

would like a report—with some timescales in it—showing what you are doing over the next two or three years to change those systems.

Andrew Baigent: I come back to the work that is being done on the local sustainability and transformation plans and how they will be funded. We have asked NHS England to lead on that. Ministers and officials are working with NHS England to deliver it. At the moment, it is too early to talk to the Committee about the outcomes of that work.

Lord Warner: We are not asking for the outcomes. I am asking about payment systems. Payment systems are separate from those plans. As I understand your answer, you are relying on payment by results and local commissioning, a system that has led you to the deficits that you have now. What is going to change, in significant terms, to make sure that there is some lasting sustainability in these arrangements?

Andrew Baigent: As you say, at the moment we are relying on those mechanisms.

Dr Edward Scully: There is exploratory work being done around capitated budgets. Monitor, working with the Department of Health, instigated work on a possible shift. As you probably know, the rules allow areas to shift on to capitated budgets and off payment by results. One area in the vanguard is Stockport, which is using weighted capitated budgets. You have seen examples internationally such as Valencia, where they have gone to capitated budgets and think that they have made 30% reductions around emergency admissions. There is some developmental work going on between the department and what is now NHS Improvement around what that would be. However, as Andrew said, it is early days. There is concern that there may be some inherent risks around using capitated budgets, so there is a desire to trial them slowly.

Lord Warner: Let us have some more information about how many trials there are, how many parts of the country have moved away from the present system, what the success is and how fast you are going to change. Personally, I cannot see how you can deliver the five-year view and produce a sustainable NHS, in funding terms, when you are carrying on using the system that has got you into a mess in the first place.

Dr Edward Scully: We can provide information about the areas that are doing it and the timescales for the project.

The Chairman: We would be grateful if we could have that information. Lord Ribeiro, you have some questions on workforce. We have heard about the plan, but you have some supplementaries.

Q10 **Lord Ribeiro:** You have already told us something about the workforce issues. In 2001, the Wanless report identified that there would need to be skill mixtures and changes in the workforce in time to come. Currently, some two-thirds of the health service budget goes on salaries and wages for staff. We also have an issue on the question of international migration and the fact that some 10% of our doctors and 4% of nurses currently come from the EU. What modelling or planning has been done? You have talked about what the Centre for Workforce Intelligence has done up to 2035. How much of that was done against the background that there may well be a change to staffing coming in from the EU and of our

commitment to reduce poaching, if you like that word—taking nurses and doctors from low-income countries?

Gavin Larnner: I will need to check in what detail *Horizon 2035* looked at future migration patterns. The Health Education England annual planning process for commissioning not just medical training, but nursing and allied health professional training, tries to take account of who will fall out of the domestic population and what the scope for international recruitment is to fill those gaps. As you say, currently about 5% of NHS staff are EU nationals. The figure is higher in places like London. Across social care, it is slightly higher still, at about 6%. We will continue to need international recruitment for some time, even if we increase domestic supply to try to become less dependent on that.

Lord Ribeiro: In the modelling that has been done—in the Centre for Workforce Intelligence work, we are talking about 2035—how much of the proportion of migrant staff has been modelled to tell us how many of our own staff need to be recruited to overcome that? If we stick with a policy of not recruiting from low-income countries—and we made that decision as a policy decision—how do we fill the gap?

Gavin Larnner: I will need to check the report and write to the Chair on that. I am sorry.

Baroness Blackstone: I want to ask you about the present skills mix and how far you think that is appropriate for the next five to 10 years. Does it need to be changed? Are there ways of changing it that would help us to reduce costs and to deal with the deficit we talked about earlier?

Gavin Larnner: With the introduction of new roles, such as 1,000 nursing associates and 1,000 physician associates by the end of this Parliament, we are starting to look at how adding less costly roles into the mix can start to free up time for the costlier ones to focus on the things that they do best. A thousand of each is a start. The longer-term picture is that we will continue to need more in the 1 to 4 roles, as there is more chronic disease and long-term conditions around. It is about other, costlier roles, such as senior nurses and doctors, being able to flex more readily and to adapt to changing circumstances.

Baroness Blackstone: How will you bring that about and get this more flexible mix? Which areas in the higher-level skills groups do you see being reduced, possibly, as a result of bringing in more people with lower-level skills to work in the NHS?

Gavin Larnner: At the moment, we are not talking about reducing any levels. Overall, the current plan is for the workforce to stay relatively stable in size over the next five years, but with an increase of 6,000 extra consultants, 5,000 extra doctors in primary care and another 5,000 staff in primary care. There will be more support grades, such as the counsellors for mental health, as part of the IAPT scheme. Overall, HEE is planning to continue to increase medicine each year and to increase nursing by about 260 places a year, which will give us another 20,000 by 2020. For the moment, the workforce is relatively stable in its composition, but it will need to become more dependent on assistants and lower grades as demand increases.

Baroness Blackstone: There seems to be a bit of a contradiction in what you are saying. On the one hand, you are saying that you need more lower-level skills in the NHS, to take some of the work away from people with higher-level skills. However, at the same time, you are saying that you also need more nurses and that you are not changing the medical manpower numbers. What you seem to be saying is that NHS manpower will simply go on growing. If that is true, what impact does it have on the current cost problems?

Gavin Larnar: How it grows after 2020-21 depends on the resources that are put into the system and what we can afford. What I am saying is that, for now, the pattern in the five year forward view is for the overall workforce to stay fairly stable in size, but for there to be an increase in the number of nurses, the number of consultants and the number of doctors in general practice. Beyond that, the planning-out work that I mentioned earlier—the 15-year forward view and the 2035 forward view—needs to inform HEE commissioning over the next two, three or four years, to grow the numbers that we need for the 2020s and the 2030s. At the same time, there is a piece of work about continuing professional development of the existing stock of people we have and how we adapt them to the new challenges that we face.

Q11 **Lord Willis of Knaresborough:** I have been quite impressed—I am not always negative—by what HEE is attempting to do, in looking forward to 2035. I declare an interest here, having produced the work on nursing assistants. It is the devil's job to get any change at all within the silo-laden protectionism of the professional groups within the NHS. It was absolutely horrendous simply to get in that one change and to classify it not as lower-cost staff but as staff doing a more appropriate job. First, what you are going to do to attack the real challenges within junior doctors and the consultant workforce, for example, of having greater generic specialisms, rather than simply more and more of the same? Secondly, what are you doing about the huge issue of attrition? We lose about 25% of our nurses during their training and another 25% in their first three years on the wards. We cannot afford to do that. What plans are in place to deal with those two massive workforce issues?

Gavin Larnar: On the last point, NHS Improvement is currently reviewing turnover, retention and attrition. NHS Employers is also working on that. We are hoping for the outcome of that in the autumn, to give a sense of what short-term things you can practically do.

Lord Willis of Knaresborough: Could we have that? I think that it is important.

Gavin Larnar: I can certainly give you an update on where they have got to so far.

The first question was about the slow nature of the change in the skill mix. I agree that there are strong culturally conservative parts of our healthcare system, where the different professional tribes see particular ways of delivering services. That is not necessarily always a self-regarding thing—it can be a genuine concern about what they feel is the best place to deliver the safest care. There is a lot of work to be done, partly on new models of care, in some of the vanguard stuff that is going on in the five

year forward view, to put in charge the leadership that can build trust with clinicians—particularly senior doctors, who are often the enabler, the “vetoer” or the enthusiast for change—so that they really give these things a go. Alongside the technical, technocratic stuff of commissioning numbers of places and designing new roles, there is a leadership and culture shift piece that is probably more difficult. We need to talk about that a lot more and to support leaders in pushing it. It is particularly powerful when professionals themselves step out of their particular cultural places in the name of the higher calling of patient care to do new and interesting things.

The Chairman: So there is a lot of thinking but no action as yet.

Gavin Larnar: There is quite a lot of work going on in Health Education England about the roles themselves and commissioning new roles and a new skill mix. What is difficult is for leaders and staff who are dealing with the pressure of how to create the headroom to do the change that will help us to move forward on this.

Q12 **Lord Warner:** May I come back to the issue of the capability of the system to deliver what you may want? I appreciate that you have been here for only four weeks, so I will be very gentle about this. Somewhere in the system—whether it is by you, Health Education England or whoever—presumably some work must be being done on whether there will be the capacity in the training schools, the educational institutions and the practice placements to deliver more people. It is no good saying, “We need X thousand more nurses”, or whatever. What work is being done on the capacity of the system to deliver that?

Gavin Larnar: I will need to check back on medicine, because I have not delved into that area yet. With the current work to reform the funding of nursing education and allied health professional education, we are talking to Universities UK and HEFCE about how we can get the high-quality placements that we need to allow expansion of 10,000 places by the end of the Parliament. All that I can say at the moment is that those discussions are going on. We will publish proposals in the autumn about how we think that will work.

Lord Warner: Is there a financial risk problem associated with that? Who takes the risk?

Gavin Larnar: There is a discussion about how that is shared across the system.

Baroness Blackstone: Following up what Lord Warner and Lord Willis have just asked you about, is anybody thinking more radically about existing roles and whether they are all fit for purpose? About half of our medical workforce are GPs. It is not clear to me whether, in the longer term, the current role of GPs will be the right one for the kind of system that we need. Who is thinking about that? If you are not doing it in the Department of Health, who is doing it elsewhere? Can you tell the Committee a bit about that?

Gavin Larnar: There has been a bit of thinking in think tank-land. The Health Foundation, the Nuffield Trust and the King’s Fund have all

touched on this area. In the past, the Royal College of Physicians' future hospital report looked at it a bit, as did Greenaway.

The Chairman: They are think tanks. They are not official government bodies. Baroness Blackstone is asking who is doing the thinking.

Gavin Larner: Strategically, within the system, it would sit with Health Education England to do that thinking. However, it is legitimate to say that there needs to be a conversation around the system, in the light of the 15-year strategy and the 2035 strategy that I keep mentioning, about what that means for medicine and whether we can start to think a bit harder about what we recommission.

Lord Mawhinney: You have been extremely gracious in saying, when you did not know the answer, that you would write to us briefly. In the next week or 10 days, would you write to us with the names of three or four people in the department—or in government—who are thinking about this, so that we can see what they are thinking?

Gavin Larner: Certainly.

The Chairman: We could get evidence from them.

Dr Edward Scully: In one niche area, Ministers in the department have commissioned Health Education England and Skills for Care to go away and do a strategic piece of work, to think about the workforce requirements for a better-integrated system. There are three areas they have focused on, in talking to me. The first is capacity and numbers, particularly around those groups that straddle both health and social care. I am thinking particularly about OTs and care workers. The second area is what we call co-ordination. You have touched on new roles. They have been commissioned to look at what new roles may be required. I am thinking particularly about new emergency roles—care co-ordinators, care navigators and the various different names that we have seen emerge in pioneers and vanguards. The third area is culture. They have been asked to go away and think about what the different issues are if you have two systems that have existed in very separate places—Lord Willis touched on the fact that you have a lot of professional silos—and what is required with regard to leadership and culture to start to get the two to operate in a proper multidisciplinary fashion.

The Chairman: I will take a quick question from Lord Ribeiro and then move on to Lord Lipsey.

Lord Ribeiro: You have talked a lot about roles, et cetera, but there is the question of the gender and feminisation of the workforce. Not only is there a demand for work/life balance, which affects males as well as females, but it is quite clear that there will be far more job sharing and part-time working. That will have an implication for staffing costs. Is there any long-term modelling on that?

Gavin Larner: I will need to check back.

The Chairman: That is another one you will have to write to us about.

Gavin Larner: I am sorry.

Q13 **Lord Lipsey:** We have not been able to resist touching on social care and

health integration already, slightly ahead of the agenda, but I would like to ask two specific questions. As soon as you start thinking about this subject, it is pretty obvious that integrating the two is very difficult unless you have integrated budgets. I first wrote that in 1999, in the minority report of the Royal Commission on Long-Term Care. Could you tell us where we are now on integrating local authority and health inputs into budgets?

Dr Edward Scully: Yes, of course. As Graham touched on before, the better care fund was initiated last year. That was the first national step to try to bring them together formally. The initial pooling amount was £3.8 billion for 2015-16, but local areas went above and beyond that, to £5.3 billion, which showed that there was appetite for it. In the next week or two, we will announce that we believe that the amount for the better care fund and pooled budgets will go up to £6 billion this year. We think it has been shown that there is some appetite for that.

As you know, the Government are trying to bring together a number of different pieces of advice on health and social care integration. As I see it, there are three different layers and three different ways of integrating. You can integrate at the person level, at the commissioning level and at the provider level. The better care fund is geared to trying to integrate at the commissioner level, to try to bring about better strategic alignment. As Graham touched on before, it is about relationships, but it goes beyond that—it is about how you start to get people to walk in one another's shoes. Our early informal feedback on the better care fund was that, while some areas—particularly advanced ones—said that it had held them back a bit, because there was quite a bit of bureaucracy, there were a number of areas where the chief executives of the different organisations had never even spoken to each other. We found that the better care fund brought people together to start that strategic alignment.

On integrating at the provider level, I have mentioned the vanguards. My personal belief is that that is one of the most effective ways forward. Integrating the budgets and the commissioner level is a means to an end, because the way in which people experience better joined-up services is through joined-up services at the provider level.

I have two more points. Your question was specifically about budgets and commissioning. In the last six months, we have changed the regulations to enable GPs to access the better care fund from this year. We are also going to undertake further exploratory policy work and to consult on whether the secondary regulations that enable the better care fund and pooled budgets are still fit for purpose, because of feedback that we have had. Greater Manchester, for example, is using Section 75 for the Greater Manchester integration, but it was not designed for something on that scale. We think that we need to look at it again to see what changes we may need to make to enable integration on a greater scale.

Lord Lipsey: The second question that I want to ask is this. Better integration is used practically as the magic wand to solve the health service's sustainability problem. I was therefore very struck to read the report by the National Audit Office, which casts grave doubts on whether you will be able to save a lot of money in that way. Do you have any comment to make on the NAO report, or do you accept its findings?

Dr Edward Scully: My own take is that the potential for savings through integration of health and social care is not what people have set out; it is more limited. It is not a utopia or a panacea for releasing savings. We have done some internal work and believe that it could release savings in the region of £300 million to £500 million a year.

Lord Turnberg: I wonder whether there has been any follow-up on the Dalton report, in which Sir David Dalton produced a summary of examples around the country where services have been integrated in different ways. He, of course, has done it quite successfully in Salford. Where has that movement got to now? Is it spreading? These are local initiatives.

Dr Edward Scully: They are spreading. That is part of the point of the five-year forward view vanguards, of which Salford is one. The difficulty with the vanguards is separating it out. Not all the vanguards cover integration of health and social care; only a much more limited subsection of the 50 do. For the primary and acute care system model, you have Salford. Northumberland is another good example. There is the Symphony project in South Somerset. Some of the multi-specialty community provider models also integrate: Stockport Together is one of them. There is spread.

My own take, from going around the country and visiting areas such as Cornwall, Greenwich and South Warwickshire, is that it is happening, but it is incredibly dependent on local leadership. Wherever I see a big, successful project that is well done, I encounter dynamic leaders who are almost social entrepreneurs—who spot where the gaps are and how they can improve things. That is my take. It is spreading, and the vanguard and pioneers programmes are there to drive it. We are also trying to drive it through the better care fund. It is spreading, but there is still a fair way to go.

Lord Turnberg: It is local leadership that we need.

Dr Edward Scully: It is local leadership. There are a number of factors. I do not know whether you want me to go into them, as I know that this is question 5 and I may be going off the point. There is a paradoxical factor around organisations. It is stating the obvious, but you have completely different organisational structures and different access and entitlements. There is a lack of coterminosity. On the one hand, we see that the structural issues are really important. On the other, we are being told by areas, “Please do not reorganise again, whatever you do”. It is about taking on board and understanding that, although it is difficult because of the structural issues, from the bottom up we are hearing, “Do not reorganise”.

One thing that is worth dropping in here is the sustainability and transformation plan process, which is a genuine attempt to go for place-based commissioning. That is why it is trying to involve the local NHS plus social care plus public health, to bring them all together to plan on a five-year, more strategic basis.

Q14 **Lord Bradley:** I have two questions. One is on the short term. Do you think that, through those initiatives—the better care fund and the transformation fund—enough money is being put in to allow that change

to take place in a timely way, sometimes with double running of services, so that an alternative, community-based service that the public will have confidence in is in place before a service is shifted out of the acute sector? Do you not see a continued tension between the acute sector not wanting to give up some of its financial control over local health economies and shifting that money into the community? To extend that further, while we have been slightly depressed by the short-term thinking of the Department of Health, where do you think you want to get to? What is the strategic planning for the balance between hospital-based and community-based care over the next 15 to 20 years?

The Chairman: The emphasis being on the next 15 to 20 years.

Dr Edward Scully: On the transformation of funding, I know that some areas have managed to do a bit of double running. In an ideal world, you would double-run when trying to change the configuration of provision of services in local areas. It is always a challenge for areas. You have touched on the transformation of funding for vanguard areas. One of them, in Manchester, got £450 million over the period to help with that.

Lord Bradley: Over the five years?

Dr Edward Scully: Over the five years. That is obviously a massive help. In an ideal world, you would want that.

Your third question was about the longer-term plan. Last year, the spending review set out a commitment to drive better health and social integration and for areas to have plans in 2017 for how they will integrate more fully by 2020. It is still the Government's intention to fulfil that SR commitment. There is a lot of work going on at the moment between departments—DCLG, the Treasury and the Department of Health, working with NHS England—on how that is done. That is still in policy development. Unfortunately, I cannot talk too much about it, because it is still being worked up. We are consulting the Local Government Association, ADASS and NHS colleagues on making that a reality.

Could you remind me of your second question?

The Chairman: I think you have covered part of it.

Q15 **Baroness Redfern:** I have a very quick question. You have talked about pooled budgets, working with partners, et cetera. How far have we come with sharing data? There has always been a nervousness about confidentiality and sharing data. I wonder whether you can give us some evidence on how we can integrate and share data.

Dr Edward Scully: Tim is the expert, so I will hand over to him on this.

Tim Donohoe: This has long been recognised as one of the areas in which we need to make progress. Our national data guardian, Dame Fiona Caldicott, reported a few days ago. What she has proposed is intended to help people across the system understand what their responsibilities are to protect information and to make it much simpler for people to share information for legitimate purposes, when necessary. That will be one of the key underpinning changes. A period of consultation has now started on that, to give people a chance to comment on the opt-out model that is being proposed. That will form the basis on which we then test a model

that is acceptable and simple enough for people to understand, so that people can feel that their data are being used for what they see as legitimate purposes and they are not surprised to find their data being used in a particular way.

Dame Fiona's report shows that, by and large, people have confidence in the NHS to protect their data. Data breaches, when they occur, are seen as undermining that trust. The other angle of what Dame Fiona is proposing is very much to make this a leadership issue. This is something that leaders of organisations have to take as seriously as they take financial accountability and accountability for outcomes. It should become part of the CQC inspection regime going forward. That is slightly the negative side of it. The key point is the potential to use the data to improve outcomes at individual patient level and to integrate services. The data in and of themselves are not of use—it is about what you do with it to plan service and population health. That is what we hope Dame Fiona's report will unlock.

Lord Mawhinney: Dr Scully, you have told us about plans better to integrate health and social care and that by 2020 they ought to be reasonably well integrated. I think that that is a fair reflection of what you said.

Dr Edward Scully: Yes.

Lord Mawhinney: Although it is only for the next five years, of course. We are constantly bombarded with anecdotal and factual evidence that—if they are lucky—frail, elderly people at home may get two visits a day, each of 25 minutes, from a care worker. In 2020, with this newly integrated health and social care system, how many visits can frail, elderly people at home expect to receive, and of what length?

Dr Edward Scully: It is impossible to specify how many there will be and of what length. You hear stories where an NHS person goes in to treat one part of a person and someone from social care also goes in to see them. The belief is that, if you bring the two systems together, you can release some allocative and technical efficiencies. By doing that, hopefully you should be able to invest more time in people. That is the thinking behind this.

Lord Mawhinney: If you will forgive me for saying so, that is just not acceptable. It is absolutely not impressive. One of the things that has characterised the last hour and a half has been that you are very good at plans, reviews and thinking—though not at strategy—and the patients are not getting a mention. When I ask about a patient, there are blank looks. Your body language is quite clear. Just as the deputy director for care in the Department for Communities and Local Government thought that I did not know that health was responsible for absolutely everything, you think that it is unreasonable of me to ask, from a patient point of view, what the advantage will be of this integrated system, which goes only up to 2020.

Dr Edward Scully: I do not think it is at all unreasonable for you to say—

Lord Mawhinney: When will you be able to answer it?

Dr Edward Scully: There are two points. First, it is not unreasonable. The whole point of the integrated care agenda is to improve care for people, so that they do not go from pillar to post in different parts of the system and they get a proper, decent service, co-ordinated care and a proper care plan. That is the whole point of it, and that is what we have worked for. For the last two years, I have been doing that. It is not at all unreasonable of you, but I can guarantee that that is our whole focus. If anything, my experience of working on the integrated care agenda for two years has made me believe—the evidence shows this—that better integrated care, when you start to make one service, will lead to a much better patient experience and much better outcomes, but not necessarily to massive efficiencies. You will get some technical and allocative efficiencies, but not massive ones.

I did not think that it was unreasonable. All that I was trying to get across was that it is quite hard to specify the exact implication in five years' time of different resource levels. That is partly because, at the moment, social care is run by local government. There is a single set of eligibility criteria, but there is still some difference between how services are provided by different local authorities. I do not want to give you an answer that will not be true and that I do not think I can give.

Lord Mawhinney: The Department of Health is responsible for everything in this area. I think that I am right in saying that I was the Minister—or one of the Ministers—responsible for the introduction of community care 25 years ago. Mr Duncan tells us that it is still on a journey and has not yet got to the end of that, so we do not know what the outcome is going to be. Is your integrated care on a 30-year journey? If it is, you need to be careful, otherwise you will have to do some long-term thinking.

Dr Edward Scully: I can assure you that we have done some long-term thinking around the integrated care agenda. That is why we have done the basis of whether we think that we have released enough efficiencies.

Baroness Redfern: It worked well when public health came into local authorities. That was really good and that was moved on very quickly.

Dr Edward Scully: I totally agree with that.

Q16 **Lord Scriven:** May I ask about disruptive technology, digitisation and data, which are affecting every industry and how humans work with organisations? Where is the NHS with digitisation? Could you give me a percentage of services, rather than just what is happening? Where are we with integration of data, either around personalisation within health or— one question has already been asked about this—across different organisations? What percentage is really integrated? What are the issues?

Tim Donohoe: We think about it in this way. First and foremost, are the technologies in place at individual organisational level? Beyond that, are they being used to deliver services? Beyond that, the third level is whether those services are integrated and the technology is serving that integration. When you look across health and social care, you see a mixed picture. For example, something in excess of 98% of GP practices use an electronic system for patient records and in the administration of their

practice. You can look at some of the national services—things like the summary care record. A very high percentage of patients now have a record. Those are starting to become available across different care settings. Forgive me, as I do not have all the percentages in front of me. However, I can certainly let you have the current figures.

The area where there is much to be done is in the digital maturity of the provider sector—the extent to which systems are in place and are being used within individual organisations—and in integration at local level, so that local care teams have a single view of a patient and know what is happening across all the different organisations involved in that patient's treatment. Over time, we have seen a swing in policy. At one time, we saw a drive to centralisation, which was seen as a top-down attempt to impose standards and technologies on the system. We have seen very local initiatives. The downside of the very local is that they do not tend to spread beyond the areas in which they are initiated. Where we are now is that the department has taken a slightly different view of how this will—

The Chairman: Mr Donohoe, answer the question that Lord Scriven asked. You are not answering. You are giving us what the thinking is, as all of you have done for most of the morning. Can you say where you wish to be in, say, 2025? Where do you expect to be? What are the steps from now until then that you can take to achieve that?

Tim Donohoe: There is a whole programme in place. With respect, I am trying to answer the question. I am trying to set out everything that is currently in train as a result of what we have learned over the past decade about what works and what does not work. The department has created a National Information Board, which brings together stakeholders from across the system. That group has taken some of the challenges set out in the five year forward view and tried to look at the technologies that will permit a different approach to service delivery.

In the question, you asked about disruption. Technology can disrupt in two ways. It can disrupt in an adverse way—we have seen lots of that in the past—and it can disrupt in a very positive way, because of the transformation that it makes possible.

Lord Scriven: Yes, but in the NHS it tends to be disruptive technology, because of lack of planning from the centre. What I am trying to get at is this. Clearly, this will be a huge step change in the way in which health and social care are provided, because it is happening across cultures. I am not clear about what the plan is over the next 10 to 15 years to implement this successfully. What is in place? What planning is there? You keep coming back to local leadership, so it is not just about what you do at national level. What is there to increase capacity down at local level to implement this in a way that is clever and smart, as well as integrated?

Tim Donohoe: You are absolutely right to emphasise the local aspect. In the National Information Board, we have tried to bring local stakeholders and people who are succeeding at local level in integrating information and services right into the heart of what we are trying to do over the next decade. Right now, there is a programme of investment that leads to 2020. That will put in place the ability for the system to become much more digitally mature in general. Within that set of initiatives, there are

specific things around integration of social care, for example, which we have discussed already. There are things about making sure that local leadership teams are sufficiently skilled and sufficiently aware of what technology can do, so that they see technologies not just as projects for implementing technology, but as change processes, and have a clear view of the outcomes we are trying to get to.

Lord Scriven: You have raised a really important issue—that it is not just about the technology. What incentives or changes in payments are being put in place to encourage this kind of working?

Tim Donohoe: Right now, the focus is on making sure that the technologies are in place and helping to make funding available to local organisations, so that they can select and choose the technologies. Each local area has been asked to put together a digital road map, which essentially sets out—

Lord Scriven: Can I ask the question again? What planning is going on to incentivise the use of this type of work that proves to be successful, at scale?

Tim Donohoe: I cannot answer specifically around incentivisation.

Dr Edward Scully: I do not believe that there is specific incentivisation of ways—

Lord Scriven: So good practice could happen, but there is no incentive for it to be taken at scale across the NHS. Is that what you saying?

Dr Edward Scully: It will try to drive the spread of good practice in other ways, but not necessarily through incentivisation. With the new care models, I know that there is a National Information Board team whose specific role is to go out to local areas to try to spread best practice.

Lord Scriven: What percentage of services are digitised now? In forward planning for 2020 and 2020-plus, what assumptions are there? What will need to be put in place to do that?

Tim Donohoe: It is very hard to give an answer on a service-by-service level. There are services that are offered. We can be very clear about the extent to which those services are being taken up. There are the things that I have mentioned, such as the summary care record. At local level, we do not have a clear picture. NHS England has done the first iteration of something called the digital maturity index, which sampled acute providers and asked them to self-assess the extent to which their services were being offered and technology was being utilised in the delivery of those services. Again, that showed a very mixed picture. The results were published on the “My NHS” website a few weeks ago. If it would be helpful, we could try to summarise those and give you a written response.

Lord Warner: Who is in charge of all this? I have heard many of the same answers that you have given from NHS England staff. Do we have two lines of command and control?

Tim Donohoe: No, absolutely not.

Lord Warner: Explain the difference.

Tim Donohoe: The department's role here is to steward the system. In this context, that means that we have within NHS England a recently appointed CCIO, Professor Keith McNeil, who will be responsible, on behalf of the whole health and social care system, for commissioning the technologies, the services and the enablers that we believe the system needs. Most of that will be delivered by what was formerly known as the Health and Social Care Information Centre and is now called NHS Digital. The department's role is a strategic one. It is overseeing that and assuring the delivery, to make sure that the things that are being funded are being delivered.

Lord Warner: Can I stop you? I have heard some of these people. They are rather impressive. Why do we need you?

Tim Donohoe: The system that we have designed needs someone to oversee it. It needs to be clear. If things are not working in the system for any reason, which we have seen in the past, part of the function of the department will be to look at those arrangements over time, to make sure that they are working. When it comes to hands-on delivery, we are trying to make sure that the people who are best able to do that are given every chance to succeed and to deliver what we think will help the system.

Lord Scriven: *Making IT Work* is a report that was meant to be published in June 2016. That is when it was meant to be published.

Tim Donohoe: Yes—Professor Wachter's review.

Lord Scriven: Where are we with that? That is exactly the work that you should be doing, which is about the first base—getting the right IT in place. Why has it not been published yet? What are the issues?

Tim Donohoe: My understanding is that Professor Wachter's report will be published in September.

Lord Scriven: So it is late.

Tim Donohoe: Yes—partly because of the referendum, but partly because there was a need to do some further work in a couple of areas.

The Chairman: So, hopefully, by September we will get a report from you on that. We have been informed of how important disease-based informatics will be to getting better outcomes for the patient, reducing cost in health and social care and increasing productivity in both health and social care. Will NHS Digital be responsible for driving that informatics?

Tim Donohoe: NHS Digital is essentially responsible for delivery. That may mean that, on occasion, it will directly build and supply technologies, but it also means that it will procure technologies on behalf of the system, where necessary, or administer the funding that has been put out to the system to enable it to supply its own technology.

The Chairman: My question is about long-term thinking. Is that being done now? Will it be done—or may it be done?

Tim Donohoe: We have done some initial work within the department on the period beyond 2025. As Professor McNeil has taken up the post—

The Chairman: Why is it that, when the evidence has been available for

several years on how such information can improve outcomes, reduce costs and increase productivity, you are just beginning to think about doing some thinking?

Tim Donohoe: That is a rather unfair characterisation, if I may say so. The thinking has been going on. Over the last year or so, the effort has gone into the immediate pressures of responding to the five year forward view, building on some of the technologies that we could see working and making a difference out in the service, and trying to plan that at national level, to ensure that we have a coherent delivery that is not another major IT programme, but a series of targeted interventions that are specifically grouped around some of the transformations that we need to see in the system. Many of these technologies will remain and have a long-term relevance. On population health, integrated datasets will permit the kind of analysis you are referring to. That is what we are trying to achieve with this.

Q17 **Lord Turnberg:** Everyone agrees that public health and prevention are very important. It is one of the most difficult areas in which to work and to demonstrate that we are doing anything good, apart from in a few small areas. The question is: what is the long-term strategy for public health and prevention, particularly given that it is so dependent on the public themselves? How do we get them engaged in the long term? Have Ministers asked you to develop a long-term strategy?

Mark Davies: As a director of population health, I will answer that. Our long-term strategy has three elements to it. You are seeing some of them being implemented as we speak. Baroness Redfern referred to the move of public health into local government. That has happened. It is still in transition, but, by and large, it is seen as a positive move. It gives leadership to local government and allows it to work across all responsibilities and to look at health in all policies. At the same time, we have developed Public Health England as the delivery vehicle that provides the evidence and supports local government. We have also given NHS England a key role, through Section 7A of the legislation, which allows us to commission it to do really important work on immunisation, vaccination and screening. That seems to be working very well at the moment.

The third element is what we are doing about particular issues and looking forward at some of the biggest killers across the health and care system. We are quite proud as a nation that, effectively, we lead the world on smoking and tobacco control. We have done an enormous amount of work there. All this is subject to political considerations, but we are planning to do a further tobacco control plan, which will push beyond the work that we have done on plain packaging, smoking in cars and those sorts of things. We have got the level of smoking down to 18% of the population, which is one of the best in the world, but we still have 8 million people smoking. We think that that leads to about 80,000 deaths per year. There is a huge opportunity to address that and that is what we are planning to do.

The other area—the second biggest cause of death—is obesity, which is a developing problem. We have been working for many months on a

childhood obesity strategy. There is a lot of anticipation about that piece of work. We have one prepared. It has been announced that it will be launched in the summer, but we are still waiting to press the button on it. If and when it is published, we hope that it will be a really cross-sectoral look at all aspects of childhood obesity and all the things that drive it, including behaviour, family attitude, promotion, reformulation of food and what happens in school. We are working on a comprehensive strategy. It is a long-term strategy. If we get it right, it will have intergenerational impact and will stretch way beyond the next five or 10 years.

As part of the five year forward view, NHS England has done an important piece of work on diabetes prevention, looking at the needs of adults at risk of diabetes. That programme is starting to roll out. I see it as a long-term programme. What we do now will impact on adults' need for services in 15, 20 or 30 years' time.

There are three elements: shifting responsibility to different parts of the system and making it clearer; putting the national organisations in the lead of various elements of it; and thinking about the biggest killers. That is our long-term strategy.

Lord Turnberg: It sounds as if we are just carrying on with what we know now. Has there been any thinking about looking at how we might begin screening populations? As we develop genetic tests, might detecting genetic predispositions to diseases come into your planning for the future, along with how we detect disease early, before it is symptomatic, and how we prevent it? Will you ever take folic acid supplementation of the diet on to your agenda? There are big issues of dementia and early detection. There are all sorts of techniques coming along. How far are you taking those into account in your planning for the future, quite apart from the ones we know about?

Mark Davies: The good thing about the public health world is that we are blessed with good evidence and people doing a lot of thinking about this work. We have our vaccination and immunisation programme. We should be proud as a nation that that is informed by the best evidence from the Joint Committee on Vaccination and Immunisation. Genomics England is doing the work on sequencing the human genome. That is slightly out of my knowledge area.

Lord Turnberg: It is the sort of thing it is doing that you might take into account in developing a plan for the future.

Mark Davies: Of course. In a sense, that is why one of the key functions of Public Health England is to bring together that evidence and to be objective about the way in which it is presented. We look to Public Health England to advise both us and NHS England on exactly that. I am confident that that work is taking place within Public Health England.

Dementia is a relatively rapidly developing area of knowledge. We know that we are starting to find ways of addressing and preventing dementia, but that is all in development. We need to find a way—that is what we ask Public Health England to do—of putting it into the mainstream, so that we can apply it nationally and across all areas.

The Chairman: I am well aware that we have gone slightly over time,

but we started slightly late. I see that there is still passion to ask you some very relevant questions, because we will not get you again.

Q18 Bishop of Carlisle: On the question of prevention, can I take you back to what you said earlier about workforce? If we are going to take prevention much more seriously, are there any implications for the make-up of the workforce—for instance, the employment of health visitors, whom you have not mentioned thus far?

The Chairman: Please keep the answers short—yes, no, maybe or absolutely.

Mark Davies: I am sure that the answer is yes, but that is probably not enough. It is more about what the workforce does. In deploying the workforce to help people to make beneficial changes to their behaviour, the form of words that we use is “making every contact count”. That is about the workforce being more adept at spotting the opportunities to intervene. For example, the health check that all people over a certain age are invited to do now includes an alcohol element because, opportunistically, you can ask questions about people’s alcohol consumption, which has an important impact on their future. It is a workforce issue, but it is not about the type of workforce—it is about what the workforce does.

Lord Scriven: In answer to Lord Warner’s question earlier, you said that your role was to oversee the system when it was not working well. There is a real example of where the system is not working at the moment. That is on PrEP for HIV, where different parts of the system are arguing. I do not want you to take PrEP, because I understand there are legal issues involved, but I want to use it as an example. Given that people in the system are arguing about who is responsible for PrEP and we want to move to prevention, what work will you do in the long term to make sure that we do not get another PrEP situation, so that we are working together for prevention, rather than arguing about who will pay for it?

Mark Davies: I believe that the PrEP issue will be resolved—

Lord Scriven: I want to use that as an example of the wider system.

Mark Davies: I am relatively new to this area of the system, but I have not observed many cases where we dispute who is responsible. NHS England has taken a particular view on PrEP, which has been challenged. Mostly, these things are resolved. It is not really an issue. This one is a particular issue. I am quite new to it, but I assume that it will be resolved in the courts tomorrow.

Lord Scriven: So everybody at local level is working towards prevention.

Mark Davies: I cannot say that everyone at local level is doing that. From the way in which the national organisations work and the way in which we get intelligence from the local level, I think that there is a good focus on prevention. We are still looking at, and kicking the tyres on, the sustainability and transformation plans. However, as I mentioned earlier, they seem to be showing that most areas—43 out of 44—have prevention as one of their highest priorities. That suggests to me that, locally, people are really starting to think about this.

Lord Bradley: I am disappointed that, in your list of initiatives, not one related to mental health. The five year forward view estimated that that costs £100 billion a year as the cost to the whole of the NHS. Comment.

Mark Davies: We have focused mostly on physical health, so that is fair comment. We know less about the behaviours that cause subsequent mental health problems. As was observed previously, I used to be responsible for mental health policy. I helped to implement the IAPT programme and the former National Service Framework for Mental Health. It is less clear what we can do to intervene early to prevent mental health problems. That is an important area for research and investigation. We follow the evidence. The evidence shows that, if you tackle smoking and obesity, you will tackle a significant amount of future disease.

Lord Bradley: So you are arguing for further investment in research into mental health.

Mark Davies: I think that you have identified a gap, Lord Bradley. That is all that I would say.

Q19 **Baroness Blackstone:** I want to come back to obesity. I think I am right in saying that the UK has one of the worst records on grossly obese people. We are close to the top of the league table for the number of people who are hugely overweight. You have not said anything about the food industry. For a very long time, the Government refused to move, but recently they have made some move towards the taxation of food companies that provide food, or particularly drink, that is hugely over-sugared. Do you think that the Government have gone far enough in that respect and that what they have done so far will have any impact?

Mark Davies: We have not published our strategy yet. As the director responsible for the development of the strategy—

The Chairman: When will that strategy appear?

Mark Davies: I do not know. We were planning it, but obviously there have been some changes.

The Chairman: You have been promising this strategy for a long time.

Mark Davies: It was delayed by the referendum, as many things were. That is the case. It is ready. We are hoping to publish it—

The Chairman: What does the referendum have to do with a national strategy on obesity?

Mark Davies: There are European elements to it. Some of the nutrition legislation is founded on European legislation. These are the rules that we have to follow as government officials, I am afraid. We do not make them—we just slavishly observe them. It is up to the politicians to decide when to publish the childhood obesity strategy.

Baroness Blackstone: It is not just up to the politicians. It is also up to the NHS and the Department of Health, which has politicians in it, to reach agreement with their colleagues in other departments.

Mark Davies: Of course.

Baroness Blackstone: It is also up to you and NHS England to have a tougher strategy on the sale of some of these products all over the NHS. You can see them all over our hospitals.

Mark Davies: Indeed. You will find that Simon Stevens has made a commitment to remove unhealthy foods from hospitals. That is something that we want NHS England to pursue rigorously.

You mentioned the food industry. The Chancellor has announced what is known as the soft drinks industry levy—the sugar tax—which will be introduced from 2018. We hope to consult on how that will work very soon. It is a good sign of the importance that the Government place on the need to address unnecessary sugar in food. The childhood obesity strategy, should it be published, addresses the whole range of issues relating to food and the food industry.

Lord Ribeiro: Aside from the fact that we are spending nearly £13 billion on obesity, smoking, inactivity and alcohol, what are you doing to shine a mirror on patients and to ask them who is responsible for their health?

Mark Davies: That is always a challenging one, is it not? We are very clear about our position on smoking. We tax it. We seem to be allowed to tax tobacco as much as we like. We are very clear about regulating things such as where people smoke and how they buy cigarettes. We could not be clearer on tobacco in society.

Alcohol is slightly more difficult, but some really positive work is being done by alcohol-funded initiatives such as Drinkaware, which is very clear about safe drinking. The Chief Medical Officer's guidelines on alcohol are changing as well. We are about to publish the follow-up to the consultation on that, we hope. The guidelines are influential as regards how people perceive their own drinking. Again, we are doing quite a lot on that.

The inactivity issue is more of a challenge, because this is how people live their lives. There is a limit to how far the Government can—

Lord Ribeiro: It is about taking responsibility and making sure that they are aware that they have a responsibility.

Mark Davies: It is, yes. We have made lots of improvements in the way we address alcohol, through the Chief Medical Officer and the messages that the industry puts out, and people's alcohol use, through things like the health checks. The other thing that you may have noticed, which launched earlier this year, is a programme run by Public Health England called One You. It is aimed at unfortunate people like me who have hit middle years, do not do enough exercise and probably have a slightly unhealthy lifestyle.

Q20 **Lord Warner:** Can I bring you back to the money? I have quite good contacts in public health. All the messages that I have been picking up from Public Health England and from the public health people in local government are that, when budgets are tight and there is overspending in prospect, people come calling and cut their budgets. Do we need to be a bit more rigorous about protecting public health budgets nationally and locally?

Mark Davies: The public health budget to local authorities is ring-fenced. Although it has reduced slightly over the last few years, the evidence that we have is that this year local authorities are planning to spend slightly more than the grant, by a small amount. The grant for local authorities is £3.4 billion this year. The plans that we have seen for 2016-17 show planned spending of £3.5 billion, which is a small increase. It is tough, but I do not think that the evidence shows that people are necessarily going straight for public health as the soft option. Only a very small number of local authorities are reducing their spend this year over last. The majority are either keeping it level or increasing it. The evidence is still emerging. It is quite a new set of responsibilities, but I do not get the feeling that this is the place where people are going first.

Lord Warner: Public Health England had £200 million taken out of its budget.

Mark Davies: Indeed. That was a one-off. It will not be repeated, as far as we know. Actually, local authorities seem to have coped with that. I have every admiration for local government in the way it copes with spending.

Baroness Redfern: It has given local authorities more flexibility to use that budget. On mental health, we are doing different things, such as walking. That does not cost a lot of money, but it helps to focus on new ideas and where we can work collaboratively with health.

Q21 **The Chairman:** As I said at the outset, the focus of the inquiry is long-term sustainability, which requires thinking to be done in the long term, as well as looking at the evidence of what developments in healthcare may be coming down the line and how they will impact on delivery and cost, and how you can make the whole system work in the most cost-effective way, based on cost-benefit analysis. From what you have told us today, it appears that there is not such thinking being done in the long term. Do you look at other health systems and how they do their long-term thinking? Is there learning from there?

Dr Edward Scully: From an integration point of view, we do.

The Chairman: Which countries?

Dr Edward Scully: We look at Spain and the United States. We look close to home as well. We have looked at Scotland. We have done visits in Scotland.

The Chairman: So you have some evidence of what you looked at and what you gained or did not gain from that. Have you come to some judgments?

Dr Edward Scully: Yes.

The Chairman: Are you able to send us that evidence?

Dr Edward Scully: I would be happy to. Some of the key bits around that are probably the various different meta-analyses of the evidence and the systematic reviews of both its effectiveness and what it does on outcomes.

The Chairman: No—I am talking about long-term thinking. Have you

looked at other health systems and how they do long-term thinking about their healthcare, social care and preventive care systems?

Dr Edward Scully: We have not.

The Chairman: You have not.

Dr Edward Scully: We have looked at how they do it, all the things that they have done and how they have planned for it. However, we do not have access to their internal long-term planning, so I do not think that that is possible for the specific question of integration.

The Chairman: Surely how they do it cannot be a secret.

Dr Edward Scully: No, it is not a secret how they do it. We have their short-term and medium-term policy frameworks and their example. We do not have the work that they will have done internally about where they see themselves 20 years down the line. We just do not have that.

Mark Davies: On prevention, yes, indeed we do. We talk to other countries all the time and learn from them. On things like smoking, we are probably the leading country in the world, but we still learn from Australia, which was the first to do plain packaging, for example. On the sugary drinks tax, we have looked at what Mexico has done and we look at what France is planning. We are learning from all those countries.

The Chairman: You go on about that, but there are other areas. I explored one with you—informatics. You did not give me the confidence that you were looking at it.

Tim Donohoe: We are certainly talking to other countries. We have done a lot of work with the US on its future thinking around this area. The Wachter review is partly a result of that. I think that there is much more to be done. There is a huge opportunity here, but one of the things we have focused on this morning is slightly beyond the horizon we have been working in.

The Chairman: Thank you very much for coming today. We will send you the transcript of today's session very soon—not for you to change it, but so that you can let us know if there is any misinformation. I know that it has not been easy for you, but we are really trying to find out—to help you for the future—how we can have a system in place that can look at the long-term sustainability of the NHS.

Nuffield Trust, The King's Fund and The Health Foundation – Oral evidence (QQ22-31)

Evidence Session No. 2

Heard in Public

Questions 22 - 31

Tuesday 19 July 2016

10.10 am

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Lord Bradley; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Nigel Edwards, Chief Executive, Nuffield Trust, Richard Murray, Director of Policy, The King's Fund, and Dr Jennifer Dixon, Chief Executive, The Health Foundation.

Q22 The Chairman: Good morning to you all. Welcome. Thank you for coming to help us today with the inquiry that we are doing on NHS sustainability. I have two points. First, we are being broadcast. Any conversation that you may have in private—this applies to all of us—may well be picked up, so be careful what you say. The best thing is to avoid having private conversations. I will let you know when we are off the air. Secondly, a photographer is going around taking photographs of various Committees, so somebody may appear to take your picture. Please ignore him or her. They will go away pretty quickly.

Before we start, if you wish to introduce yourself or to make a statement, please do so. The procedure will be that each of us, in turn, will ask you questions that we have. We want to cover the full gamut of questions that we have for you, so I ask both the Committee and our panel of witnesses to be as short and clear as they possibly can. Who would like to start?

Nigel Edwards: I am Nigel Edwards. I am the chief executive of the Nuffield Trust, which is a health services research and policy think tank.

Richard Murray: I am Richard Murray. I am director of policy at the King's Fund. We are a think tank working in health and social care.

Dr Jennifer Dixon: Hello. I am Jennifer Dixon. I am the chief executive of the Health Foundation, which is an endowed foundation doing policy analysis and giving funds out to the service for quality improvement.

Q23 The Chairman: Thank you very much. Do any of you wish to make a statement? If not, that is good.

The first question is from me. We have statements on what the funding requirements for healthcare will be in the future. The OBR predicts that the figure will go from 6.2% of GDP to 8% in the mid-2060s. On the other hand, we have OECD projections that are quite different. What do you think needs to happen for the health system to be sustainable? I emphasise that this inquiry is interested only in a health system that is sustainable beyond 2025 and further into the future. We do not want to focus on the current issues in the health service. What do you feel needs to happen to make it sustainable in the long term?

Richard Murray: First, particularly over the longer term, with the ageing population and the demographic pressures we are under, you need to think about health and social care. It is already difficult to separate out the health service. It is no longer an island that stands alone from what is going on around social care. As the years go by—particularly as you throw out to those years into the future—you need to think about both at the same time.

Secondly, within the question there is a slightly unspoken assumption, which is that we mean a health service that looks something like the health service of today—a comprehensive health service that is free at the point of use and in which people have confidence. In a very narrow way, you could make the health service sustainable simply by cutting the offer over time—by rolling it back and looking towards alternative sources of funding, such as charging. However, we rather assume that you do not mean that.

If you are thinking about the long term, there are not many alternatives to paying, over time, to raise the share of GDP that goes on health and social care in the light of demographic change. As you look over long periods of time across the OECD and, of course, within the United Kingdom, that is exactly what you see. There may be an ability to bring about reductions in health spending in the short term. If you look over longer periods, you find that those do not survive and do not work. We have seen experience in places such as Canada. Sweden brought down healthcare's share of GDP for a while, but, as the years go by, they go back to trend. If you are thinking about the very long term, in particular, there are not many alternatives but to pay. The question is: who pays? Is it the public sector, or is it private pay?

Nigel Edwards: There is the effect of ageing. Proximity to death is also a major predictor of health spending. We have been fortunate, in many ways, over the last four decades in that the death rate has been falling. It is now about to start rising inexorably, for the next 40 to 50 years, as the baby boomers come through. That means that, in addition to ageing, there will be complexity, because of the number of patients with comorbid conditions. That is a big driver.

Historically, new medicines and technologies have also been a significant driver. Healthcare is unusual in that the application of technology seems to increase costs. In most other sectors of the economy, technology reduces costs. Unfortunately—or fortunately, in many ways—the technology in healthcare has been additive. There is a big pipeline of very expensive biologicals and other treatments coming down the track. Historically, it has been very hard for policymakers, Governments and,

indeed, insurers—in insurance-based systems—to say no to that pressure. If you add together the increasing complexity of the patients, the growth in the number of people who will die over the next five decades, the changes in the age structure and the increasing demands that will be made just because things are available, it will be very difficult to hold the line much below the historic trend, which has been about 4% growth in the UK. There may even be pressure to drive it above that.

Dr Jennifer Dixon: Funding is the big issue. Over the last 20 years, healthcare costs across OECD countries have outstripped GDP growth. Funding over that period—not just for health and social care, which Richard pointed to, but also for welfare spending—very much influences healthcare costs. There is a recent RAND study you may want to take a look at. It looked at 30 countries in the past, to see whether there is an association between social spending, health outcomes and health spending. It found that there is, particularly in countries where there are greater inequalities in welfare and income distribution.

If you do not want to ration, very big changes in productivity are needed. We have a whole range of intelligent policies to this end at the moment, but they need to be seriously stepped up. That is one thing the Committee could really look at. It is an issue not just for the NHS in the UK but for health systems across the developed world. Everybody is chasing the same solutions. There is no one big-ticket item to increase productivity I can see across the OECD that we are not doing and others are.

The Chairman: To pick up the point about efficiency and productivity, is there any evidence that a different kind of funding system—social insurance, charging or whatever—improves efficiency in healthcare? Secondly, how do you increase productivity?

Nigel Edwards: I am not aware of any studies showing differences between funding systems. It is noticeable that Bismarck systems seem to have produced more doctors, because their finance ministries have been less keen on restraining the supply side. They tend to pay their doctors more. However, often, as in Germany, they have had quite long lengths of stay and relatively low admission thresholds. There is no immediate link between how you collect money and how efficiently it is disbursed. Because some social insurance systems have more supply, they are able to have more competitive environments. There is some evidence that competition in some bits of the system improves provider efficiency, but there are also dead-weight costs to having competition. It works quite well in certain sectors of the health system, such as diagnostics and elective surgery.

The technique that most systems have used to improve efficiency is payment systems that try to pay providers prospectively, generally using some sort of diagnosis-related group pricing system. We are probably reaching the limits of the ability of that type of system, on its own, to improve efficiency. That is partly because, generally, healthcare systems have been very slow to adopt the redesign and re-engineering approaches that we have seen in other industries. The job of health service

administration and management has often stopped short of the clinical processes. It has managed the support services—the porters and the administration—and has helped the clinicians to do their jobs better, but it has not really applied the same sort of rigour to saying, “Could these processes and systems be done better?”. That is partly because you probably need to have a very strong clinical background to be able to do that effectively. You almost need two sets of skills, which is quite rare. I think that we have missed a trick. You can send a pricing signal to the hospitals to say, “Please become more efficient”, and set a price that says, “We need better efficiency”. The missing bit of the equation is the hospital's own knowledge and ability to do the change to get the efficiency improvement to meet the pricing signals that it has been receiving.

Richard Murray: I absolutely agree that, if you do not engage the workforce with a message that it understands and accepts, you will not get traditional efficiency measures to work. If we think of your timeframe, the challenge will be how to do high-quality care appropriately and efficiently with larger numbers of very old people who are frail and have multiple comorbidities. That is partly about what we have traditionally done, which is to lean on the hospital sector. That is what most countries have done, because it is the biggest cost centre. Twenty or 30 years into the future, you may end up with a system that is still overwhelmingly hospital-based, but that will be very expensive to run. At the moment, efficiency measures have tended to focus on the acute sector. As we look out over the next 20 to 30 years, we will want ways to try to bind together an integrated approach, to provide efficient care that crosses both primary care—general practice, services in the community and social care—and the acute sector. We should not try to compartmentalise the system into small buckets, because that is not the population group we will be dealing with.

The Chairman: I will take Lord Warner and Lord Lipsey. Then I will move on to the next question.

Lord Willis of Knaresborough: Chairman, would it be possible to hear what Dr Dixon has to say on this, given that she introduced the idea of efficiency? Do you have any ideas, Dr Dixon?

Dr Jennifer Dixon: I am mindful of the fact that there is a very good study by Mark Pearson, from the OECD, that clumped health systems into different archetypes: market-based systems, national health systems, Bismarckian systems and heterogeneous systems. When he looked at the performance of those systems, including efficiency measures, he found that no one archetype outperformed another and that there was more variation within archetypes than across them. His conclusion was that a health system that is seriously trying to improve performance should not necessarily look to any other system but should work with what it has. That was quite an interesting message.

Secondly, like Nigel and Richard, in my job I go around the world and see interesting examples—as you may do, too. There are some really excellent examples of technical efficiency in hospitals. A lot of those are in high performing providers in the US, where they have had massive engagement of clinicians in quality improvement techniques. They also

have huge amounts of data, banks of analysts and leaders who have been in place for 12 to 20 years. Those examples do not easily translate here.

I go back to my point: I do not think there is one quick thing that we can do to raise productivity. Everyone knows that. The approach should be gradual but robust progress using a more comprehensive set of approaches than we have at the moment.

Lord Warner: Can we go back to the issue of payment systems? Let us assume that you cannot easily increase the total quantum and that you have to work harder at making the quantum deliver what you want. What thinking is coming out of the think tanks about payment systems, particularly to providers, and dealing with the issue of provider-induced demand? What payment systems should we be trying to move our health and social care system to in order to get a better bang for our buck?

Nigel Edwards: Jamie Robinson, the health economist from UC Berkeley, says that the three worst ways of paying healthcare providers are capitation, fee for service and salary. In other words, every single payment method has some form of downside. Up to now, in common with the US and, more recently, Canada and Australia, as well as quite a lot of continental Europe, we have used a modified diagnosis-related group payment to hospitals for the activity that they do. Largely, we have paid general practitioners on a capitation basis, with some quality incentives and a very small number of items as service payments.

The downside of paying hospitals for volume is that there is quite a lot of what they do where you do not want more, particularly in emergency admissions. We see a shift to trying to get hospitals to take some capitation. The result of that is that the commissioners in our system have held much of the risk for volume. The move that we see in this country and, to some extent, in the US is an attempt to get hospitals and other providers to take the shared risk for a capitated population. You retain the episodic payment model, using DRGs, largely for elective surgery, diagnostics and things where you may want to incentivise volume. Even there, you may want to set limits to try to control volume. The overall movement is to shift the risk that you hold as an insurer to increase volume to the providers. They are better able, it is thought, to design a system to make the decisions that mean that you can have some control over a phenomenon many of you will be familiar with—the fact that if you increase supply the level of demand seems to go up. You sometimes hear people say, “If you build it, they will come”. That seems to be the movement.

The downside of capitation, particularly in our system, is potentially the creation of unchallenged local monopolies. Capitation encourages slacking, in that you have received a set sum of money. Unless you get very good at measuring the outcomes for your population, you are at risk from capitation models as well, in that, potentially, you introduce a different type of inefficiency into your system—an allocative inefficiency. You spend money on the wrong things, or your providers do not do the things that they should be doing. It is fair to say that the art of measuring outcomes at a population level, by commissioners or others, is still in its infancy. We have to be able to do better than HbA1C for diabetes, which is the standard example that is always trotted out. That sort of precision

of measurement is one of the problems that is holding back the payment system at the moment from a more full-blooded move to a capitated model.

Lord Lipsey: Mr Murray, you said that it would be vital to increase the share of GDP going to healthcare, but is there not a prior point, which is that it all depends on how fast GDP is growing in the first place? When GDP was growing merrily in the early 2000s, at 3% a year, we did not have much trouble financing health. Since it stopped growing, we have had ghastly problems. Of course, the growth rate is not a matter wholly for the health system, but health priorities can affect growth rates. For example, the more prevention you do so that people can go on working during their working lifetime, the better. I am afraid that end-of-life care, important though it is, does not contribute a penny to growth. Is it not necessary to put growth at the centre of your models when looking at how we fund healthcare?

Richard Murray: Yes, I agree. The slower the growth of the economy, the harder it will be to finance health and social care as you go forward—absolutely. I said that it was inevitable that spending would have to go up, but there is a prior assumption in there about what kind of service you would hope for—if you want it to look comprehensive and free at the point of use, and if we are talking about public spending.

Over the next 20 to 30 years, there are things that the health service may be able to do to support the growth rate. We are a high-tech industry, so it feeds in both ways. It is quite difficult for the health service to do that if it is very short of staff, time and money. If you have a set of priorities in front of clinicians and they have long lists of patients waiting at the front door, it is not easy to divert them into GDP-growing research.

I want to say a bit about the incentive issue. I agree with everything that Nigel has said. I would add only that we should think more often about pathways that try to unite elements of care, so that people do not fall between gaps as they move between different providers, and that we must be able to do better on outcomes than we do at the moment. That is the key problem around capitation and the incentives that it gives.

My final point is that we spend a lot of time fiddling around with payment systems, but if your providers are all bust anyway it does not make a lot of difference. You are pouring water into a paper bag, and the paper bag has a great big hole near the bottom. There is a lot of very fine-tuning that goes on, but I am not sure what benefit it has. Fundamentally, trying to have clarity on what you want the system to deliver, and making sure that clinicians are on board and enabled to do the things that patients want them to do, will probably help a lot more on efficiency going forward.

The Chairman: On resources, the next issue is the big issue of the workforce, of course. Just now there does not seem to be much of a solution there. Again, I want you to think ahead, to 2025, 2030 and beyond.

Q24 **Lord Ribeiro:** We have had paper bags filling up with water. Workforce seems to be one of the Achilles heels of planning that we do not seem to

get right. As far as consultant staff are concerned, the pipeline is anything from 10 to 15 years before you get the product. Thinking long term, what are the main challenges affecting workforce planning? What will the requirements for the workforce be? What will it do?

Richard Murray: We are struggling at the moment with the difference in workforce planning between models that build up from population need, which tell you that you will need an awful lot of people going forward, and models that build up from what NHS employers will actually be able to pay for—what size of pay bill is affordable. Part of the problem we have at the moment is that we have a workforce that was designed to be affordable. It has turned out to be too small, so we have turned to more expensive staff. That is the failure of planning. There is a fundamental difference around these approaches. Do you base it on what you think you will need if you are to meet all the needs of the population, or do you base it on how much pay you are willing to give out?

As we look over multiple years, we have to get workforce planning better than it is now. Everybody knows that. As we were standing outside, I said that we always think that planning is terrible, but the huge waiting lists that the NHS had inherited by 2000 were removed. That was done by a huge expansion in the workforce, which was designed to link to the growth in activity. It may have been messy, and it was not always perfect, but planning is not always a failure. Sometimes it has scored some major successes.

The challenges as you look out into the future, alongside the demand and affordability piece, are particularly around new roles. We have an old model of consultants, nurses and more junior staff. As you look out—particularly reflecting the changing demographic needs of the population—is that appropriate? It is very difficult for a planner to know now, as some of the roles are nascent roles that are not with us yet. Hopefully, they can begin to reduce some of the problems about the length of planning that you need to do, not just for the consultant workforce but for the nursing workforce. There is no element of the workforce in healthcare that is easy to push up. It is expensive to reduce it, too.

Lord Ribeiro: On the nursing side—this is something that you may want to pick up, Jennifer, as it appears in your paper—one thing seems to be how different countries have determined how they will recruit and retain nurses. In the table that you show, there is a very dramatic figure. In the UK, 12.7% of nurses are foreign trained. In the USA, the figure is 6%. In Denmark, it is 0.7%. Somewhere along the line, these countries are taking a view on how they will grow their own workforce and how much they will recruit from outside. What is our problem?

Dr Jennifer Dixon: Thank you for referring to our report. We have produced two reports in the last few months. One looks at the architecture of workforce planning bodies and professional groups that help to define roles, et cetera. It shows that the architecture is quite byzantine; a very complex set of bodies is involved. Secondly, there is the report you have referred to, which looks at numbers—in, out, planning over a certain period, and so on. Some figures are very stark, as you say—not just the proportion of nurses trained overseas but that of

doctors. One-third of our doctors are now trained overseas. Did we plan that? Do we want that? Half of new registrants to the nursing register last year were from the EU, for example.

Lord Ribeiro: Presumably it will get more acute if we come out of the EU in two years' time. That will be a major problem.

Dr Jennifer Dixon: Indeed. Whatever has happened with bottom-up planning of staff numbers, which has been restricted by the overall envelope of funding, is not producing the trained staff the NHS needs. As David Metcalf said on the Migration Advisory Committee, the "get-out-of-jail-free card" for planning which is suboptimal is the use of overseas recruitment. At ward level, it means that you have people from different countries, with different skill sets. If you are trying to make improvements over time, but you have a churn of people with different skill sets and experience, it is like running in sand. The churn and the heterogeneity of training levels of different staff groups will multiply the challenges you face, if you are trying to make a sustained progress towards more efficiency.

The Chairman: Mr Edwards, do you have a comment?

Nigel Edwards: No, I have nothing to add to that. I agree with both of you.

Q25 **Lord Willis of Knaresborough:** I have a question specifically on this issue. I declare an interest. At the moment, I am doing work for HEE on planning the workforce. The thing that I found, which I could not believe, was the level of attrition in training, particularly of nurses. On average, roughly 24% of starts leave, which is an incredible cost. In addition, many of those people do not come into the system. There is also massive attrition in the first two to three years when a registered nurse actually starts work. If we could do just a little to improve that, we would suddenly reduce the number of people we have to recruit from abroad, and yet there does not seem to be any real drive to change the culture that is driving people out of the system. Does anybody do that better? Are we aware of that?

Dr Jennifer Dixon: You have to look at overall HR practices in the National Health Service—for all staff groups, not just nurses—to know whether there is more that could be done. Our work has shown that there are a lot of things that could be done locally to improve retention—not just for nursing staff but for others. HR management is a pretty underpowered profession. We just do not devote enough thinking in national or local policy to the wellbeing and motivation of staff, even though they are our biggest asset. Overall, if you look at the figures for staff joining and leaving the NHS, in some years the percentage joining and leaving is more or less the same, so you have a big leaky bucket. This is a big area the Committee could focus on very usefully.

If I am allowed, I would like to go back to Norman's point, because we got through it rather quickly. Could I say something on the financial incentives? At the moment, the biggest stimulus in the health sector, on money, is the fact that there is a global budget and it is very tight. Underneath that, on payment, there are two issues. One is the level of

the price of payments. The other, which you were alluding to, is the payment currency. The evidence I have seen shows that relying on one system of payment or currency has obvious disadvantages and that constructing a blend reduced those disadvantages. However, the overall point that I would like to make is that our capacity in this country to work out optimal price and currency blend of payments is very limited. There are just a handful of economists outside the NHS, mostly located in York, who do this type of analysis. There are relatively few inside the NHS. We are largely flying blind as to the impact of changes in payments.

The other obvious point to make, which is a long-standing one, is that a lot of big cost centres, such as hospitals, do not know what their costs truly are. Progress on that, which links through to another of your interests—progress on informatics—is also a critical point going into the longer term.

The Chairman: I now seek quick-fire questions and quick-fire responses.

Baroness Redfern: Before I ask my supplementary, I declare that I was chair of specialist healthcare on the council back home. My question is about whether changing the skill mix of the workforce is a cost-effective option. Could you give any examples of that?

Nigel Edwards: Yes; we can send you some. There are a lot of very good examples already. Because we are short of doctors and tend to rely on trainees, we have seen a large expansion in the role of nurses, who have taken on specialist duties that we would traditionally have expected junior doctors to do. They do them very effectively. It is a bit more cost-effective. There is a price difference between a nurse and a junior doctor, but the nurses tend to take a little longer, so it is quite finely balanced. There are plenty of opportunities to use physiotherapists and occupational therapists in better ways. In Scotland, there is a tendency increasingly to refer all musculoskeletal conditions straight to a physiotherapist, without patients seeing a GP. That is some 20% of the general practice workload, so there are interesting examples there.

The bit of the skill mix that has remained largely untouched is the senior medical skill mix. We have a system in this country where everyone is a consultant. There is no hierarchy within that. That is slightly unusual compared with other countries, where you would expect to see a bit more differentiation between different types of doctors. We had—they are still around—a staff grade of associate specialist doctors. It was always said that, if you were having your hip replaced, you would be better off having it done by one of them, because they did them a lot—and did them very effectively. However, they have been phased out, to some extent. There is still a lot more that we could do with the skill mix, but it needs to be done with care and with careful planning. One of the risks that we have seen is the multiplication of slightly different types of role that are not very comparable. Then people cannot move about, because they do not have portable qualifications. There is also a lagging regulatory system, which means that you have people who are quite capable of prescribing from a limited formulary, for example, but who are not allowed to do so because of the legislative framework.

Baroness Redfern: If I may, I will point my question to GPs, as well,

because GPs can help with skill mixing. Health and social care, in particular, will be a big player. I wonder whether there is a huge opportunity there. I know that there may be in the acute sector, but I am looking at the primary sector.

Nigel Edwards: In general practice, there are some very interesting models in the US, where the ratio of GPs to patients is different. There you have one GP and a large multidisciplinary team supporting them. The GP focuses on the things where their particular expertise is valuable—complex cases, difficult diagnoses and the co-ordination of care with specialties. I think that we will see more of that. However, to make it work, you need general practice to be at a larger scale than it currently is. It needs back-up and support, with telephone centres and a variety of other bits of infrastructure. We have now started to see that change happen very quickly, below the radar. GPs are already starting to scale up. They are not yet ready to start doing that, but I would predict—

Baroness Redfern: There seems to be some mileage in that area.

Nigel Edwards: Yes. We will see that.

The Chairman: Once, when I tried to raise the issue that not everybody needs to be a consultant and there might be other grades, the whole wrath of the medical profession fell on me.

Nigel Edwards: Yes. I said that being close to the door.

The Chairman: I tried it, and look what happened to me.

Lord Scriven: Have you come across any models that link future planning to productivity gains? In a number of reports, you refer to productivity. How do you use planning to get the most productive workforce for the future? Have you come across that anywhere?

Nigel Edwards: Getting the numbers right is difficult enough. I am not sure that I have come across any examples of that internationally. Some countries only plan doctors, because doctors are expensive to produce. If you have too many, there is a danger that, because doctors like doing things and working, you will end up with a supply-induced demand problem. Most countries try to regulate the number of doctors, but even a few of those have stopped. A number of other countries tend to leave production more to the market, rather than try to plan the numbers exquisitely. I have not seen any examples in a modern system, as opposed to the former Soviet Union.

Lord Scriven: As complex as it may be, do you think that it is something that would be useful?

Dr Jennifer Dixon: There is so much variation, if you look at trust-level productivity in England, for example. That is the first place to look. Why are some trusts more productive than others? Is it something to do with how they have planned their workforce, or is it something entirely different—the structures that they have inherited or the processes of care that they do, outwith any staffing numbers? I would have thought that that was the place to start. We should look at Scotland and Wales, too.

Nigel Edwards: One issue is that the speed with which some of the technology and treatments in medicine change makes that quite hard. We

should train people so that there is more opportunity for them to be flexible and to acquire new skills and competences. Again, this is sensitive territory; something called the shape of training review tried to look at it. That will allow them to adapt their skills as technology changes. The answer is probably to train people to be flexible, so that they can use and find knowledge, and to be able to retrain them quickly as technology changes, so that when someone comes up with a new treatment and the thing that they have spent the last 10 years learning suddenly becomes obsolete—which will happen increasingly—they are able to adapt to that quickly. Your question is interesting, but I do not think that there are any international examples.

Lord McColl of Dulwich: Looking at wastage, do you have any data on why large numbers of GPs, nurses and practice nurses are leaving? What is destroying the morale? I know quite a bit about general practice, and I know why many of them are leaving. I wondered whether you had any data.

Richard Murray: Recently the fund published on general practice. That involved a series of discussions with trainees, those who are GPs now and the people who work around them. We have done the same with district and community nurses, who are also suffering very heavily from people leaving the profession. That will be published quite soon. If I were to summarise, what comes across quite a lot is burnout—the fact that they are tired and stressed. We have had examples of district nurses, in particular, saying that they are leaving because they no longer think that their care is safe and they no longer have enough time to do the job. Those are the things that are coming across. Pay does not seem to come up very often—it is about the nature of the job. When some younger people, in particular—those who are joining the professions now—look at it, their answer is instead to look for a portfolio career. They say, “I will be only a part-time GP. I will not be a part-time member of the NHS workforce—I shall do something else as well—but I will not do that job full time”. We have an imbalance between the asks on staff and what they feel capable of doing.

Lord McColl of Dulwich: The CQC has been acknowledged to be a disaster in general practice. It is demoralising GPs. Its staff, who are often unqualified and do not know what they are talking about, go in and nitpick. I will give just one example. When they went into a very good general practice, the chap in charge was someone of 25, covered with acne, which is not a very good thing to have in general practice. All that they discovered was that one ampule in the refrigerator was a month out of date. That was a very serious complaint and was put in the report. Surely these people should know that any doctor or nurse checks an ampule to see whether it is in date and what it is. Two people check it. That is the sort of thing that is demoralising health.

The Chairman: We will take that as a comment. I move on to Lord Warner.

Q26 **Lord Warner:** Can I move us on to integration? Underpinning the five year forward view is a very considerable emphasis on integration, particularly in social care. You know that things are starting to change

when the chief executive of NHS England starts saying that if you have any spare cash in the NHS you ought to give it to social care. There is a movement, ideologically at least. What are the practical changes required to provide the population with an integrated national health and care service? In particular, what are the obstacles to that movement in the longer term that the Committee should be trying to remove?

Richard Murray: In the longer term, the Barker commission, which was supported by the King's Fund, identified as issues the separation of budgets between health and social care and the extent of means testing in social care, compared with care free at the point of use in the NHS. Looking into the years ahead, it is fundamental to think about having a single, ring-fenced budget for social care and one that tries progressively to be more generous on the social care side, to take away the extent of means testing that we have at the moment. Without that, there is a fundamental question about what integration looks like, as you look to the years ahead. Social care probably came through the spending review slightly better than many had feared that it would. That is not to say that it came through well—it is just that the fears were very great beforehand. It is one thing to integrate between two public payers. It is a very different thing for the health service to try to integrate with 200,000 private payers, because the extent of public financing retreats over time—certainly if it were to continue at the rate that we have seen more recently.

That is on the big-picture piece. There are things that get in the way of integration at local level. One is just how complicated it is. This is not something that you do quickly—it takes a lot of time to think through. You need to think about how patients and users move through the system and what they want from a more integrated system. There are two separate workforces here—in fact, more than two in the NHS—that have different cultures and ways of working. Bringing those together into a coherent whole is not the work of a short period of time. It is great that we are seeing lots of work going on in the vanguards and in other areas to try to knit these two different systems together. However, I do not think that we will ever end up with a single bullet that provides what you want right from one end of the country to the other, no doubt because of the variation that you are seeing.

Dr Jennifer Dixon: I agree with all of that, plus the obvious points, which are about local leadership and stability of leadership. You can see some of the greater advances in areas where boards and senior staff have been in place for some time and have good, trusting relationships. We also need data on impact. A lot of places do not know what the impact of their efforts has been, so they may be discouraged if they do not see it, but in fact there is progress. We need time, as has been said, and rigorous, detailed planning and project management. Over and over again—I was involved in the integrated care pioneer programme, for example—that is what is needed. It is often in short supply.

The Chairman: Nigel, do you have a quick comment?

Nigel Edwards: I will not add anything to what has been said. That covers it.

Lord Bradley: Under the general umbrella of integration, you have health and social care, physical and mental health—around whole-person care—and the shift from hospital-based care to community-based care. Richard, earlier today you said that is still overwhelmingly hospital-based. What do you think the levers are over 15 or 20 years to get to a community-based, integrated service? We have touched on funding, workforce planning and other barriers to that change. Do you think that there is enough money in the transformation fund and the vanguards really to shift away from hospital-based service when there are so many incentives to retain patients in hospital?

Richard Murray: At the moment, no. Much of the transformation funding that is available will end up being directed at deficits in the acute sector, so it will not show up in mental health and out-of-hospital settings. There are some other things that you need to do to rebalance the imbalances that we have at the moment. Our understanding of outcomes is not great in the acute sector, but we have some understanding of outcomes. We do not in most out-of-hospital settings, so a lot of what goes on there is invisible. It is not easy to see and is the bit that tends to get cut. I echo what Jennifer has said about data. We do not really know what the workforce is doing in community settings. We think that it is going down, but it is very difficult to track. Even basics like that are not easy to see.

We have a system that is trying to deliver a set of targets for the acute sector. When the system comes under pressure, what it does—we have seen this—is move money bit by bit back into the acute sector, to try to maintain the targets that sit there. There is no visibility and no comparability counterweight, other than exhortation and hopefulness that commissioners may try to move the money in the other way. Thinking about the workforce, that is why, when NHS England asks employers in community settings and in mental health what they want for the future, their answer is, "Fewer staff", because they do not think that their budgets will turn around and go back up. Until you overcome that fundamental problem, it is quite difficult to move things into the community. That is certainly not happening at the moment.

Lord Bradley: I should have declared my interests.

The Chairman: Just now we have compartmentalised thinking about workforce planning and funding—managing the money. Do you think that the separation is too great? Workforce is resources. Do you think that thinking should be done by NHS England—I know that we have a second session with NHS England—which is managing the money? Is this a problem of dichotomy of thinking—different organisations with different responsibilities?

Richard Murray: I think so. If you think back to when we were doing things like national service frameworks, which were trying to change how care was delivered, you tried to ensure that there was the money. However, because of everything that we have said about workforce, the money in the health service is not enough—you also need to know where you are going to get the staff, and on what timetable, to deliver that level of service. We can see the downside of not doing that. We have pushed acute hospitals on to a recruitment round for nurses. Those nurses did not exist. Consequently, they have been pushed into using agency staff as

well. You want to try to make sure that your objectives around the health service and social care are matched with resources: do you have the money to do it, is there a system of data and outcomes that can try to track how performance is doing, and are there the staff to deliver it? They need to go together.

The Chairman: Dr Dixon, the Health Foundation had a comment on this.

Dr Jennifer Dixon: There is a wider point, which is about the national leadership for the ALBs how coordinated it is. You mentioned NHS England, but HEE and NHS Improvement are also in the picture. We have just produced a report on quality. An overarching strategy on quality is absent, in part because of a lack of coordinated leadership on that particular issue. There is a good start with the five year forward view, which is a great example of people coming together, but this needs to address the wider issue of quality of care and longer term than the next five years. The department of health has a role to help coordinate this, but much of the thinking should come from the arm's-length collection of so called 'system stewards'.

Nigel Edwards: I wonder whether the sheer scale of the NHS makes investing that planning in one set of central bodies sensible. I am not aware of any successful health system that tries to do that on such a large scale that is so focused on national bodies, as opposed to the amalgamation of more regional authorities. Other NHS systems do not run the system nationally. Spain and Italy are perhaps not models that you would copy normally. However, if you look at other health systems, there is something about the scale of the NHS that, I suspect, means that the overall complexity is likely to overwhelm the people you have, however smart they are. I may be remembering a golden age—I am probably being overly nostalgic—but we have stripped out the knowledge and planning abilities that may have been there. That local ability to plan, which you might have been able to amalgamate up, has gone. There is a very serious question to be asked about whether, however good you get the stewardship bits at the top, 53 million people is too large a unit to do things with.

Dr Jennifer Dixon: I agree with that. There is planning, but there is also the separate issue of a coherent strategy overall. That is the point that I was trying to make.

Lord Bradley: To declare my interest, do you think that the devolution deal for Greater Manchester, for example, is an opportunity to test out what you have just described?

Nigel Edwards: It would be if it were devolution, as opposed to delegation.

Lord Scriven: Mr Edwards has more or less answered part of my next question. Going back to international comparisons, are there any international comparators that get integration between different parts of the health service or between health and social care better than the UK? What are the key components that you think are missing that could be transferred into the British system?

Nigel Edwards: Even the Scandinavian countries have struggled with disputes. In Sweden, the municipalities run social care and the counties run hospital care. One thing that is worth pointing out here—it is one of the reasons why this takes time—is that the mental models, value system and approach to the problem of social work staff are very different from those of medical staff. There is a good reason why they are different, and there is value in both. However, it means that when they come together it is not just a straightforward thing of putting everybody in the same building, under the same management, and telling them to integrate.

Lord Scriven: What about integration between healthcare providers—not just between trusts, but between primary, community and acute providers?

Nigel Edwards: You are asking for an international example. No—

Richard Murray: There are individual examples. You would struggle to say that an entire system had managed to do it. Indeed, surprising as it may seem, on some international comparisons—for example, by the Commonwealth Fund—England tends to do relatively better, partly because we have GPs who at least form a bedrock for the population. You find individual examples in many countries that have got further down that road, but you can also find ones in England that have got further down the road of integrating health and social care.

Lord Scriven: Do you see any commonality on which are the key issues?

Richard Murray: It goes back to some of the things that Jennifer said about strong local leadership and stability in the leadership team. They need to have a clear vision and to go through the quite long slog of thinking through the plan, adjusting as they go through and recognising the very cultural differences that Nigel has noted. It is harder if you just think that merging organisations will bring about integrated care. It does not. You can go to acute hospitals that are not a real hospital, but separate fiefdoms all around the building. Just merging organisations does not do that. There needs to be a recognition of the complexity of the staff and just how important the task is. Many other countries are on the same demographic journey we are on. We were in a world where you could separate health and social care, to some extent. However, given the way in which the demographics have gone across the whole developed world, that is looking harder and harder. The integration agenda is one that many other countries understand. I do not think that anyone has found a magic bullet.

The Chairman: There is no evidence we can look at, in a whole system.

Dr Jennifer Dixon: Not in a whole system. Richard was absolutely right to say that there are individual examples. However, every health system is different, because the context is very different. It is very difficult to read across to the NHS, so you can only get glimpses of what we might try. The thing I am closest to—as I guess my colleagues are—is looking at the developing accountable care organisations in the United States. Generally, they do not include social care, but try to integrate across health care settings and shift care outside hospitals. They are absolutely rigorous in programme management to make that happen, as well as monitoring impact. Financial incentives and data are the two big levers

that they have been using to help stimulate change. They are very well supported by the CMS Innovation Center: it has commissioned rapid cycle evaluation, which gives regular feedback to local ACOs to allow people trying things out at the front line to course-correct within weeks, instead of waiting a year for data. There are some examples of how it can work.

Q27 Lord Kakkar: I remind the Committee, particularly for this question, of my interest in UCLPartners. To what extent has digitisation of data and services taken place? Building on the comments that we have just heard, how important are data and informatics in driving forward changes? What evidence do we have that the appropriate collection of data and health informatics has resulted in improved efficiency and more effective use of funds?

Dr Jennifer Dixon: Personally, I think that we are in the foothills of what this asset can do for us in the National Health Service—that is the existing asset, let alone developing it. We have a ton of data, and it is not used enough. That is in part because of blockages in getting hold of data, particularly person-level data, to allow people to be tracked anonymously across the health system, so that we can spot who is at high risk, who might need greater support and which general practices and communities they are coming from. Some parts of the country can do that, but it is not typical across the country as a whole. That is a very promising area work on, to try to improve efficiencies.

Without getting all technical, there is a whole set of data—routine administrative data—that you can use to track patients, because it is always collected automatically when they use the NHS. However, there is another separate set of information, which is clinical audit data. Only last week, I was seeing the most advanced collection of clinical data in the world on cancer, at the National Cancer Intelligence Network in Cambridge and its related bodies. I note that it has linked together multiple sources of data in hospitals, in a way no other country has done before. It has done so incrementally, slowly, over time, rigorously and carefully. The result is that we have more data about cancer care in this country, by cohorts of people, on everyone who has cancer or a suspected diagnosis than any other country in the world. Your question is, how do you translate that into productivity savings? That is where there is a gap. It is about sweating that asset and using it for benefit.

Lord Kakkar: How do we bridge that gap? How will we get there, so that we use this opportunity with regard to data and informatics to answer the sustainability question 20 years hence?

Dr Jennifer Dixon: A practical example is that we need to give those vanguard sites that are trying to shift care out into the community feedback of information on the quality and cost of the impact of their efforts in a rapid way. That means freeing up a lot more data than they have from national sources and docking it with audit data, to give them useable information about progress. At the moment, they cannot easily track progress of their efforts. That is avoidable with better access to data and analytical support. Data is a massive NHS asset that is underexploited.

Nigel Edwards: With the privacy restrictions and the fact that 1.5 million people have opted out of the hospital episode system for secondary use, there is a risk of our going backwards. We could be in the paradoxical situation where more data is available, but it is increasingly hard to get at and to use for research and improvement. Although you can opt out of having your clinical data shared between clinicians, hopefully we can at least get the improvement that clinical data will be available to treating clinicians, with the patient's permission. However, we lose the opportunity to improve both productivity and epidemiology-type research, because of restrictions that are increasingly being put on the availability of this sort of data for secondary use.

Richard Murray: The three of us have probably changed our tone on this point, because the issue of getting hold of data for secondary use is getting worse, not better. There is a real problem there. You talk about using the data, but you cannot even get hold of it. When it comes to data and linking that to direct patient care, a lot of it is now about delivery. Areas are putting together their digital road maps. I know that you will have NHS England and others here later. At local level, they are trying to come to agreements on how data moves across the system, to facilitate direct patient care. There is a lot of optimism around that, but it is right at the critical point, as you begin to turn agreements into reality.

The other question is: is there evidence that sometimes data can really unlock change? I think that there is. There are many examples in the literature where being able to provide quicker, real-term or near-real-term feedback to staff makes an enormous difference. It can make a difference to managers and to everybody else. It becomes actionable—you can do things about it. We have just done something about getting feedback from users of maternity services. The staff react to it. There is a lot of granular evidence that it can work. What we probably have not done yet is manage to make it work at any kind of reasonable scale. There is major work under way, as we speak, to try to make that happen.

The Chairman: Who will be best placed—looking ahead to 2030 onwards, as Lord Kakkar said—on the use of appropriate data to improve productivity and the use of informatics to improve patient care, with the new science and the new means of diagnosis that will develop by 2030? Who should be in charge of doing that? Who will describe the road map for where we should be and how we get there?

Richard Murray: Some of the ACOs in the United States are at the cutting edge. They will be one place to look, to see what is potentially possible. As you do that, you will also want to think about some of the barriers. We have spoken about data sharing, but some of those issues also arise in the United States. The Americans spend an awful lot more money—vastly more money—on this.

The Chairman: Why do they spend more money on it?

Richard Murray: They spend about twice the share of GDP that we do on healthcare, anyway, so they are much better funded. Their costs are much higher than ours, so saving elements of care provides them with a much bigger bang than it does here. They have raised the money.

Lord Kakkar: Have they been able to demonstrate as a result that their

system and the ACOs are more efficient and sustainable?

Dr Jennifer Dixon: Some have, yes, because they also have rigorous analysis of costs. They have had a fee-for-service system, so they rely on billing and have granular data on costing, whereas we do not. There are some examples within the UK that are more advanced, in Scotland and some parts of England.

The Chairman: I was hoping that you would say that.

Dr Jennifer Dixon: We can send you some information on those places. Nobody has joined up all the dots. There is no area where everything is singing, but there are a few areas you could look at that are vanguard areas on informatics. Bob Wachter is clearly focusing on this too.

Q28 **Baroness Redfern:** My question may have been asked previously. Are you saying that we have to get data sharing across the system right and up to date before we can see any benefits?

Dr Jennifer Dixon: We are seeing some benefits already, but nowhere near as many as we could if we could unlock some of the data flows. As has been said, it is not just about the data—it is about having the analysts there who can help. Those are the very people who have been stripped out of the NHS because of administrative savings.

Lord Willis of Knaresborough: Is it not a folly sometimes to look too big? You are quite right—a mass of data is available. However, in trying to convince the public that sharing data is important, sometimes you have to have small successes. The Yorkshire CLAHRC, in which I declare an interest, produced a frailty index, using existing data, but 97% of GPs across England now use that to target the patients who require the greatest help. Examples like that eventually create scale, but they also bring buy-in from everyone. I wonder whether we are starting from the wrong end of the telescope.

Dr Jennifer Dixon: I chose the example of cancer care, where a tremendous database has been built up gradually over the last 10 years, without fuss and with the risks managed carefully. It all complies clearly with data protection. There is a lot that can be done locally. In certain parts of the country, the kind of datasets we are talking about have been linked up at person level. Nevertheless, there are some national issues, to do with governance, that need to be addressed to help.

Nigel Edwards: Particularly around data interoperability and data definitions, which need to be done nationally. There is a definite role for national bodies, but it is probably not in designing and implementing large systems.

Lord Kakkar: I want to deal with the second part of the question, beyond data—that is, the adoption of technology at scale and pace. We heard earlier that often, technological innovation is associated with an increase in cost. What are the barriers to adoption of technology in the medium term? In your view, how might that drive forward a more sustainable NHS?

Nigel Edwards: Do you mean digital technology specifically?

Lord Kakkar: Yes.

Nigel Edwards: One of the peculiar things Bob Wachter, who was referred to earlier, has written about is that the introduction of digital technology has often been associated with a drop in productivity in healthcare, rather than an increase. It is because we have often focused on the technology, rather than on redesigning the workflows and then fitting the technology to support the new workflow. It seems that a double loop of learning is required: you get the technology, you collect the data and then you are able to work out how your workflow needs to change. It is a more painful journey than people have tended to think. That is not uncommon in other industries. The productivity paradox—that you get an initial drop and then use the technology to get the data that you need to do the learning to do the redesign—has been a feature there, too. The question is: how much are you investing? Never mind the fact that the US and its health system are richer—the investment is also much more significant as a proportion of turnover than it is here. A large health system in the US will probably invest 4% or 5% of its turnover in IT systems. I do not know what the comparable number is here, but I suspect that it is half of that, at best.

Dr Jennifer Dixon: There is new technology. Nobody really knows the potential benefits of that, but important to invest in. Every year, my organisation funds a lot of projects in the NHS to try to improve care, some of them using new technologies and some not. It is absolutely clear that, with or without new technologies, the skills and culture of the staff embedding those projects is almost more important than the technology itself. Some of our projects have shown the quite significant changes that can be made without any kind of technology, to do with learning a process of care, for example—creating more order where there has been quite a lot of disorder in the clinical pathway of care and reducing the time wasted on work-arounds on the ward because people waste time trying find things, do not know where things are or are trying to get hold of somebody. There is quite a lot that can be done, as we have shown, although what that would add up to across the NHS is another matter. We can give examples from our portfolio.

Q29 **Lord Turnberg:** My question is about public health and prevention. Before I ask it, can I follow up on the productivity question? It is very hard to demonstrate that the new technologies of all sorts, the new treatments and the biologicals, which are all very expensive, produce improved productivity. However, if you look more widely at society, there is quite a lot of evidence that, if you invest in research in cancer or heart disease, you gain productivity, with lower sickness rates, fewer sickness benefits and increased productivity by the workforce, as people get back to work because they have been treated. It depends on where you look at productivity. Is it the nation's productivity or the NHS's productivity? That is a problem for the NHS. Its gains are felt by the Treasury, but not within the Department of Health. Do you want to comment on that?

Nigel Edwards: There is a literature on this, although I am not an expert in it. When Marc Suhrcke, who was formerly at the University of East Anglia, did work on the Tallinn charter for the WHO about 10 years ago, he calculated a positive economic multiplier for spending on health—

although, to be honest, it was not as good as the multiplier for spending on education, if I remember rightly. You may need a different witness, but my recollection of the literature on this is that there is definitely a case to be made. I suspect that even end-of-life care may be able to demonstrate that. At the very least, good end-of-life care probably reduces the burden on carers. It also tends to be cheaper than what we often do now.

Lord Turnberg: So there is good evidence in that research.

Nigel Edwards: There is.

Richard Murray: I completely agree. The evidence is good, if you look at health per se. It depends on whether or not you are in competition with education. However, you have to remember that, for chief executives of NHS trusts, this is unlikely to be what gets them—

Lord Turnberg: That is the problem.

Richard Murray: Busting the budget or missing your A&E target could end with your P45 being on your desk quite quickly. It is one thing to exhort the service to be more supportive of research and development agendas, but in the behaviours that the system actually adopts, it does not do that—it gives you a slap. You cannot trade the two. If you want to encourage more of it, the system needs to recognise it and to integrate it into the way in which it judges how well people have done.

The Chairman: Can I ask you to move on, Lord Turnberg?

Q30 **Lord Turnberg:** I am sorry, my Lord Chairman. I strayed a bit.

We have not yet spoken much about public health and prevention. We know all about the fact that we have managed to have some success on smoking reduction and modest success on alcohol reduction. We have not done so well on obesity reduction. We know that those are the issues. However, if we are looking forward some considerable time, we have to think about what more needs to be done in two areas. What research is being done on how one is able to influence public behaviour better in the future? We have a lot of rhetoric in this field, but not much action. The other thing is how we think about developments in areas other than the three that I have mentioned. How do we think about preventive measures for things like dementia, of which there are some? How do we begin to take advantage of all the novel developments in prediction of ill health, using genomics and like techniques, that we can use in preventive programmes? Is any work being done in that area?

Richard Murray: There is a lot of work on return on investment in prevention, often at more local levels, looking at what a local authority or the NHS might be able to do and where you get a bang for your buck. At the higher, national level, the clue is in some of the examples that you gave at the start. I will pick on smoking, in particular. That was a combined effort, involving the NHS, which provided stop smoking services, aggressive use of taxation levers, to make it expensive to smoke, and, increasingly, use of regulatory powers, to make it difficult to smoke. To some extent, alcohol has gone down the same path, although you could argue about quite how regulation has played its part on alcohol.

Before looking for any radical, unknown lever, we want the system to rethink both what the NHS and local government can do and what you can do using the national levers of taxation and regulation to try to deal with the other public health issues. We have a set of tools that work pretty well on smoking and have had some successes in other areas, such as regulation on wearing a seatbelt. People tend to forget how powerful and successful a change that was. There is a set of traditional levers we are just not thinking about or using as we could. All credit for the tax on sugary drinks, which begins to reopen the debate about using tax in a more imaginative way.

On dementia, you are absolutely right. It is partly about a change in mindset and seeing that elements of both dementia and mental health issues are preventable. We need to broaden out the conversation about what you can design and do around environments that help people with either dementia or mental health issues. A lot of this needs to be based on what people want. There is a lot of evidence on green space and the built environment. Local authorities have the powers to bring those about. Some of it is about a change in mindset and seeing that some of the things that we have tended to think are inevitable consequences of growing old are not and can be stopped.

The Chairman: Mr Edwards, do you have any comments?

Nigel Edwards: No, I have nothing to add.

The Chairman: Dr Dixon?

Dr Jennifer Dixon: I have nothing to add, except that, from our perspective, we know enough. It is far more about action, and managing that well. On teen pregnancies, there was a fantastic success story, through multisectoral action over a period of time, with a concentrated focus and management.

Lord Turnberg: Do you think that Public Health England is putting enough effort into these sorts of ideas?

Dr Jennifer Dixon: Maybe that is something you should ask it.

Richard Murray: It is tricky for Public Health England. It is part of the department, so some of the levers we spoke about around taxation and regulation are difficult for it. It puts them in a constitutionally awkward place.

Q31 **The Chairman:** We are continuously told, in report after report, that, for the long-term sustainability of both health and social care, we need to keep people well for a longer period of time and to make sure that people do what will reduce their chances of getting diseases. If you are going to do that, and that is going to keep the costs down and keep people healthy, we need to put bigger effort in. The question is right. Who is in charge just now? If it is Public Health England, is it doing enough, or should it be somebody else? Unless we give this a priority, we will not get to a health service where people are healthier for longer. Do you have a comment to make about that?

Richard Murray: I completely agree on the priority around public health—it is just not instantly straightforward to think of what the

constitutional and governance arrangement would be that would make that happen. In some senses, Public Health England was created to do that. Clearly, it is doing a lot of good work with local authorities and the NHS. It does not seem to make quite the same amount of progress—

The Chairman: The Wanless report made some key points. One of them was that you had to get to a situation of being fully engaged. We have never got to that stage.

Nigel Edwards: For the reasons that Richard has explained, it is difficult to ask Public Health England to do all the heavy lifting on that. This is a cross-government problem. I seem to remember that Andrew Lansley's original conception was that his role would become much more that of the Minister for Public Health, working across government. Various things intervened to frustrate that, but the thinking behind it was that public health is cross-government. It is as important in education as it is in health. The ability of the health system to improve health is estimated at probably no better than 20% to 25%; the literature varies on this. Most of the rest is done in other bits of government, through the creative use of taxation, what local government does to create healthy environments, what we do in schools and, particularly, early years and support for new parents, and, increasingly—as Michael Marmot has pointed out—what we do on income inequality. None of those things is within the reach of Public Health England, except by very indirect influence. It is constrained in how it does that by where it sits.

Dr Jennifer Dixon: There is a question here about how changes in local government could be accelerated. Everybody knows what the things to do are—the question is, how can they be done faster? One aspect to consider here is how local authorities share good practice. When I was on the Audit Commission, there was a local government group called IDeA, which was a bit like a modernisation agency for local government. It helped to cross-fertilise ideas and gave people support to make the changes that they needed. If, as we all agree, we do not think that everything can be done nationally, we should look more carefully at the regional or local government level to see what extra support might help.

Lord Lipsey: Is there not a tendency to fall back on generalisations in the health prevention field? It would be terribly helpful if one had a table that said, "If you spend an extra £1 on stopping smoking, your return will be X", or, "If you spend £1 on obesity, your return will be Y". That is especially true because these calculations are not altogether simple; if you do not die of smoking, you will die of something else later on. I may be wrong—you may tell me that this exists—but I feel that there is a terrific lack of hard evidence in this area.

Dr Jennifer Dixon: I have not seen that it exists in England, but Wales has just produced the very document that you are describing. It shows what the ROI—the return on investment—is for a string of major public health interventions. It is worth having a look at. Dr Tracey Cooper has been behind that.

Richard Murray: It does exist. You have to have an understanding of what you have included and not included in your costs. A lot of them do not factor in the cost that, if they stop you dying of one thing, ultimately

you will die of something else. There is a bit of methodological understanding about it. However, many of the things we are talking about—whether it is dementia, obesity or the consequences of physical inactivity—make you ill a long time before you die, so they inflict both a lot of costs on the individual who has them, primarily, and a long period of ill health that the health and social care system needs to adopt. In many cases, it is not just about life expectancy.

Such documents do exist. They tend not to be of the nature that you would find in NICE. Generally, they are not randomised control trials—they tend to come from other sources. However, they do exist. They have proved to be quite influential with local government, when the information has been put in front of it, but they are not instantly accessible.

Dr Jennifer Dixon: I am sorry for banging on about data just one more time. As a country, we have greater opportunities to track cohorts of people from cradle to grave than any other country in the world. That would allow us to do cohort analyses, looking at the potential for secondary and primary prevention for people who ultimately become ill. That is not a population health issue—it is much more an issue of primary and secondary prevention at a person level. However, in thinking through to the future, that should be a priority.

Lord Warner: We took evidence from the Department of Health on this. I came away with a very strong impression of a deeply fragmented service area. I could not work out who was really in charge. If this is a national priority, can your three organisations, which are full of clever chaps and chapesses, produce some thoughts for us on what a coherent national priority set of strategies could look like and who would drive them? That would be extraordinarily helpful.

The Chairman: Is the answer yes?

Dr Jennifer Dixon: Yes, we could help.

Richard Murray: Absolutely. It is fascinating that you have just said that. We have been in conversation with some private companies and other charities working around the public health agenda that have begun to ask the same question.

Lord Bradley: As you have touched on this, would you ensure that downstream mental health elements of that co-ordination are included? They do tend to emphasise physical health interventions, rather than the interventions in mental health you have alluded to.

Richard Murray: Absolutely.

Dr Jennifer Dixon: We have already kicked off one or two pieces of work. This year we have done quite a lot of reconnaissance on exactly these opportunities for public health gains. We can share some material.

The Chairman: Thank you very much. Today is an evidence session, so it is all on record. However, we issued our call for evidence only yesterday. We have read various publications that your organisations have produced, but we cannot have those as evidence. If, after today's discussion, there is any material that you feel would be beneficial relating to our call for evidence, we would welcome that. If you were able to distil

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your various reports into the themes that we have identified in our call for evidence and to submit that as evidence, it would be very useful. Any information that you could send us after today's session would also be useful.

Thank you for coming in. It has been most useful.

NHS England, Public Health England and NHS Improvement – Oral Evidence (QQ 32-48)

Evidence Session No. 3 Heard in Public Questions 32 - 48

Tuesday 19 July 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Lord Bradley; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Michael Macdonnell, Director of Strategy, NHS England, Sam Higginson, Director of Strategic Finance, NHS England, Caroline Corrigan, National Workforce Lead - New Care Models, NHS England, Richard Gleave, Deputy Chief Executive and Chief Operating Officer, Public Health England, and Bob Alexander, Executive Director of Resources and Deputy Chief Executive, NHS Improvement.

Q32 The Chairman: I welcome you all to this session. I know you were all listening to the last session, so obviously you are geared up and ready to fire at us. Thank you for coming. We realise that you are the current NHS, but our focus, as you have probably gathered, is on long-term sustainability, thinking about beyond 2025 and finding out from you what we need to have in place by 2025-30 in key areas to make the NHS sustainable in the long term, so that we do not end up with the problems that you and providers out there face today. That is our focus, not the current issues. I know that might be a bit difficult for you, but we hope you will focus on the long term, not the short term.

As I said earlier, we are being broadcast, so any conversations that you and Committee members have will be recorded and seen, and we should try to refrain from that. Committee members will declare interests if they are relevant to the questions they ask. Would you like quickly to introduce yourselves? We will then progress to questions, unless you have an opening statement to make. I encourage all of us—Committee members and you—to keep questions and answers brief to get through, in the time, the many questions we have.

Michael Macdonnell: I am Michael Macdonnell, director of the strategy group at NHS England.

Sam Higginson: I am Sam Higginson, the director of strategic finance at NHS England.

Caroline Corrigan: Hello. My name is Caroline Corrigan. I am the workforce lead for the new care model programme.

Richard Gleave: I am Richard Gleave, the deputy chief executive and chief operating officer at Public Health England.

Bob Alexander: Good morning. I am Bob Alexander, the deputy chief executive and director of resources at NHS Improvement, which is the umbrella organisation for Monitor, the regulator, and TDA, the oversight body for non-foundation trusts.

The Chairman: We welcome you too. I know you are not part of NHS England, but you are important. Does anyone want to make an opening statement?

Sam Higginson: We did not know whether it would be helpful for me to make a few comments about our medium to longer-term financial modelling, given your interest in 2025 and beyond.

The Chairman: There was an interesting letter from the chief executive in the *Daily Telegraph* today.

Sam Higginson: Indeed. Perhaps we could touch on capital later on, if that is of interest to the Committee. It might be helpful to talk a bit about the modelling that we did to support the five-year forward view, because, although it only goes to 2020, it informs our thinking about what might happen after that. Briefly, the forward view made three big arguments about sustainability: first, that we needed a radical upgrade in prevention and people taking control of their health; secondly, that we needed to move to new models of care and redesign how we deliver care; and, thirdly, that we needed to deliver a step change in efficiency, in part delivered through our transformation investment. When we did the modelling that underpinned the five-year forward view, we looked at demographic and non-demographic pressures, which we projected to 2020-21 and which gave us the £30 billion challenge that many of you are probably familiar with from the documents we published. We then looked at the level of efficiency that we thought the service could deliver over time, which is why we modelled a 2% per annum efficiency delivery, rising to 3% at the back end of the Parliament. We argued that the additional 1% could be delivered through improvements in demand management, whether improvements from investment in prevention, new models of care or other demand management initiatives. Then we made the argument about what we needed to close the gap, because, in effect, the 2% to 3% delivered about £22 billion in efficiencies—challenging but doable—and the argument that we made at the time of the spending review was that we needed the extra £8 billion, which would close the gap. The Government agreed that that was the best way forward in the spending settlement.

If we think about what that means after 2020-21, inevitably our modelling is much less developed, because the further out we go, the more variable it is and the more there is uncertainty. Our long-term trend modelling suggests that certainly the demographic and non-demographic pressures will continue. For us, from 2020-25 onwards, it is running at about 7.5% per annum, so we asked what level of efficiency we think the NHS might be able to continue to deliver year on year that far out, and we think it is reasonable to assume about 2% per annum as a long-run average, which gives a 5.5% gap. To try to articulate what that means, it

would be the equivalent of funding the NHS in that period at about 3% real-terms growth, which is higher than we currently receive in this Parliament, but lower than the amount of funding we put into the NHS in the 2005-10 Parliament, for example. That is as far as we got in our longer-term view.

The Chairman: But the whole argument is dependent on efficiency savings. What would make you feel that in 2025-30 you could achieve those higher efficiency savings if you cannot achieve them now?

Sam Higginson: I am arguing that the level of efficiency we might achieve in that period is 2%.

The Chairman: Per annum.

Sam Higginson: Per annum. Work that has been done on long-run averages by York University suggests efficiencies running at about 1.4% per annum over time. Work we jointly did with NHS Improvement and Deloitte argued that we could deliver a secure 1.5% over time, and we could do better than that in getting some catch-up efficiency. Work done by the Health Foundation suggested lower, flatter efficiency over the last Parliament, but, in the year 2011-12, 3% efficiency was delivered. We do not think that 2% is unachievable.

Lord Warner: How much of that efficiency saving assumes pay restraint, and how much pay restraint?

Sam Higginson: Of the £22 billion that we modelled for 2015-20, between £6 billion and £7 billion is a combination of pay restraint and national actions, which leaves about £15 billion for the service. Within that £15 billion, we assumed about £4.5 billion for demand management savings that commissioners can make and about £11 billion that could be delivered by the provider sector in its entirety. Within that £11 billion, we assumed that about £2 billion can be delivered by primary care, which leaves about £9 billion to be delivered by the rest of the provider sector. In our modelling, we assumed that pay restraint continues up to 2019-20.

Lord Warner: Ten years of pay restraint.

Sam Higginson: Yes.

The Chairman: What effect does that have on workforce morale?

Michael Macdonnell: In the original discussions on the five-year forward view—

The Chairman: No, answer that question—not any other question. What effect does pay restraint for 10 years have on workforce morale, when workforce pressures, which we will come to, are horrendous now?

Michael Macdonnell: It will have long-term effects on workforce morale, so, for the reasons Sam outlined, we will have to think about new ways to capture efficiencies beyond this Parliament.

Q33 **Lord Mawhinney:** I want to ask you about this modelling that goes on year after year after year. I want to talk about today, Chairman, but only as a direction for the long term. Every year, we have modelling and we build in efficiencies and we wind up with a deficit at the end of the year. This past year was a real doolally; we had £2.5 billion of deficits. We have

modelling and statements that it will be okay and that by the end of 2017 we will virtually be back to a level playing field, but I bet a fiver to a bent farthing that it will be serious again. This demonstrates year after year an inability to do what you claim to do, so why should we believe any of it when we are looking between 20 and 25 years down the path?

Sam Higginson: I think the deficits that you refer to are the deficits in the provider sector, so Bob might want to comment on some of those. The modelling approach that we take looks at the NHS in the round, so we need to think about the number you refer to for this year in the context of the £600 million surplus that the commissioning sector delivered, the overall position for our capital spend and what happened with the department's budget. As you say, in the last couple of years, the provider sector has run a significant deficit, but over the medium term our strategy would be to bring that into balance.

Lord Mawhinney: Of course your strategy would be to bring it into balance, but we can look at the history, at the amount of money the Government keep having to pump in, because your strategy is, "If we could just have another £5 billion for this Parliament, we would break even", but before we blink an eye it is £8 billion to break even. I give you another fiver to a bent farthing that before we get to the end of this Parliament it will be a lot more than £8 billion to break even. Whether you do it just on providers or whether you do it in the round, why should we believe you?

Michael Macdonnell: Historically, we have not run consistent deficits in the provider sector and we have been able to manage within our limits. It is important to remind ourselves of that context. It is true that this year in particular and the coming years are incredibly tight. I would argue that we have to keep that in mind. The other thing I would argue is that at 9% GDP a year we are still a pretty cost-effective health system. We are undoubtedly constrained and we can see the effects, but there is room, should a choice be made, to fund it more.

Sam Higginson: Another point is that, as part of the spending review strategy, we argued that we needed the £8 billion front-loaded, so £3.8 billion of it comes this year, because we recognise that we need to address some of our current challenges and get on the right transformation trajectory to get back to a sustainable position.

Lord Mawhinney: You would have us believe that, before the election in 2020, you are not going to ask the Government to increase the £8 billion already set aside in this Parliament.

Sam Higginson: Yes, our current strategy is to bring the NHS—

Lord Mawhinney: I am not asking about your strategy; I am asking if that is a commitment.

Sam Higginson: Yes.

Lord Mawhinney: It is a commitment.

Michael Macdonnell: Parliament votes, and that is what we are getting on with.

The Chairman: Are you also saying that you have a coherent plan that

will close the gap between resource need and patient need, looking ahead to 2025-30?

Sam Higginson: No, what we are talking about is a coherent strategy up to 2020, which is 2020-21.

The Chairman: But looking beyond.

Sam Higginson: Looking beyond that, I was talking about our long-term modelling. What we can do with the modelling we have currently—to 2020-21—is projected further.

The Chairman: You are saying that your current plan, looking to 2020, is the model you used, but you cannot be sure, looking at 2025-30, that the model is coherent enough, or that you are confident that it will close the gap between resource need and patient need by 2030.

Sam Higginson: What I outlined was that if we take the demographic and non-demographic trends to 2025-30, that is my 7.5% per annum pressure, and if we then assume that the NHS can deliver 2% efficiency year on year, it leaves me with my 5.5% gap, which is the equivalent of a 3% real-terms increase in funding year on year for the NHS.

The Chairman: If we come down to the real 3% increase per annum that you will require, how do you think we might meet that in resource terms? Is it by direct taxation and free at the point of need, or do you think that another model of funding needs to be looked at?

Sam Higginson: We would argue that 3% real-terms increase year on year is affordable within the current NHS model. I referred to 2005-10, when the average funding increase for the NHS was 4% in real terms, so 3% is not unreasonable.

Lord Lipsey: I am confused. Why is a 5.5% gap filled by a 3% real increase?

Sam Higginson: Because inflation is built in.

Lord Lipsey: The 7.5% figure includes inflation.

Sam Higginson: The 3% real is 3% plus inflation.

Lord Lipsey: The 7.5% is a cash figure.

Sam Higginson: Yes.

Lord Lipsey: How much of that is inflation?

Sam Higginson: About 2%.

Lord Kakkar: I declare my interests in general and as chairman of UCLPartners. **To be clear, those assumptions take into account all the changing demographics and the increased burden of illness that the population will experience over that period.**

Sam Higginson: Yes, we have built in a series of demographic pressures, which try to take into account the changing age profile and health of the population, and non-demographic pressures, which try to measure things such as new drugs coming through the system. Inevitably, non-demographic pressures are more difficult to model; we can predict some types of drug coming through, but we cannot pick up all

of them. To give a sense of that, in the modelling we assume that high-cost drugs increase by 10% year on year, so we have built in quite a large number. This year, for example, a new Hep C drug came through, and that sort of impact is difficult to model over a long period of time.

The Chairman: Is it available as a document or is it just thinking?

Sam Higginson: About six months ago, we provided the Select Committee on Health with the document I have here.

The Chairman: Will you be able to respond by submitting evidence to us today?

Sam Higginson: Yes, I am very happy to. This document is our detailed modelling up to 2020, which will give all the numbers I have been talking about.

Q34 **Lord Warner:** The five-year forward view and the NHS chief executive assumed adequate funding of social care to deliver it. What assumptions have you made for the period after 2020 about the funding of social care to live within the parameters you have just given?

Sam Higginson: You are absolutely right, Lord Warner. One of our key issues was that all our modelling for the five-year forward view assumed that the level of social care—the offer—was maintained. The modelling I have just been talking about is more indicative, so it does not assume anything about social care at the moment. I guess you would argue that the offer remains flat.

Michael Macdonnell: More generally, referring to the article that Simon Stevens put out today, our view would be that, if there was additional money, we would need to talk seriously about trying to get social care to a more sustainable place, not only because of the effects on the people we are caring for but because of the effects on the NHS.

Lord Warner: Can we be clear about what you are saying? You are assuming a real-terms flat increase, so you just cover inflation, for social care for the period up to 2020 and after. Is that the assumption?

Sam Higginson: The five-year forward view is for the NHS—a health model only—so it does not have social care in it, but as an input to the model we assumed that the current social care offer remained flat, because if it increased or decreased there would be an impact on pressures in the health service.

The Chairman: Lord Kakkar has a supplementary, and then we will move to the next question.

Lord Kakkar: Just to be clear, in this type of modelling, if the levels of increase in funding between 2005 and 2010 were maintained beyond 2020, the view of NHS England would be that the NHS was sustainable.

Sam Higginson: Yes, but subject to Lord Warner's point; it is very health-centric. Obviously, we do not have a current view for 2020-25 about social care, but our principal argument would be that the offer needed to be maintained.

Lord Willis of Knaresborough: There is legislation that says that we will have integrated health and social care. There is legislation that says

that you have to increase your offer on mental health. Those two huge things are not even included in your assumptions. I find that absolutely staggering.

Sam Higginson: Mental health spend is included in our assumptions, because—

Lord Willis of Knaresborough: At current levels.

Sam Higginson: Yes. The current commitment on parity of esteem is to continue to increase mental health spending in line with overall growth.

Michael Macdonnell: In fact, we published plans today that show that increase in mental health services year on year. We can provide them to the Committee.

Lord Scriven: If social service funding does not increase to your assumptions, what is the effect on the healthcare system? If there is a 1% or 2% reduction over the period after 2020, what is the implication?

Sam Higginson: I cannot give you a numerical answer, but the implication would be that demand for services from the NHS would increase.

Lord Scriven: Could you write to us with that? I think it is quite important, because it is the fundamental basis on which you have made the calculations for a sustainable healthcare system.

Michael Macdonnell: Additionally, in several of our hospitals, beds are being clogged up and people are being cared for in environments where they should not be, so we are seeing the real effects right now. That is why Simon Stevens set out that one of the tests of the five-year forward view would be an adequate social care funding settlement. Another test was that we would have an upgrade in prevention and public health. I think we would all agree that the jury is still out on that—I am sure we will come to that. We have to do more about it, not least on the national obesity strategy that we are still waiting for.

Q35 **Lord Bradley:** You said you would write to us about the rebalancing. Is the mental health addition a transfer from physical health money, or is it new money to mental health on a projection going forward from the 13% to a significant balancing, to parity of esteem?

Sam Higginson: There are two things going on. One is the parity of esteem commitment, which is that the mental health share of spend should grow in line with overall funding growth. That will mean that spending on mental health will go up over time. Secondly, there are some specific funding commitments—for example, on IAPT, which is additional funding that we are putting into mental health.

Michael Macdonnell: The plan published today shows that in the SR settlements we have additional funding in mental health rising to £1 billion a year by the end of the Parliament. It shows year by year how we are allocating that and stepping it up.

Lord Bradley: We will see the figures. I should have declared my interest.

Q36 **The Chairman:** The responses that you have given created a lot of excitement, but the fundamental question that I do not think you have answered is the question I asked initially: do you have a coherent plan now for the NHS, social care, mental health and the prevention strategy that will close the gap between resources and patient needs by 2025-30? The answer is either yes or no. If you have a plan and the answer is yes, would you please submit evidence to us?

Sam Higginson: The answer is no. We have a coherent plan up to 2020 and our key priorities for delivering it.

The Chairman: As I said at the beginning, our inquiry is looking at 2025 and beyond. The answer is no, you do not have a coherent plan.

Michael Macdonnell: May we explain a little bit about why we do not plan on that kind of basis, or would you like to move on? It is important to recognise that we get resource settlements every five years, so planning for that is very difficult. More importantly, the job right now is to do less strategising and more implementing. Our job has to be getting on with getting stuff done—what we have already committed to do.

The Chairman: The question I asked, and this is the final question before we move on, is: should somebody be doing that? It could be you, but, if it is not you, should somebody be doing it? You referred to it; you said that beyond 2021 you had looked at the demographic changes that might occur and you had looked at the kind of drugs that might come in and the costs that might have to be addressed. You have done some thinking, if not planning. Would it not be better that somebody does actual planning rather than just thinking?

Sam Higginson: It is important that it is done. The issue is partly, as Michael referred to, that a key element is to do with the decisions the Government make about long-term funding commitments. Obviously, we can project pressures and efficiency assumptions, but it is very difficult to come up with a coherent plan without longer-term funding commitments.

The Chairman: Lord Warner, do you have any more questions?

Lord Warner: Not on the quantum. Do you want to move to the next set of questions?

The Chairman: Yes.

Q37 **Lord Warner:** The next bit of the equation that we want to try to understand better is the whole issue of how you actually fund services, and how you can develop payment systems that are more likely to give the service delivery systems you want. I assume that, if you are going down the path of vanguards and STPs, some work has been done on the adaptation of payment systems to help you deliver what you say is the best way forward on service delivery systems. Can you tell us more about that, particularly what has happened to some of the work that Monitor did on different payment systems?

Sam Higginson: I am happy to start. Bob may want to come in. We are working with the vanguards to look at the most appropriate payment system to support their objectives on integration and changing models of care. In principle, we think that the best way to address their objectives is

to move towards what we call a whole-population budget, or capitation-type system, for much of the care they deliver. That is currently possible in the existing tariff structure, so, although in the existing payment structure about £30 billion of activity is on payment by results—activity-based pricing—it is possible within the current structure for commissioners and providers to agree to opt out and move to an alternative structure. We aim to pilot the new whole-population budgets and capitation-type budgets from the beginning of the next financial year in a selection of the vanguards.

Lord Warner: Do you want to add anything, Mr Alexander?

Bob Alexander: Yes, of course. Sam is right. The thing that was most interesting when you spoke with the previous evidence-givers was that no one could say there was a single payment funding solution. As Sam said, we are looking at supporting the vanguard in coming up with whole-population budget payment flows, where they can evidence how that would work, and then we need to stay very close to make sure that we and especially NHSE understand what the outcomes of that payment funding give and what the risks are to the financials of the vanguard. That becomes very important.

We have to look at upgrading the HRG currency that we use in the traditional payment mechanism to make it at least fitter for purpose in the now to inform how we take that forward. As Sam said, we are keen to encourage local health systems to opt out and come up with local pricing mechanisms, as long as we understand the impact that has on both the quality of patient care and the financial positions of the health systems we are engaging with. We are of course looking at introducing mental health payment mechanisms. Again, we have to be really careful about the impact on the organisation and what it does to the quality of care. Underpinning that, and not really part of the payment mechanism but absolutely crucial in giving us confidence as to how we are moving forward on payment flows, is doing a piece of work across the system to improve dramatically the quality of cost capture in NHS organisations, so that when we start promoting payment mechanisms we know that we are doing it on a better financial information basis than we might have done previously.

Lord Warner: To be clear, by the time we get to 2020 and we start the new decade, will we have got rid of payment by results, or will payment by results still be a major driver of costs in the NHS?

Sam Higginson: There are some services that we will always want on an activity basis; examples would be some specialised services where it might not be appropriate to use a small geography to run a whole-population budget. Similarly, there are probably some elective services where we would want particularly to maintain patient choice and an element of competition. By 2020, I think we will have a mixed economy where there will be some payment by result services but a much greater proportion of services will be on a whole-population budget or capitation-type approach.

Lord Warner: Can you send us a paper showing where you think you will be on payments systems by 2020? That is when you will be starting your

forecasting for the next five to 20 years.

Sam Higginson: In the next couple of weeks, we will publish our tariff engagement document, which will set out our thinking on payment for the next couple of years. I am sure that in addition we could provide you with the thinking that went out a bit further.

Q38 **Baroness Redfern:** There is difficulty in measuring outcomes on capitation, so data sharing is critical. Could you elaborate on that?

Sam Higginson: Absolutely. You might be thinking: why move to whole-population budgets? The argument behind that is that we would help to facilitate integration and closer working of services. There are two challenges; I think you heard a bit about them from the previous evidence-givers. There is a big challenge about how to maintain patient choice. What happens if someone is not happy with the caregiver in the locality? How we do maintain the opportunity for them to opt out and go somewhere else? The second issue is that, with a whole-population budget, where you are giving a provider, albeit it an integrated provider, a total contract sum for the year, how does the commissioner track performance, particularly on outcomes?

Baroness Redfern: Precisely. You get efficiencies when you can do that.

Sam Higginson: We absolutely recognise that there is a lot more work to do in that area, hence we are planning to pilot it in a small number of places next year.

Michael Macdonnell: International evidence, especially in the US, showed that, when they could not work out where the costs truly lie, a lot of providers lost their shirt. It is incredibly important to do that kind of groundwork, and it takes a bit of time.

The Chairman: Mr Alexander, did you want to come back?

Bob Alexander: No, thank you.

The Chairman: Lord Warner, have you finished?

Lord Warner: Yes.

The Chairman: We will move on to Lord Kakkar's questions.

Q39 **Lord Kakkar:** I want to turn to the question of workforce. To go back to earlier exchanges on that matter, how do you think the NHS can develop a strategy to ensure that we retain a well-trained and effective workforce who feel valued and committed to an entire career delivering healthcare for our fellow citizens?

Caroline Corrigan: First, we need a strategy. I do not believe there is a workforce strategy for the NHS at this moment. Parts of a strategy sit in individual arm's-length bodies. It joins up—for example, Health Education England, Lord Willis's point about attrition and how important the pipeline is. It goes through to who owns the student and who is trying to attract the student. I am thinking particularly of nurses. There is a need for a joined-up strategy to address recruitment and retention. It exists locally, in local organisations and in parts of us as arm's-length bodies. There is an opportunity to pull it together more coherently.

Lord Kakkar: In the last session, we heard that the size of the NHS makes it quite difficult to do that type of planning across the entire country and across the entire organisation. To achieve a strategy for a sustainable workforce to 2025 and beyond, what model of planning, based more regionally, might be adopted? How are you going to overcome that particular challenge?

Caroline Corrigan: As you probably heard earlier, the job of workforce planning sits with Health Education England, and I can talk to you about some of its work and some of our experience of supporting the vanguard sites in their elements of workforce planning. I think that members of the previous panel talked about the complexity of the NHS and whether it was more effective to plan local to regional than to plan such a complex system continuing at national level. My personal view is that regional and local works.

Michael Macdonnell: To add to that, we are developing 44 sustainability and transformation plans around the country; they are not quite regional but some of the populations range between several hundred thousand and several million. One of the things we want to see through that process is whether those planning footprints are more effective ways of looking at workforce needs, given that they are closer to what they are trying to do on new care models or the retention problems they are having. We would like to see a subnational way of doing it emerge that can connect with the national. Clearly we will need some sort of view nationally of the consequences, but that is one mechanism that might answer the question.

Lord Kakkar: Let us say that the STPs have a view about what the workforce needs are. What exists in the system at the moment, or in what way might we describe the medium-term needs, by way of capacity to develop the workforce?

Caroline Corrigan: To develop the workforce for—

Lord Kakkar: To address medium-term needs beyond 2025-30.

Caroline Corrigan: The aggregation of those plans through Health Education England and the forecast supply and demand pictures are all driven through Health Education England processes.

Lord Kakkar: Health Education England is now interacting with the STPs and starting to receive that information.

Caroline Corrigan: Yes. Colleagues in Health Education England talk about local workforce action boards that have been set up on each of the STP footprints, and natural flows of both labour market and students, and being able to look at the data of the workforce plan against the financial plan for the STP. Some of the work we are doing in the vanguards informs that planning process.

Lord Kakkar: Do you think the workforce planning and future longer-term workforce needs properly inform the financial plan? We heard earlier that the two are very distinct and that a 10-year effective pay freeze for the workforce will have a profound impact on morale? Do you think the two are properly joined up: the financial and the workforce assets?

Caroline Corrigan: Personally I believe that they are more joined up than they have been. It is the first time in some time that I have seen the financial and workforce templates go out together. Between us, as arm's-length bodies with Health Education, we are talking more about better data collection than potentially duplicative and fragmented data collection on the workforce.

Michael Macdonnell: Bob might want to come in on this. If we are being honest, one of the things we see at provider level is unrealistic staffing assumptions, including agency staff. I think there is still a job of work to look at what we can afford and what they think they want to bring on.

Lord Kakkar: I think Mr Alexander might have a view.

Bob Alexander: In no particular order of priority, if there is one area of medium-term, even short-term, planning the service could dramatically improve, it is the triangulation of workforce planning with financial planning. Where we are at the moment starts us on the aspirational journey to do that. In the past, it has been disappointing.

Lord Kakkar: Why has it not happened in the past? Why has it been disappointing?

Bob Alexander: Probably because it has been siloed—the purview of the finance director and the HR director. I am sure we are moving through that, but if you had asked me X years ago I would have said there was something in it. If even the timescales when people ask for a financial plan versus a workforce plan are not aligned, the likelihood is that there will be things that do not necessarily reconcile. We are in a completely different place now.

Specifically on medium-term strategies and what we can do, it strikes me that the strategy is best informed by understanding what is happening now, because then we know what we are trying to fix. A Commons Committee—the PAC—has already asked my organisation to do a piece of work on understanding the current key drivers of nursing turnover and the retention issues that need to be addressed. The result of that should be some time in the autumn. We are doing that piece of work with organisations; it is not just NHSI. I suspect that, having done it, we will try to move into the areas of medical turnover and medical retention. We hope that those pieces of work can directly inform medium workforce planning, let alone longer-term workforce planning, because it strikes me that that would be very beneficial.

The Chairman: Several people want to speak. Lord Willis first.

Q40 **Lord Willis of Knaresborough:** What is coming out of the STPs is very interesting, but what it tells us is that the current skills mix of staff is inappropriate for today's use, let alone in 10 years' time. In the past, the big failing in looking ahead 10 years was designing a future workforce based on the needs of today. We have to get away from that. What thinking is going on at strategic level to drive the changes that appeared in Greenaway's report and in my report, all of which get pushback from the professions themselves? They like silos.

Caroline Corrigan: I can talk about our experiences through the vanguard programme to tackle exactly that point—working with sites to say, “How would you redesign your workforce?” It starts with the basics, which are not to keep counting it in the same way. At the moment, the processes and systems ask providers to say how many doctors, how many nurses and how many of the individual professions they think they will need next year. We are working with vanguard sites to start talking about skills, care functions and the design of work and the design of skill and competence to enable that new service. It is happening now, bottom up, in vanguard sites, stepping away from the processes and systems that demand that you count the same and model the same. Strategically, we take that work to Health Education England to say what we are learning through those sites and how it informs strategic direction, not just the workforce planning pieces but strategy around skills and training pipelines.

Michael Macdonnell: I would add three things strategically, drawn from this and from international examples. One is that we certainly need more generalists than specialists. The number of hospital doctors has grown at three times the rate of GPs in the past, and we need to turn that round. We may need other generalists—geriatricians and so forth. We need maximum flexibility between roles, because we do not know—

Lord Willis of Knaresborough: Whether they are going to come.

Michael Macdonnell: Exactly. We need people to be able to work across hospitals, in mental health, physical health or social care.

We need more incentives for people to work as a team—in multidisciplinary teams. All the international examples are about autonomous teams being able to work around patients, and I do not think we have the funding flows.

The Chairman: Thinking long term, one aspect is the pool that you have to recruit people from. If that pool is not big enough, you cannot recruit people. The second thing is retaining them, and the skill mix that Lord Willis referred to. We need to do some thinking out of the box. You say that we need more generalists, and we agree. Sitting around the table, there are five specialists. Why do people choose a specialism? Because that is what they want to do and there is an opportunity. If you increase the pool you draw from and you do not control its size—the number of doctors we train—your pool will be bigger and you can say to the pool, “We need more generalists”. Why do we not think out of the box?

Caroline Corrigan: We take those challenges to colleagues at Health Education England and say, “How do we do this? How do we change the training pipelines? How do we pay better attention to the labour markets that sit around STPs, for example, and consider the workforce model of the future differently?”

The Chairman: Good.

Lord Ribeiro: One of the problems with a pipeline, whether it is for doctors or nurses, is that it takes a heck of a long time. That has probably predicated British policy on recruiting from overseas. We have one of the highest recruitments of nurses from overseas, compared with many other

countries. Given that we are leaving the EU and that 10% of our doctors and 4% of our nurses come from there, you must have done some planning. The Government have been accused of not doing any planning if we came out, but you must have done some on what would happen if we no longer had access to those staff. What have you done on that score?

Caroline Corrigan: I can refer both to work that Health Education England has done with the Centre for Workforce Intelligence on some of that modelling and to some of the work that is flagged in Health Education England's commissioning and workforce plans, which flagged those sorts of issues. It talks about some of the European labour market analysis and whether that is sustainable. I am flagging; I have knowledge of Health Education England's work in that area rather than our work.

Lord Ribeiro: The Centre for Workforce Intelligence work, looking to 2035, must have been done before we decided to exit. Therefore, those ideas have not been introduced into it. Will there now be some thinking?

Caroline Corrigan: I would need to check with Health Education England colleagues and the department.

The Chairman: When we have them as witnesses, we will pursue that. Lord Scriven, is your question answered?

Q41 **Lord Scriven:** I declare my interest as a member of Sheffield City Council. Clearly, in the new world of integration, workforce planning means much more than just healthcare planning. Beyond STPs, which are a bit patchy around the country, what is the thinking regarding joint healthcare planning, looking at what will be needed in the new network-type approach to delivering services, rather than just within organisational boundaries?

Michael Macdonnell: STPs are our main mechanism for trying to drive this. They are patchy, although Sheffield is a good one. We need to make them better, not to find many other planning mechanisms. STPs have to be a way in which we look across the system, across multiple years. There are smaller, more localised examples—the vanguards are some of them—where social care has been planning together with physical and mental health services. However, when it comes to getting together a geography or place-based plan that brings together local government and health, that is how we want to drive it across the country.

Baroness Redfern: Did you say "place-based"?

Michael Macdonnell: Yes.

Baroness Redfern: I must declare that I represent a local authority. How do STPs play with devolution, on the boundaries and the commitment? How important is that?

Michael Macdonnell: One of the things that we expect to see is horses for courses out in the country. Not everywhere will be amenable to a Manchester-type settlement, but we want to invite as many places as possible to take control of their own destiny. We see STPs doing that. There are graduated steps along the way—

Baroness Redfern: There are flexibilities built into that, if you issue a

good case.

Michael Macdonnell: Yes. We are giving them an indication of their blended budgets. We are trying to get joint governance and decision-making in place between local government and healthcare. In some places, we may put control totals in place. We can talk about that, if you would like. There are a number of steps along the way—depending on the strength of their plan and, much more importantly, on the strength of their leadership team—that go some way towards a more devolved system.

Q42 **Lord Lipsey:** Can we turn to integration, particularly health and social care integration? We know that big efforts are being made to move that forward, but there seems to be quite a contradiction between the belief among many people that you can wave a magic wand and all the problems will go away, and some of the actual estimates. The NAO said that the evidence for any savings was not strong. When the Department of Health saw us, it put them at the top end of £500 million. Can we resolve the contradiction between this as an ambition and the rather modest estimates for savings?

Michael Macdonnell: There are different types of integration—horizontal, vertical and so forth. My take on it is that, when we talk about savings, we are talking not about cutting money but about spending less than we otherwise would, on the projections Sam has talked about. We are trying to bend either the demand curve or the supply curve—or both, if we can. Those are the sorts of savings that we are looking to get. We are seeing green shoots in some of our vanguard sites. It is early days, and we need to do much more work on it, but some of them are getting reductions of as much as 30% in non-elective admissions. If that carries on, it is a material reduction in demand and cashes out in lower funding requirements down the line. If you are looking as far as 2025 and are able to bend that demand line—or to moderate it slightly—it makes an enormous difference. To my mind, that is what we are looking for. You are right to say that the evidence is not cut and dried. However, if we do not start now, I do not know when we will. We have to get on with putting some of these reforms in place.

Lord Lipsey: Could I follow that with a supplementary? There are two big things that need to be considered for integration. One is joint budgeting, on which various experiments are taking place. The other, which is joint payment systems for the individual, is much trickier, because healthcare is free at the point of use and social care is not—it is means-tested. Even on the modest Dilnot proposals, which would not have eliminated that difference entirely by any means, it would be £3 billion by 2025. If you start talking about free social care, on the Scottish experience I guess it would be £8 billion to £10 billion, which just will not be available. That is cracking on for nearly 10% of the health service budget. I do not know whether you think that you can do a good deal of integrating without integrating the amount that people pay.

Michael Macdonnell: On global integration at a national level, there are different systems of eligibility and different levels of funding. In my view, that needs to be resolved before we can go any further out. There are two

other ways in which to integrate. One is in provision terms. That is much more meaningful for patients, as they see people able to manage services around them and can navigate through services. Some of Caroline's work is based precisely on that. There is also more localised budgetary blending. Personal budgets are an obvious example of that. We want to expand it to many thousands over the coming five years. People will be able to blend their social and healthcare budgets and will have control—or partial control, alongside advisers—of those funding decisions. There is a lot that we can get on with locally. Internationally, I remember meeting somebody who had looked across all 800 ACOs in the US. They said that, although they are very different, the one thing that they had all done was invest in what we would call social care, because that is where the costs come from. That will happen locally and organically, even if we do not solve our national question in the next couple of years.

Q43 Lord Warner: Could you walk us through a bit more what you are seeing from the STPs? I will not hold you to the 30% figure, but these are stonkingly big gains. What are the implications of that? Is it widespread? What are the implications for learning out of this experience? What barriers need to be removed? What are the implications for the workforce? What will you change there? Traditionally, people in social care have been rather good at stopping medicalisation of problems, which is much cheaper than medicalising problems. What lessons are there? For the purposes of this Committee, how quickly will we get them from some of the STPs?

Caroline Corrigan: You asked about the learning to date from the vanguard programme. What are we learning from the sites? What are the enablers? What are the blockers? We have information that we can share with the Committee on exactly those things. Based on evidence when the programme was set up, we knew that we would need to do work on workforce and clinical leadership to take forward the changes would be critical. We knew that IT and digital would be important enablers. That is what we are learning from the vanguard sites.

Now that the vanguards have been up and running for nearly a year, in some cases—in others, it is less than that—we are pulling together information on what green shoots we are starting to see, in which sites and how they have made that happen. The vanguards themselves are probably the best advocates and the best people to talk with their peers about how they have made the change, what journey they are on and what they need to do next. Where we are seeing a spread of the vanguard sites or the specific examples where there are green shoots—where they are starting both to spread the learning and to persuade clinical colleagues that this is a good thing—the strongest voice comes from the vanguards themselves. We can share information about the green shoots, the sites themselves and what they are focused on. From the workforce perspective in particular we can share information on the notion of multidisciplinary teams. It is not new, but the most effective areas are those where multidisciplinary teams of staff from different organisations come together, look at the health and care needs of individuals, and plan and manage those. It can be quite simple. It does not require big organisational change; it requires great clinical leadership

and great team leadership. We have examples of our teams significantly changing, improving care for patients and making that more cost-effective. That is the sort of work that we are doing in the vanguard programme. We are happy to share those green shoots.

Lord Mawhinney: Can I bring integration down into the lives of real people and patients, particularly those who are most exposed to it—namely, the elderly, for health and social care? The NHS constitution says that the NHS “is there to improve our health and wellbeing ... to the end of our lives”. It is the “end of our lives” bit. In the context of integration, what are the most recent improvements in health and well-being for people who are in the last couple of years of their lives? How will that improve even further over the next five or 10 years?

Caroline Corrigan: Can I pick up some examples? I am flicking through some papers that I have here. I am thinking particularly of the work that we are doing with care home sites. As part of the vanguard programme, we are supporting six care homes, with the systems in which they operate, to make improvement in end-of-life care and to improve workforce issues, such as the workforce that sits between health and social care and how those people move between the sectors. Those six vanguard sites in and around care homes are focused on improving frail-elderly and end-of-life care. We can give you some examples therein of the difference that they are making.

Michael Macdonnell: Here are two tangible ones that I have seen. The small example is a red bag for people who are towards the end of their life and go into hospitals very often. It enables them to have all their belongings and information with them, so that they do not get medicated wrongly and they know whom to call. That has made an enormous difference in one of the care home vanguards. Another is Airedale, which has used technology to link GPs with care homes so that people do not have to go into hospital. GPs themselves are giving them care and keeping them where they are.

Lord Mawhinney: Do you want me to believe that the NHS constitution is satisfied if you are making real progress for 2%, 3% or 4% of the public and that it does not really matter what happens to the other 90-something per cent? What will you do more generally to improve the health and well-being of the frail elderly? For example, bed-blocking has been a significant, disgraceful problem in the NHS for years. Everybody says that it is somebody else’s fault. What happens, first, to the poor patients who cannot get into the beds and, secondly, to those who cannot get out of the beds? How does that fit into improving “health and wellbeing ... to the end of our lives”?

Sam Higginson: The point about the vanguard programme is that, rather than being a top-down thing, where we think up some ideas here and try to impose them on everyone, it is a bottom-up thing, where places get to try out ideas and to understand what really works in their locality. In the next phase of the work, the idea is to try to spread that as quickly as possible around the country. Going back to your 2% versus 96% argument, while we have only a small number of vanguards working at the moment, the idea is that we will spread that to the rest of the country as quickly as possible. You will then improve your reach.

Lord Mawhinney: If it comes from the bottom up, how will you spread it?

Michael Macdonnell: There is a mixture of ways in which we try to spread this, but it is not invented ourselves. One way is to reduce barriers or to give enablers. One thing that we can do is create new blended contracts that give control of our primary and community care budgets. We can also use our purchasing power in a harder way, to make sure that people implement what we know works.

Lord Mawhinney: Just before the Chairman tells me to shut up, can you explain to me what you are planning to do about bed-blocking?

Michael Macdonnell: We have a couple of things. It is not something that we can solve by ourselves. The better care fund has been put in place for that, in part. Perhaps it has not had the success that people wanted it to have, but in some places we are seeing real success. One example is Oxford, where the new chief executive has employed his own social care workers and closed 75 beds that were previously blocked, as you put it. There is progress, but we cannot solve it all ourselves. It goes back to some of the initial arguments about the implications of social care not being properly funded.

Lord Turnberg: It will be interesting to see how the vanguard sites work out. As you say, it needs long-term, high-quality leadership. Unfortunately, that does not grow on trees. The Committee is probably a bit fed up of my banging on about Salford Royal hospital, which has had a chief executive in post for maybe 15 years. He has a very good team of clinicians working with him. He has taken on the budget for social care from the local authority and has all his GPs linked up to his IT system. I would be interested to know whether you have made an assessment of that. It can work, but it needs these people. How do you get them?

Caroline Corrigan: Where to start? At a strategic level, what is our plan for growing leadership—the sorts of leadership that we need for the services of today and of the future? The work between NHS Improvement and Health Education England in particular on leadership and development strategy is really important. Clinical leadership is where we need to focus more of our energy. You have described great organisations that have great leaders. Most usually have great clinical leadership teams. There is something about whether we invest enough in clinical leadership versus what is sometimes termed heroic management leadership. At a strategic level, it is coming together. More questions are being asked about how we invest in leadership development, who we invest for and what type of leadership we are really trying to grow through these pipelines. Are the leaders of today fit for the future?

Locally, through the STPs and that process, we are seeing a reinvigoration of the conversation about the sort of leadership that we need and how we invest locally, not just nationally, in the type of leadership that we will need. We are likely to see more regional and local leadership development, versus a national strategy that says, “We are the only place that can grow them”. I could go on. There is much commentary out there. It is a great step forward that we have NHS Improvement, with Health

Education England, refreshing—that is probably the best word—the leadership strategy going forward.

Michael Macdonnell: Of course, one other response to the problem is to make that leadership go a bit further. David Dalton is a good example of where chains, hospital groups and so forth are an attempt to make use of the limited resource that we have in that sort of leadership.

Q44 **The Chairman:** When I listen to you talk about vanguards, the STPs, et cetera, it is obvious that you do the thinking. You are responsible for running NHS England. You were the first ones who came up with a forward view of how the service could develop over the five years. You have answered my question. Are you not able to go beyond that and say, “In 2030, this is what healthcare, social care, the preventive aspect and everything else should look like. If that is where we want to be, these are the steps to get there, and this is what the cost will be”? I accept that you are not charged to do that, but somebody needs to be charged to do it. If you are the kid who comes around the block only every five years, we will not get that long-term sustainability of the NHS. Is that correct?

Michael Macdonnell: The part that we do not do, on a much longer time horizon, is the funding or the resources, for some of the reasons that we have discussed. We do a lot of other thinking further down the line. The new care models programme is based on a vision of where we want to get to.

The Chairman: Okay. It would be helpful to this Committee, whose task is to look longer term, if you would submit as evidence what you are doing that will make the NHS sustainable in these areas if we do X, Y and Z now to get to that position. At the same time, in the evidence that you submit, you could say what things you are not doing because you cannot do them or are not asked to do them—giving the honest answers. That would help us. I hope that it would help you, too, in the long term.

Lord Warner: Can I follow up on that point? Could you take a specific part of the country and, based on what you know about vanguards and STPs now or what you will know in the next few weeks, say what the health service in that geographical territory will look like in 2025? I am not asking you to do more than your best guess; no one can ask more than that. We are struggling to get a picture of what the NHS will start to look like in 2025 or 2030. No one seems to be able to give us that picture. You are the nearest that we have for that, because you are looking at new service delivery models.

Michael Macdonnell: I can put some stakes in the ground. We can write—

Lord Warner: You need not answer the question now. It was really just to get some stuff flowing to us.

Lord Mawhinney: You have told us about good things—vanguards, STPs and so on—and have given us an example of where bed-blocking has reduced, but I do not have any sense of how quickly that will become the norm. It would be extremely helpful to know when you think 25%, 50%, 75% and 95% will be achieved on these sorts of things.

Baroness Redfern: I feel sorry for Richard, because he has not had an opportunity to speak on public health.

The Chairman: We will come on to that.

Baroness Redfern: Following on from Lord Warner, with the STPs and the vanguards, can we also see how public health has played its part, and the part that it will play in future, in the sustainability of the NHS?

The Chairman: We are coming on to a question specifically about that. Lord Willis will lead on it.

Baroness Redfern: Okay. I beg your pardon.

The Chairman: Lord Scriven, you have a question before that.

Q45 **Lord Scriven:** Yes. I want to look at data and digitisation. In the last two evidence sessions, it has become quite clear that the NHS does not have a good record on collection, use and sharing of data. Everyone has said that it is really important to help us to move forward and to help with planning and delivery of healthcare. What is the thinking about improving collection, sharing, use and analytics of data going forward, to help to make the NHS more sustainable? The second question is: what role do you see for digitisation of services in the delivery of healthcare? How is the NHS looking at the implementation of only effective services in that field, as it would for any other service that it introduced?

Michael Macdonnell: You are right. You asked the Department of Health to what extent this service is digitised. That is a very difficult question to answer, because the service is broken up into sectors. We think about patient records, services to patients, back-office—

Lord Scriven: That is why I asked the question.

Michael Macdonnell: At the broadest level, we are moving towards a much clearer focus on setting the basic standards that are required nationally and then letting people locally build what they need to around that. Interoperability is a good example of that. In the past, we have pushed out a single solution nationally. That is no longer where we want to be. It is certainly not the direction that Bob Wachter will recommend that we go in when his report comes out. It is about getting and enforcing some basic standards that allow people interoperability, so that they can work together and share data. We have some different mechanisms to do that.

Lord Scriven: A lot of it is not about machinery—it is about human behaviour. You can have all the correct IT kit in the world, but this is about human behaviour.

Michael Macdonnell: Absolutely. We can do only so much about that at the national level. One thing that we can do, for instance, is put clinicians at the heart of this and in leadership positions. That is why we have just appointed a clinical CIO. We will expect other systems to go down that route. Indeed, we will help some exemplar systems to show how this is done better, in a world-class way. For instance, we will work with some of our emerging chains on showing how IT can drive standardisation. We need to show what best practice is so that others can replicate it. Equally,

there are some parts of the country that have solved the data-sharing problem better than others. Lancashire and South Cumbria is one I have been to recently. It has solved all kinds of problems that other people say cannot be solved. We need to push that outwards. That is what we can do.

Lord Scriven: Making it sustainable is about finding good practice. In everything we have talked about, one of your roles is getting that to scale, using your management overhead nationally. What will you do to bring this to scale, so that it helps the NHS to become more sustainable, more efficient and more effective, and to get better outcomes?

Michael Macdonnell: Beyond identifying those standards, we need to start enforcing them. We will start increasingly to do that in our commissioning decisions. We will not buy from providers that are unable to meet the standards that we require. Minimum standards on interoperability are one example of those. We can also support that directly through funding decisions. We have a £4.2 billion fund, through the spending review, that we need to use judiciously and conditionally to drive the spread of this sort of best practice.

Caroline Corrigan: Having those sorts of leaders and those sorts of things done addresses your point about human behaviour. In the meantime, there is also the job of role models—clinicians—talking to other clinicians about why they can do a Skype call and how it works behind them, in the clinical services wrapped around that type of simple digital. Yes, there are levers and contracts, but clinicians have a part to play in scaling this, by stepping forward and role-modelling it.

Lord Scriven: One of the key issues that we have heard in previous evidence is on the analytics—the use of big data, which is beyond the local, to drive improvement. What systematically is the forward thinking about the use of big data, integrating it into the work of the NHS and making sure that the analytics about health information are used appropriately to drive improvement, efficiency and effectiveness?

Michael Macdonnell: We are still in the foothills of this. There is no claim that we are using big data far and wide. Clearly, we need to encourage more of that. The area where I see green shoots most is in increasingly predictive analytics about populations and their health risks. One area I am in touch with—Rochdale, up in Manchester—is working with part of Google and building a predictive analytical platform that looks not just at health and care data but at other data to try to understand better when people are likely to get sick or to have different needs, so that we can make better allocative and, indeed, operational decisions on them. Several other parts of the country are doing that.

Lord Scriven: From what the Department of Health said and from what you have said, I do not get the feeling that anyone has a grip on this strategically. There is a lot of good practice and you talk about a lot of things, but where is this in the strategic planning and focus to help to deliver a more sustainable, effective and efficient NHS? Who has the lead? What is happening to get this at scale, across the board, to make sure that it is delivered in a way that is effective in helping the NHS to deal with its problems?

Michael Macdonnell: We have the lead. On our board, Matthew Swindells has the lead and has appointed a new CCIO, who works on behalf of the system. We accept the accountability on that. We may not be doing enough, but it is baked right into the forward view and right into the STP process. We have digital maturity assessments. We are trying to bring it up the strategic planning agenda. That is quite different from saying that it is as widespread as it needs to be.

Bob Alexander: I may be able to help a little more on that. There is a national digital 2020 strategy, which is backed by the existing Secretary of State for Health. As Michael said, it is backed by some funds that were made available in the spending review. The appointment of a clinical chief information officer who will lead that strategy on behalf of NHS England, the department and NHS Improvement has been an important part of that. The strategy is broken up into particular domains, each of which has a governance and a work programme. Frankly, some are more developed than others. As Michael said, there is a bit of foothills stuff here—some are better than others. That can be made available in evidence to the Committee, now that you have opened your evidence door.

The piece about digital maturity and assessing how patches are has been done. The trick now is to map it into STP environments, to make sure that there is congruity and that the STPs themselves are switched on to it. The real trick is both to back exemplars as best-case demonstrators, to encourage other parts of the country and to show what the art of the possible is, and, by the same token, to identify parts that will not get there by themselves, with the best will in the world, because of capability. We must support them either by linking them through to the exemplar piece or by working across arm's-length bodies, as Michael has intimated, to make sure that we support the right people. We can make something available to the Committee as part of this.

Q46 **Lord Willis of Knaresborough:** I would like to end with a very easy set of questions to Richard, who has waited very patiently. As you have mentioned before, in his foreword to the five-year review Simon Stevens said that we had to have a radical approach to prevention. When you look at the figures, you find that obesity is costing us £5.1 billion, smoking is costing us £3.3 billion, alcohol is costing us £3.3 billion and inactivity is costing us nearly £1 billion. Those are huge sums of money that we need to tackle. Public Health England was set up to address that and to improve the health of the nation. What is happening at the moment that you can project after the five-year plan that will give huge savings that can accrue to the health service and solve the problem that Sam and Michael have?

Richard Gleave: All the time we are jumping between the now and the future. Let us start by doing some of the “now” stuff and then look forward to what that means in the future. If we look at what is happening now, of the 180 or so indicators in the public health outcomes framework, 82% have remained stable or have improved over the last three years. As we know, life expectancy is going upwards really markedly. That is an international phenomenon, but in this country, in some places, it has been happening at a faster speed than in other countries. One of the big issues is that healthy life expectancy, although increasing, is not

increasing at the same rate as life expectancy. That is creating some of what we have called in the five-year forward view the health and well-being gap that is there.

The radical upgrade in prevention has a whole set of aspects to it. It is about prevention to improve people's quality and length of life—their health status—but it is also about prevention of use of high-cost health services by looking at the alternatives. We have talked quite a bit about that component of it.

Lord Willis of Knaresborough: Can I stop you, Richard? The Committee and I know all that. What are we doing to project forward to address these issues? Wanless had some ideas, but that seems to have gone into the long grass. What are you doing now to create a platform so that, by the end of this five years, we really have a platform to address these fundamental issues? Ten per cent of our children are leaving primary schools overweight or morbidly obese. That has huge problems 10 years down the line.

Richard Gleave: We are taking practical steps now, for the five-year forward view. We have identified six areas of interventions. In another 13 areas, we have provided very specific advice to STP teams about interventions that they can put in place and fund in order to address the five-year forward view. I can run through or share those, which have been sent to STP leaders. They are very practical. I have the alcohol one here, if you want me to run through it.

That is the foundation for the next five years. In effect, it creates a platform on which the longer-term sets of issues then need to be addressed. Some of them are about rolling that out across the whole country. In today's hearing, we have already talked in a number of settings about the rollout issue—how fast things roll out. Inevitably, with public health, which is not a tightly managed and controlled system and puts together the multifactorial set of interventions that Jennifer, Nigel and Richard talked about—national government legislation, taxation incentives, personal behaviours and services that the NHS and local government commission—sometimes that rollout is not as fast as we would like.

Lord Willis of Knaresborough: I understand that. I am just asking you what traction you have with the rest of government to address some of those fundamental issues. We know that education and housing, for instance, are fundamental factors in improving health and life chances. Do we have any traction in those areas, or will it all be left to Public Health England? You have no money to do any of this. Do you just pray?

Richard Gleave: We are not a commissioner of services. The commissioning budgets sit with NHS England, for national public health intervention, and with local government.

Lord Willis of Knaresborough: Yes. They will not take any notice of you unless you can say to them, "By doing this, we will save Y".

Richard Gleave: With NHS England, there is a whole series of examples where we have said, "This is what the best-practice advice and the evidence base say". We see that around vaccination programmes. We

have a world-leading vaccination programme in this country that NHS England commissions. We are seeing it in the diabetes prevention programme, with a significant investment in diabetes that is looking to the post-five-year return, as well as the in-five-year return. You have to do both those things. There is a set of interventions we want to talk about on obesity—both childhood obesity and adult obesity. Adult obesity is where the bulk of the cost implications are now, but child obesity is where they will be in the future.

That is with the NHS. With local government, we talk about a massive range of areas. We have the framework around the public health ring-fenced grant and the way in which that is used, with a series of mandated services and functions for local government to commission on. We provide evidence, advice and support around those. E-cigarettes are a really great example. The advice on stop smoking services and what you do about stopping smoking is changing as a result of our report on e-cigarettes. That is a dramatic change. We have a world-leading piece of research there about the practical implications of e-cigarettes for tobacco control.

Lord Willis of Knaresborough: Yes, but there are some clear things missing. For instance, on mental health—I am sure that Lord Bradley will come in here—the smoking cessation programme did not touch people with mental health issues, because you could still smoke in centres. However, there is research going on—not by Public Health England, because you do not have any money, but by other organisations, in Sheffield—that is looking at that and will be rolled out across the country. Where are you doing your research? Where are you gathering the evidence to say, “This will be the next important initiative for us to address”?

Richard Gleave: There is evidence that we have put into the public domain very recently. I have mentioned the report on e-cigarettes. The sugar report that we presented has made a major impact on the public debate about sugar. There are other areas where we have reports forthcoming. We are doing some work around air pollution, which is an important area across government. We do a lot of research around new and emerging infections and future threats. That is not an area I have heard about in the evidence that you have collected so far. The national risk register has influenza as the No. 1 threat to civil contingencies. It is an absolutely central area of debate. There is also work around alcohol. We will have a report on alcohol coming out in the future. Those are some examples.

Q47 **The Chairman:** My point relates not only to this issue but to other issues that we have already discussed. This Committee is all about long-term sustainability, to get a health service in 2030 that meets the needs of the population in every respect for a preventive strategy—not just for the primary prevention of disease, which you mostly focus on, but, linking with NHS England, for the secondary prevention of disease. Stopping people who are sick getting more complications requires a different kind of delivery system. How do you get all that joined up? Are you not working in silos? You have NHS England, Public Health England and NHS Improvement, all sitting separately and thinking in different ways. Are you not sitting in the wrong place?

Richard Gleave: Most emphatically, that is not the approach that we have on the ground. We have that embedded—

The Chairman: But you are sitting in the wrong place. You are not with NHS England.

Richard Gleave: We have staff who are embedded in NHS England. If you look around the country, you will find about 300 Public Health England employees who are embedded in NHS England. We are really joined up about this.

The Chairman: Why do you not just be part of it?

Richard Gleave: That decision was taken in 2013 by Ministers. You would have to ask government why it structured it as it is. My job, and the job of my colleagues, is to deal with the system we are employed within, to make that system work as effectively as we can. We have a great set of partnerships around public health.

Michael Macdonnell: If we had to recreate the system, none of us would recreate what we currently have. However, given what we have—just to add a vote of confidence in this—under the five-year forward view, the chief executives meet every month to drive this agenda. They meet on many other occasions, at different levels. We are trying our best to co-ordinate and provide a much more unified voice. We have achieved some of that, but clearly there is more to do.

Richard Gleave: The role of local government is absolutely central to this. About a month ago, we were at the Health Select Committee. Members of the Committee said—not in a report, but as individual members—that there was no doubt in their minds that moving public health local leadership to local government was exactly the right thing to do. That addresses the wider determinants. Earlier Nigel said that healthcare was accountable for about 20% of the improvement in health. McGinnis says that it is 10%. It is not the major factor here. We have to mainstream this into what local government is doing. It is about places and making the health of local communities absolutely central to the agenda. We must then bring healthcare services in in order to play a crucial and complementary role within that. The STPs have been set up to do that.

The Chairman: I will take questions from Lord Bradley and Lord Warner. Then I will bring the hearing to a close.

Q48 **Lord Bradley:** I will rise to the challenge from Lord Willis. Another figure in the NHS forward view is that not tackling mental health is costing £100 billion—the whole of the NHS budget. All the examples that you gave—as we found last week with the Department of Health—can be caricatured as physical health interventions, rather than mental health interventions. The cost of not having early intervention, particularly for children, in mental health learning disabilities and wider complex needs is horrendous. The long-term sustainability of the NHS depends on those interventions coming in now, within the five-year forward view, and then rolling forward. What is your strategy around mental health on early intervention and prevention?

Richard Gleave: It is a central part of the overall approach within the STP. The Mental Health Taskforce has a series of specific recommendations on prevention on which we have been asked to lead. A working group on prevention has been set up as part of the five-year forward view mental health group. We play a central role in that. We act as a co-ordinator. We are not the only people who are doing important work on this. There is a major emphasis on suicide prevention, which is a big issue that appears in the taskforce report. That is a particular area of work that we are focusing on. However, there is a whole series of other issues relating to having a mentally healthy population that is sustainable. It links very crucially into social isolation, and the wider issues around isolation, and the work on work and worklessness, which is a crucial issue. That is referenced in the five-year forward view, but it is part of a major theme across government. The Department of Health has a unit set up jointly with the DWP around worklessness.

Lord Warner: Richard, I do not want you to get excited by what I am about to say. What you are saying does not sound very different from what Mark Davies told us a week or so ago. I cannot get my head around this. We have several agencies. I am sure that everyone is working in a very co-operative and collaborative way, but we have Public Health England, NHS England, the Department of Health and local authorities. It is not clear to me who is in charge and who makes sure that things happen. I am a simple soul. Can you explain to me who is in charge and who makes things happen?

The Chairman: Very briefly.

Richard Gleave: In charge of what?

Lord Warner: Public health and prevention.

Richard Gleave: The Department of Health undoubtedly has oversight of the system and is thus in charge. That is the overarching body that oversees all the bits. Many of you have played crucial roles in the NHS in a whole variety of different settings. In the NHS, there have always been different organisations that have different sets of responsibilities around them. What we have now is a national public health agency, which we have never had before in this country. Most industrialised countries have national public health agencies. France has recently merged three to create its one, so it is moving in the same direction. A national public health agency is a central part of a powerful and effective public health system. I think that we are doing a good job on that, but there is more to do and more for us to learn about doing it.

The Chairman: I think that you answered the question by saying that, for the long-term sustainability of a strategy related to public health and prevention, we have to rely on the Department of Health.

Richard Gleave: That is undoubtedly the Department of Health's job. We are operational arm's-length bodies that work together around the system. We have an interest in the long term and contribute to it—I could talk about that, but we have run out of time—but our job is about operational arm's-length body executive issues.

The Chairman: Thank you very much for coming today. I know that it is

always difficult for witnesses, because you do not know what we are going to ask and sometimes we get quite excited about the questions that we ask. You have a clear message—that you do a lot of thinking and a lot of work. There is a constraint on your ability to think beyond the next five years, at most. We recognise that. There is also a constraint in that much of your thinking relies on the resources that are available. That issue is not under your control; you cannot control that. All of you have said that you have plenty of work in progress that you would like to submit to us about the work that you have done and the work that you are about to do.

Please look at our call for evidence. If you could address the issues in that call for evidence and submit your evidence to us, we would be very grateful to you. You will pick up from the transcript all the things that you have promised to send us. We will be tracking that, to see whether you do so. Please look at the transcript. You cannot change it, but if there is anything wrong with it, please let us know, because it will be published soon. Thank you again for coming. I appreciate your evidence.

John Appleby – Oral evidence (QQ 49-58)

Evidence Session No. 4

Heard in Public

Questions 49 - 58

Tuesday 6 September 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: John Appleby, Chief Economist, Nuffield Trust (formerly Chief Economist, The King's Fund).

Q49 The Chairman: Can I remind everybody that we are being broadcast now, so any conversations you have will be picked up and listened to by the world? I have to repeat this every time, which gets a bit boring, but if there are relevant interests please declare them at the time if they are not already stated in the Register of Members' Interests.

Mr Appleby, we welcome you here to give crucial evidence. Can I thank you officially for allowing us to consider you as a specialist adviser? We had too many people apply, but we are grateful that you had considered that and you are here to give evidence. That is very important because we will get it on the record now and we could not do that if you were an adviser. I am happy for you to make an opening statement before we progress with the questions.

John Appleby: Briefly, given that this Committee's objective is to look at sustainability, and, in a sense, jumping straight to my conclusion, there is an issue not so much of long-term sustainability in the period that you are looking at up to 2030, as is my understanding, but certainly of a real financial problem in the short and medium term. There is a danger of conflating what is going on now and over the next few years and what has happened over the last five years with a deep, systemic problem with the nature of the NHS and its funding.

The Chairman: Is that all you want to say?

John Appleby: That is all.

The Chairman: Of course, we have to emphasise that, whilst we recognise the short and medium-term problems that we read and hear about all the time, in this report we are trying not to get tangled up in the

current debate.

John Appleby: I understand that.

Q50 **The Chairman:** We are trying to see if we can come up with ideas that would make the NHS sustainable in the longer term. I use the term in the broadest sense of prevention, social care and other healthcare. What are the projections up to 2030 for health and social care funding pressures from different models? What drives those projections? What is a realistic rate of efficiency improvement, because we hear a lot about efficiency improvement filling some of these financial gaps?

John Appleby: There are two types of model that are used to look at future spending. One model is so-called policy neutral. The Office for Budgetary Responsibility produces fiscal projections for public spending every year. This year has been a bit unusual. Given the Brexit vote, it has postponed its latest set of projections, which I understand will come out at some point this year although I am not sure. These are usually based on population projections essentially—what is driving demand from a population point of view—and not just the size but the demographic structure of the population. One way of doing that is simply to look at how much we spend by age group now and do a simple multiplication almost to see what happens into the future. It is not taking account of any policies regarding organisational change, which can be a pressure on costs, spending and so on.

There are other models, including the work that I know Anita was involved in with Derek Wanless, that are not policy neutral. Back in 2002, Wanless was asked to look at funding for the NHS over a 20-year period. It was not simply a mathematical calculation with population, although that was in there; there was also a desire to think about what sort of health service we want, how short the waiting times, what sort of quality and so on. That is a different sort of modelling. It is not so much a projection or prediction; it is more of a policy-driven type of model.

I should say that many countries do this sort of work—I have looked at this in the past—including Sweden, Australia and Germany, but not so much France. The US is very keen on looking at projections in health spending. The Congressional Budget Office does this work. It is a bit like the OBR but it also assesses the impacts of policy on spending. The Centers for Medicare & Medicaid Services—CMS—produces annually not just a projection of public spending in the US but private spending. It employs models to do with population. It looks at inflation, relative price effects, and so on. There is a variety of different ways of tackling this, but there are essentially two: one is policy neutral and one looks at what sort of service we want or how policies drive cost pressures, and so on.

I have looked at five models for the UK. The primary one is from the OBR. As I say, it produces this every year. I have figures from its 2015 report. I have also looked at Wanless, which is interesting, although that stopped in 2022, which is before the period that you are looking at. McKinsey has done some modelling work, as did the European Commission back in 2007, and the OECD. They have all come to slightly different conclusions about where spending may be going in the UK.

I can give you a flavour of the numbers. The OBR started with a base for UK NHS spending—and this is the number to remember—of 7.3%/7.4% of GDP in 2014. That is the baseline year. The OBR produces a central projection, and projections based on tweaking its model slightly, which is to do with different assumptions about NHS productivity. High productivity implies less need for more public money.

Lord Willis of Knaresborough: Can I clarify that you are talking about both NHS spending and social care spending when you give us this 7.4%?

John Appleby: No, that is just NHS spending. I also have the figures for social care and long-term care. The OBR looks at both NHS and long-term care spending. The baseline was 7.3%/7.4% in 2014. It does projections for 50 years, so I have just taken those up to 2030. It produces a range of numbers that go from about 6.8% to about 8.2% of GDP over that 16-year period. That is its range, and as I say it does about eight different tweaks to its model to get those different numbers, but they fall at around 7% as a ballpark figure for what the OBR projects.

McKinsey did some work in 2007 and produced a high and a low figure. Its low figure was 10% of GDP and its high figure was around 12% of GDP. The European Commission produced two figures, again dependent on two different scenarios. One scenario is where the UK health system would contain costs in some way, and the other is where this system would not be able to contain costs. The high figure was 11.3% and the lower figure was 8.4%.

Lastly, the OECD produced some slightly lower figures: by 2030, 7% and 8%, depending on the models it used and the assumptions it made.

There were a lot of numbers there and I apologise. I have offered to put these in a written note to the Committee, as I think they would be easier to consume that way. What I take from those sorts of figures is that they are not huge. The latest projection to 2030 for the US is something like 21% of GDP; over \$1 in \$5 of the entire US economy spent on healthcare. We are looking at a range of figures. If we leave McKinsey on one side for a minute, because I am not sure of the robustness of that, we are looking at between 7% and 8% of GDP over a figure in 2014 of 7.4%. It is not a huge rise over that period. I think those are broadly the figures for health. I am just checking my notes.

I want to say one thing about the short term. I realise that the Committee is not looking at that, but it has a bearing on where the figures are ending up, because they are starting from a certain position. The year 2009-10 was the peak year for spending on the NHS in the UK. It was around 7.8% of GDP on the NHS across the UK. The OBR predict that by 2019-20 that will have reduced to 6.2%. We are in a slump, as it were, and a lot of these projections come out of that slump and rise again.

To make a final point about the short term affecting the long term, on the OBR's central projection it will take until 2049 for the UK to reach the peak it was at in 2009. That dip has a bearing on the long-term trajectory. That is my point about the short term: that that is a long time to get back to where the system was in 2009.

Taking all that together, my broad view about sustainability is that, at least within the period that we are talking, about these figures are not outwith anything that you might think is unaffordable. In a sense, we are getting back to where the system was in 2009, possibly a bit higher but not tremendously so.

You can look at some other countries. In 2014, the EU14 average was about 10.3%, which includes private spending, so even then the average was higher than most of the projections to 2030 for the UK. That gives you another triangulation of it. I have to say that international comparisons are difficult to make. There have been some changes in the way the OECD accounts for health and social care spending. That is my take on the projections for health.

You mention long-term care, and the OBR also looks at that. Others, including Wanless and the OECD, have also looked at that. In 2014, the baseline figure for social care/long-term care spending in the UK was around 1% to 1.1% or so of GDP. All projections show that going up, whether they are based almost purely on population change or not, as you would expect with an increasing proportion of older people in the population. The OBR's central projection is from 1.1% to 1.6% in 2030. The various different tweaks to its model, as I mentioned before, do not have much of an impact on that. By 2026—so just short of your time period—Wanless was looking at something like 1.5% or 1.6%. The OECD had two figures of around 1.6% and 2.2%, again depending on the assumptions that it makes. The figures are in a ballpark of about 1.6% or 1.7% compared to 1.1%.

Lord Warner: Can I seek some clarification? Are we talking about publicly-funded services or publicly and privately?

John Appleby: Publicly funded.

Lord Warner: So all these figures that you have been talking about are publicly funded?

John Appleby: Yes. That is an important point, given the recent pressures on local authorities regarding public funds and the trade-off with people spending out of pocket and so on.

Lastly, I wanted to mention some work that was commissioned independently of the King's Fund from Kate Barker and colleagues, who were asked to look at future funding for health and social care. I will not summarise the entire report, but in the end they went for some sort of combined figure of health and social care. They thought that it was important not to treat them separately. That also had implications for organisations regarding how services were delivered. They came up with some similar figures, to be honest, depending on whether you had free social care and how tight the eligibility criteria were for accessing that publicly-funded care. There are two figures from their report: 1.8% of GDP by 2030; or 2.3%, depending on how you tweak the eligibility and how tough or loose you made that. That is the range of figures for social care. It is hard to judge sustainability. They are relatively small percentages of GDP. As I say, the OBR predicts it rising to 1.6%. That is something like a 5% real increase each year on average between now and 2030.

The Chairman: Can you repeat that, to be clear?

Lord Willis of Knaresborough: Is it 5% in cash terms?

John Appleby: No, in real terms. The move from 1.1% to 1.6% of GDP—I will check my figures later—is something of the order of a 4% or 5% real increase each year. You have to remember that GDP is also growing, so although 1.1% to 1.6% is 0.5% of GDP, the pie is much bigger. Those are the sorts of projections that you have for social care. Barker and perhaps Wanless were looking at policy drivers, so they asked what sort of social care we would like to see. Kate Barker and her group certainly made the point that they would like to improve the quality of and access to social care.

The Chairman: What assumptions about productivity are made when you quote these figures?

John Appleby: Most of these projections have some assumptions about productivity. OBR assumes a high and low level of productivity. By the way, “high” is not tremendously high. For the economy as a whole, something of the order of 2% is generally thought of as labour productivity improvement on average across the whole economy long term. Over the last 20 or 30 years, by most estimates, the NHS has been trundling along at about 1% on average, or something like that. Recently it has had some better years. The OBR makes some assumptions, but they are not outwith broad assumptions about productivity and our experience of productivity in the economy as a whole.

I know that Wanless had quite a battle with the Treasury about what assumptions to make about productivity, because tweaking the productivity measure by half a per cent over 20 years accumulates quite quickly, and if you have a higher productivity assumption, that can be a big offset to the amount of public money going in.

The Chairman: I am going to move on. We will come back to some of this.

Lord Warner: Before we move on—and it is related to the question I want to ask—can we explore for a moment the point that you make? What struck me from what you have just been saying is that it will take a long time to get back to where we were in 2009-10. My question relates also to your point about assumptions about productivity improvements. In effect, you end up with a position where in the short term you could almost make it inevitable that you will never catch up. That seems to be the implication, or else you have suddenly to do what a previous Labour Government did—I am not making a political point; it is a factual point—which is to shovel a huge chunk of money into this system, and which is probably not a very smart thing to do.

John Appleby: And over a relatively short period, I think is also the point there.

Lord Warner: The inference from what you are saying is that if you do not build in some incremental increases and have realistic estimates of productivity, you are creating some very serious problems for yourself in the longer term. That is what I have taken away from this.

John Appleby: I suppose the point I was trying to make was on what the OBR is saying. You could decide to put money into the service, and that would be a policy decision to make, but the OBR's figures are based more, as I say, on population projections, and that is what is driving its central projection. On that basis, it will take a long time to get back to where we were in 2009-10. I am staring at a graph here that I cannot hold up. There has been a large fall over a short period. The graph trundles along. There was a big increase in 2000 to 2009 and it has come down again—the OBR says that it will come down further—and then the projections sprout out of that trough, as it were. That is just the way the projections work out, but you could decide not to follow that path of course.

Q51 **Lord Warner:** Is the current health and care system fiscally sustainable? If not, what options should the Government be considering in the period, let us say, up to 2030?

John Appleby: The conclusion that I draw from these sorts of projections is that it is fiscally sustainable in the sense that we have been there before and the sky did not fall in. Decisions were taken to spend money. You can try to triangulate that with other things, such as international comparisons, although that can be a bit tricky. We have been in a period of austerity where budgets have been cut. The social care system has tackled that in a slightly different way from the NHS for a whole variety of reasons. On nearly all the OBR's projections and those of others, the pressure is always up, but we are starting from a much lower base. My conclusion would be that by 2030 it is fiscally sustainable.

Lord Warner: From your evidence, are things not made worse if you do not regularly each year put a chunk in? If the demography is remorselessly rising, there have to be some guarantees about the annual increase, otherwise you keep falling behind. Is that what you are saying?

John Appleby: That is a political decision about the path you would take.

Lord Warner: Forget about whether it is policy and look at the arithmetic. You were saying that in health and care you would need to put something like 5% a year in real terms into the system to stop things getting worse, in effect. I am trying to get at this point about how we stop going backwards.

John Appleby: The 5% refers to long-term care, not to healthcare, but that figure is not far off. The long-term real increase the NHS has had since 1948-49 has been around 3% to 4% a year on average. It is very bumpy, of course.

Lord Turnberg: Is that in cash terms?

John Appleby: No, that is in real terms, allowing for general inflation that is the average increase that it has had.

Lord Turnberg: Is that as a percentage of GDP?

John Appleby: As a share of national wealth it went from about 3% of GDP in 1950 to that figure of 7.8% in 2009, so it has more than doubled as a proportion, but it has taken a long time to get there. I am not quite sure I understand your point, Lord Warner.

Lord Warner: My point is that I am trying to think about 2030, not 2016. I am struck by what you have said happens in relation to the demography and associated disease profiles if year on year you do not put realistic sums in real terms into the health and care systems, because you end up with a situation where you push yourself towards what Labour did, which is shovel in a big catch-up sum of money. I am trying to understand the flow.

John Appleby: I understand your point now. That is true. When you look at the historic path the UK NHS has taken as a proportion of GDP, you can see where the recessions are, where decisions were made, and so on. My point is that, yes, there has been a falling off recently, so we are potentially on a parallel path to where we could have been, with the potential that the system becomes so poor in its performance and quality that some decision has to be made, and suddenly decisions are made. I agree that it would be better to smooth that over a longer period.

Lord Willis of Knaresborough: I want to link that line of questioning to the previous one, because “fiscal sustainability” is quite a glib phrase. When this report comes out—I was going to swear then—it will mean very little to a lot of people. When you put the figures together for us, can you include the cash in real terms, because I think that really drives home that particular point?

Secondly, when you are linking sustainability to GDP, the reality is that GDP often goes down. It blips, as it certainly has from 2009. Counterintuitively you need to put in even more money in cash terms during those times to maintain a healthy line. Given that we have the Brexit issue, where we may—and I say only “may”—see a significant dip in GDP, albeit in the short term, how do we compensate for that in our projections, and indeed what do we say in our report to overcome that?

John Appleby: I would hate to use a figure of £350 million a week, but, anyway, I think that has gone.

Lord Willis of Knaresborough: Well done, Nigel.

John Appleby: Yes, and that links to my point about the OBR’s projections for this year. It has delayed them because of the Brexit vote. It is reassessing all its economic models. We do not know what will come out of it, but given what a lot of economists’ models have shown about the impact of Brexit on GDP in the medium to long term, it could be that GDP does not follow the path upwards that it would have done and it is slightly lower, in which case that could change some of these numbers because the denominator changes, of course.

Your point about fluctuations in GDP is a good point, and it is one of the issues that I would have with, for example, a hypothecated tax linked to GDP.

Lord Willis of Knaresborough: That is the point I am making.

John Appleby: I think there are tremendous problems with that. Just when you may want to put more money in, in a sense the thing driving the tax is going the wrong way and providing less money for the system. I certainly take your point about the jargon, the percentages of GDP and so on. I did the numbers work for Kate Barker’s committee, and that is

one of the points she made. We did talk about percentages of GDP, but we also put in the cash figure to show the billions and billions that it actually means.

Q52 **Bishop of Carlisle:** You have referred several times to the Barker commission, including in your last answer, and the work that has been done on the integration of health and social care. Could we focus for a moment on social care specifically? My question has to do with the scope for efficiency savings in social care. I think you said a moment or two ago that social care tackled difficulties with funding in a slightly different way from the NHS. Looking to the future, what possibilities are there, particularly in light of the new living wage and the pressure that is putting on the whole system?

John Appleby: Some work was done on the living wage by the Resolution Foundation that I thought was quite interesting in that it showed that many care workers were getting an increase in their wages but that in fact the private sector was in a sense passing on the extra cost in part to local authorities. That is a good thing regarding people getting a better wage and so on.

The point I was trying to make, but did not quite make, about the way local authorities were tackling financial pressures compared to the NHS is, as I understand it, that local authorities have to stay within budget by law. The NHS does not. Last year, of course, the NHS in England at provider level overspent by between £3 billion and £3.5 billion. In a sense, it took its own decision to spend more.

The scope for productivity improvements in social care seems to me far less than in healthcare. One thing that local authorities have done to stay within budget is simply to close services. My first job was in the health service over 30 years ago, and that was what we did then too. We closed wards. We literally went round and chained doors, and consultants could not admit patients. The funding system was such that it was not payment by patient, so we saved some money, and then we opened the wards a month later. By the way, I think that was unacceptable then and it is certainly unacceptable now.

Lord Willis of Knaresborough: The good old days.

John Appleby: Local authorities have tackled their financial pressures in a slightly different way. They have tightened up tremendously on the eligibility criteria. The numbers of people receiving publicly funded social care packages dropped by between 25% to 28%/29% over five to six years. I am not sure where those people went. It is not as if they just disappeared. The presumption is that they started to self-fund, that they perhaps used the health service more—A&E, general practice and so on—and got more informal care and support. With the nature of social care, it is difficult to see where the productivity improvements could come. I have to say that there is not much data on productivity in social care. In fact, I have not come across any that looks at this. I just think that healthcare has a bit more scope over the longer term to improve its productivity.

Bishop of Carlisle: That is helpful. Do you feel that the integration of the two in the way that Barker has recommended would help overall

regarding the finances?

John Appleby: I think so. We have a bit of a model in the UK. Northern Ireland, notionally at least, has an integrated health and social care system. I did some work there some time ago and remember talking to some of the social care people. I said, "This is great. You have them integrated, which is the sort of thing that everybody keeps talking about", and they said, "The thing is when there is a bit of a financial squeeze, we are the ones who get it". They were integrated but not necessarily in the sort of way that Kate Barker discussed, which was in a sense at a bottom-up, professional level. We all have elderly relatives and can see where the integration should happen. To talk about social care and healthcare is wrong, because it is all care. I think that is what Kate was talking about. It was not so much about saving money or being more efficient; it was more that it was the right thing to do regarding improving the quality of care that people received. At the margins in some areas it may be a bit more efficient, but not necessarily.

Bishop of Carlisle: That is very helpful, thank you.

Q53 **Lord Warner:** Can we go back to this issue of rates of change as between social care and healthcare? On the principle that the best predictor of future behaviour is past behaviour, is there some analysis from the data you have available to you that shows the extent to which the annual increases in social care and the health service, for the same demographics, are not running in kilter with each other? Your point about small annual mistakes in assumptions, particularly about productivity, has significant effects over time, and we are interested in what happens in the longer term. Anecdotally, if you talk to directors of adult social services, they will say, "We have had a poor deal compared with the NHS over a long period and we are going to go on getting a poor deal". Is that true? Does the data support their claim? What are the implications when you project that behaviour up to 2030?

John Appleby: They have had a very poor deal. The NHS alone among publicly-funded services has had a relatively—and I emphasise relatively—good deal. I cannot remember the exact figures now, but local authorities have had something like a 30% plus real-terms cut in funding over five or six years. They have done their best to protect their services, especially adult social care services. I would remind you that the NHS is also putting money into local authorities, and has been for the last few years. It has now turned into the better care fund. Approaching £1 billion via the NHS budget is going into social care. Even with all that, when you look at the performance and activity of social care, as I mentioned before, you see that there has been about a 25% reduction in the numbers of care packages. Yes, they have had a tough time and there will be a crisis. In fact, there is a crisis now. Local authorities buy a lot of care from the private sector. They have been very tough negotiators, as far as I can see, in getting a good deal from the private sector, but there comes a point where you cannot squeeze down any more without cutting into the quality of care that is delivered to people.

Lord Warner: Could you go back 15 years and look at those comparative annual increases between health and social care and see, if you carried on

down that path to 2030, what the result would be? This is quite a critical issue for us.

The Chairman: Are you able to send us that?

John Appleby: For social care I have figures back to 1994-95 for England. It is not the whole of the UK, but they can be scaled up. There are some trends there. For the NHS we have figures back to 1950, so yes.

The Chairman: Thank you. We look forward to that.

Q54 **Baroness Blackstone:** Can I come back to productivity savings in the NHS? You implied just now that you thought there was scope for more. The level of productivity savings is around 2% per annum at the moment. If you think there is scope for continuing at this level, or indeed increasing productivity savings, could you say what the components of these savings would be? In other words, where is the scope?

John Appleby: The 2% figure I quoted was a broad figure for the economy as a whole and all industrial sectors. The NHS fluctuates, but it is about 1% on the ONS figures, and from the work of the Health Foundation and the Centre for Health Economics in York. In some sense that is not bad, but it is not brilliant.

When I was at the King's Fund I did some work looking at three areas that have driven productivity in the NHS historically. One was reductions in the length of stay. This is not unique to the NHS; it is across medicine and the world in health systems. People stay less time in hospital. That has allowed health systems to get rid of some beds and, more specifically, to treat many more people and improve the throughput of patients. That has been a big driver of productivity in the past. There is still some scope for that. I should say that it has taken a long time. It was not part of a five-year forward view. Over 20 to 30 years you can see consistent reductions in the length of stay. As far as we can tell, that was driven largely by changes in medical technology and anaesthetics and partly by changes in culture and recovery from operations: why spend your time in hospital when you could be at home? A combination of things drove that.

There are two other examples. The switch to generic drugs has been amazing in this country and in a lot of other countries. Without the increase in generic prescribing since the mid-1990s, the drugs budget for the NHS would be double what it is now. It has had a big impact. It has allowed more drugs to be prescribed per pound, so we have a bigger bang for our buck. Clearly, there is a limit. When you get into 80% to 90% of drugs prescribed and dispensed generically, there is not much further to go. Lastly, there have been changes in surgery and a big trend towards day casework. It has been cheaper and, I think, largely better for patients, and allowed hospitals to treat more people. These are all great productivity improvements.

Baroness Blackstone: But this is about the past.

John Appleby: There is a lesson to be learned from the past, which is that these things take time. You do not see any dramatic jumps. Also, they were often driven by medical technology and breakthroughs in surgical techniques, anaesthetic drugs, and so on. It was not a memo

from the Department of Health imploring the system to be more productive. The lesson for the future is how you encourage that sort of medical technology in its broadest sense.

The Chairman: Coming back to Baroness Blackstone's question, it may be that in the future drugs will be more personalised and more expensive and the technology for improving healthcare may become more expensive, so that whilst the use of generic drugs might be applicable now, it may not be then.

John Appleby: It is true that they may be more expensive at an individual drug level, but they may be more cost-effective, which is a different thing. We may be spending a bit more, but the benefits might offset that. There will still be interventions that require people to stay in hospital a long time. In mental health care, people often stay for a long time in hospital, so there may be more scope there. I am trying to draw a lesson from the past and see where things may go. It is hard to see some huge breakthrough that suddenly dramatically changes the productivity of the health system.

There is also Lord Warner's point about incremental change on the productivity side. The health system has to try to get to grips with what helps to drive and encourage that. We have tried various things, including a payment system of payment by results. In part, that was designed to encourage hospitals to be more efficient. I am not quite sure what the results are on that. We have introduced various incentives. We have had a quasi-competition within the system. I have not seen any work that has suggested that that has bolstered efficiency and productivity that much. From my reading of the history on productivity, such that it is, I would emphasise that it takes time, and it is largely medically driven. It is how you encourage that sort of thing.

Lord Turnberg: I wanted to ask about productivity being measured solely by what the NHS does, when, if we cure someone with some very expensive drug and they become productive in other ways, that productivity never gets put in. If they go back to work and they are no longer on social benefits, that productivity never gets calculated in, and yet it is an important element.

John Appleby: You are right. In a sense you are talking about the benefits and the wider outcomes of a health intervention.

Lord Turnberg: And financial benefits.

John Appleby: Yes, and financial benefits. There are studies of that. The word "productivity" has a very precise meaning in economics. It is like an engineer's use of the word. It is what you get out relative to what you put in. What you get out from the health service is outputs—activities, visits, drugs prescribed, operations performed, and so on.

Lord Turnberg: It is a broad measure.

John Appleby: It is a measure. The presumption is that being healthier is a good thing in its own right. You could extend the scope of how you measure the outputs or outcomes of the health system. It gets a bit difficult to know where to stop then.

Q55 **Lord Kakkar:** I want to return to the question of the way in which we fund health and social care systems and whether that has any impact on the spending required. We have received some evidence from Jennifer Dixon, referring to a report by Mark Pearson from the OECD, which suggests that if you are looking to improve the performance of your system, you should not look towards other systems but focus on driving improvement within your own system, because, quite frankly, there is very little variation of performance between the different systems and much more variation within systems.

John Appleby: I would accept that completely. There are two points here. The first is about the relationship between the source of funding and the total amount of funding. I had a quick look across the EU15 countries; you can do a scattergram of the percentage of GDP spent privately and publicly, and there is a clear relationship. Countries that spend more privately on healthcare tend to spend less publicly, so there does seem to be a trade-off there. Quite what you would take from that for policy I am not sure. I would be very cagey about then suggesting that one way of containing public spending is more private spending, for three reasons. The first is that we have to be careful about what we mean by private spending in other countries. It is not quite what private spending is here, ie out of pocket or through private medical insurance. It includes that and elements of social care spending that are bundled and called private because they come from individuals' pockets. However, when you look at it in Holland or Germany, or wherever, most people consider this to be a tax because they have to spend this money.

The other point is how you encourage people to spend more privately. That produces a whole range of issues regarding problematic incentives, and so on. We have tried it in this country and it was abandoned. Of course there are distributional issues. If you want to switch the proportions of funding from different sources—from public to private, from collective to more individual—that raises a whole lot of distributional and equity issues. From the evidence and from looking at other countries, there is, in a sense, a trade-off between different sources of funding.

Lord Kakkar: Regarding the overall performance, is there evidence that one approach or another, or a combined approach, will deliver better performance?

John Appleby: Regarding the source of funding?

Lord Kakkar: Yes.

John Appleby: I have not seen any convincing evidence that that is the case. You can take some extreme cases such as the US; its total spending is around 17% or 18% of GDP. It spends more as a proportion of GDP publicly than the UK does, but there is a big chunk of private. They spend a lot and get some very good results in certain areas, but some very poor results in others. The source of funding is possibly part of the explanation if you were to try to describe variations in performance between health systems, but I would not attach that much importance to it. There are other more important things, such as how you organise your health service, the economic and professional incentives within the system, the

regulatory model you may have, and so on. I think those are much more important in driving performance variations.

Lord Warner: Can I ask a question about targeted charging, because some systems have used that to reduce demand? I am not arguing for or against it, but what is the evidence about targeted charging, in France, for example, going to see a doctor? Is there any evidence that targeted charging for particular functions reduces demand? One of the issues that we are having to grapple with is this demand issue.

John Appleby: Yes, there is evidence that it does that. There was the famous RAND study in the 1970s or 1980s, I cannot remember the exact date, which looked at the introduction of charges and, yes, it had an effect on demand. There are other studies that show that the levels of charges did not have any effect on demand. There was a study on the abolition of prescription charges in Wales by economist David Cohen and his colleagues. One of their hypotheses was when the prescription charge was abolished there would be higher demand because the charge had been suppressing demand. As far as I can remember, nothing happened; demand did not change at all. There is that sort of study. It can be a bit of a sledgehammer to crack a nut, it seems to me, and it can have some adverse effects. The RAND study famously showed that there were people in need of care who were dissuaded from seeking care. You could say that is a price worth paying to get rid of the frivolous demand, or whatever it is, but that is a judgment and it seems to me that that is not without its potential costs.

Bishop of Carlisle: Can I ask one further thing about targeted funding and whether there is any evidence that the cost of administering these systems outweighs any potential benefit?

John Appleby: From memory, I think the prescription charge raises £300 million or so a year.

Lord Warner: It is more than that.

John Appleby: The administration of it is far less than that, so that is one example. I would add a point, though. If you take charging to see your GP—they do that in France and a number of other countries—it could change slightly the relationship between the patient and the general practitioner. It depends how you structure and organise these things. The point about France, of course, is that a lot of the money is just claimed back through insurance, so it does look like a bit of a bureaucratic chasing of money: having to pay, claiming it back, paying insurance, and so on. By and large, these things can work, but the charge has to be pretty high, and then you run into problems of interfering with people's actual needs for healthcare.

Q56 **Lord Turnberg:** You may have answered this question earlier in talking about the evidence that private funding could fill a gap if public funding falls. At the moment, as a proportion of GDP, what percentage of health funding is privately funded care in the UK?

John Appleby: It was assessed to be about 1.5% of GDP, and it has been pretty flat for quite a long time now, compared to the 7.4% for publicly funded. I mentioned earlier that the OECD has new accounting

methodologies for health to try to get consistent comparisons between countries. On that basis, a lot of private spending on social care is now counted as part of health. On the new figures from the OECD, just over 2% of GDP is out of pocket or through private medical insurance.

Lord Turnberg: Is that in the UK?

John Appleby: It is.

Lord Turnberg: Is there scope for more private?

John Appleby: Two per cent is about average for the EU15 countries now. It could be more. Other countries spend more. For one country—I cannot remember which—it is something like 3.5% to 4% of GDP. I think the question is how you do it. People are already free to spend privately if they want to and can afford it. You could have tax breaks or you could make it cheaper. I do not think that the experiments that we have had in this country have shown that it has been that beneficial in boosting the entire aggregate spend on healthcare. Also, as I say, it is rather skewed by who can afford to cough up the money, crudely.

The Chairman: You have mentioned previously very briefly other ways of funding—I think Lord Turnberg also referred to it—and an ex-Minister of Health recently wrote about a possible hypothecated ring-fenced tax. Do you have views about that model or any other model of funding?

John Appleby: I would suggest that hypothecation is not a good idea on balance in that it does not really solve the problems that people think it solves. First, you have to decide how you do it. One model could be to link a tax to GDP and what the country can afford. We know that there is a relationship between changes in the wealth of the country and how much countries decide to spend on healthcare. It is generally upwards, so as countries get wealthier the decision tends to be to devote a higher proportion of that increased wealth to healthcare and not to, say, potatoes or other choices in life. You could link a tax to GDP, but it could run into a number of problems. What happens when GDP goes down just when you might be wanting to spend more money? That is one problem. You still have to decide how much public money you want to put into healthcare. Somebody has to set the tax, as it were, and make these decisions. Hypothecation does not take away the broadly political public decision about how much we want to spend. I feel that sometimes people put forward hypothecation as a technical answer. You cannot escape the rather difficult decision about how much to spend and how much less to spend somewhere else regarding the opportunity costs. For those reasons, I would say that the way we decide how much to spend on healthcare is not perfect, but it is perhaps a more honest way of doing it.

Lord Willis of Knaresborough: A great deal of your work, and indeed a great deal of the analysis that we have, is about activity within the NHS. We do not have a link from that activity to successful outputs. I have looked at the States, and Magnet hospitals particularly, to see how much more effective they are in not having re-referrals into the system, which, regarding a patient's journey, cuts down resources. Is there any evidence here that anyone is doing the work on whether that efficiency is not simply about the outcome at that point but about the sustained outcome from a particular procedure?

John Appleby: Yes. I suppose there are two answers. We have a process via NICE, which looks at the cost-effectiveness of new interventions and existing ones. It demands evidence of the new technologies that it assesses not just of whether the patient survives but of more complicated outcomes. It also tries to gather the evidence over time—if that is what you are getting at—about the benefits of the intervention. It is not just about health; there may be other organisational benefits, too. That happens once and it may make a recommendation that, “Drug X is cost effective. Okay, NHS, now you can start prescribing it”, but that is not in the sense of a continuous follow-up on the outcomes and longer-term aspects. I guess there will be some ad hoc examples in the health service, but it is not a systematic way of looking at the outcomes. This is partly Lord Turnberg’s point about the range of outcomes and over what period you get a return from this investment.

Lord Warner: Could we go back to this issue of private and public funding? Is there any evidence that the more you spend from the public purse, the more the spend on private funding reduces? The reason for my question is that when I was a Minister, the private sector used to moan about the improvements in the NHS driving down its trade. Is there any evidence that there is some correlation between what you spend publicly and what a nation ends up spending privately?

John Appleby: Yes, there is. I have looked across countries, and certainly countries that spend more publicly tend to spend less privately. That is quite a strong trend. The time trend for the UK on the proportion of public and private spend is difficult to discern, to be honest. I suspect that it is not just about money; it is about some of the achievements of the NHS. I am not sure how to put this, but one of the achievements between 2000 and now has been a reduction in waiting times. That is linked partly to extra money and partly to a focus on waiting times. Waiting times used to be a big factor in driving people to go private; they are not nearly so much now. As I say, that is linked partly to money but partly to other things, too.

The Chairman: Of the different models that you have referred to, is there any evidence to show which one delivers more efficiency, more productivity and makes it affordable?

John Appleby: Regarding sources of funding?

The Chairman: Yes.

John Appleby: I do not know that there is any evidence out there that links it in a direct sense.

The Chairman: You referred to a hypothecated tax, but does an insurance model, whether it is a single-payer insurance or multiple levels of insurance, such as the Dutch model, do better?

John Appleby: I am not aware of any evidence that directly links the source of funding with productivity or efficiency in that sense. As I say, what explains productivity and relative performance is complicated and we do not fully understand it. It is hard to get the evidence on this. Clearly there may be links between how you manage your health system and what incentives you have within the system itself, regardless of how

you fund it, but they are fairly tenuous. There are probably five or 10 different factors that would explain relative performance between health systems, including their performance on productivity, but I would not lay much emphasis on the source of funding as driving that.

Q57 Lord Ribeiro: I have a question that will feed into our next session. You mentioned the French and the insurance side of it, and the fact that they can claim it back. Is there any evidence that that system has a significant impact on demand?

John Appleby: That is interesting. I do not know. I suppose it is economics 101: if you do not have a price for something, demand will be very high. I have to say, though, that I do not have much of a price for going to see the dentist and I am not clamouring to go and see a dentist just because it is cheap. The French system has some strange figures. I think the French are one of the biggest consumers of pharmaceuticals, for example, and I am not quite clear what has driven that. I suspect that culture is driving that and not so much the money aspect.

The Chairman: Is it true that the volume activity in French healthcare is no different from our volume activity?

John Appleby: Again, I do not know offhand. I would be surprised if it were radically different. I would emphasise another point regarding international comparisons. Some years ago I went to a joint conference of French and British health economists in Paris. It was in 2001, just after the WHO had come out with its ranking of health systems in the world, which put France at number one. I cannot tell you the number of French health economists who came up to us and said, "Please don't believe that. We have real problems in our system. Look at mental health care and care of the elderly. Don't just look at hip operations and cataracts, and so on. We have some very long waiting times, but we do not record them properly". I was quite struck by some of the public messages and private experience in different health systems.

Q58 Baroness Blackstone: Do you have a key suggestion for change that the Committee might recommend that would support the long-term sustainability of the NHS? I know that is a difficult question, but it would be very helpful if you could answer it.

John Appleby: It does feel like the question that you get asked at the end of an interview: "If you ran the world, what would you do?" I certainly do not have an answer that the UK needs to spend 10.3% of GDP. It is clearly a choice, and what we spend is what we spend.

A broader point that I would like to see the Committee make is one that Derek Wanless made in his first report. When he came to the King's Fund about five years later to work with me and some others to look again at his work, we made this point yet again, which is that we are relatively poor in this country at doing this sort of work, ie looking ahead and thinking not just about the next few years but the next 20 or 30 years. The only group that does it formally is the OBR, which is pretty constrained in its remit and resources, and so on. I would agree with Derek Wanless that his sort of work—not just the policy-neutral work but more expanded work, such as that done by the Congressional Budget

Office and by the Centers for Medicare & Medicaid in the States—is to set out the numbers. They will change continually and medical technology will move forward, but every three to five years somebody or some organisation needs to do this sort of work and lay out the choices. It is not that there is some pre-prescribed path into the future that spending on health and social care should or will take. There will be choices to be made at any one point. Maybe there will be this breakthrough in productivity at some point that will change all the numbers again. My plea would be for somebody—it could be the OBR, appropriately resourced and with an expanded remit—to set out what the numbers are telling us about the future for health and social care.

The Chairman: We have run slightly over time, but thank you very much. You promised to send some key figures and some data and we would be very grateful for those.

Sir Muir Gray and Professor Katherine Checkland – Oral evidence (QQ 59-68)

Evidence Session No. 5 Heard in Public Questions 59 - 68

Tuesday 6 September 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Sir Muir Gray, Honorary Professor, Nuffield Department of Primary Care Health Sciences; Professor Katherine Checkland, Professor of Health Policy and Primary Care, Institute of Population Health, University of Manchester.

Q59 The Chairman: Can I welcome Sir Muir Gray and Professor Katherine Checkland? Thank you for coming today to give evidence; it is most helpful to us. Please introduce yourself for the record, and if you have any opening statement to make or anything you want to say before we start, please do so.

Professor Katherine Checkland: I am Kath Checkland. I am professor of health policy and primary care at the University of Manchester. I am also a GP and have been working in general practice for nearly 30 years now. Some of the things I will say today will be based on my academic work and evidence, and some may be based on my anecdotal experience as a GP for a long time.

The Chairman: Whatever you have to say is most welcome.

Sir Muir Gray: I am Muir Gray. I am a consultant in public health at Oxford University and the hospital. For the last five years I have been working for the NHS Right Care programme. I do not believe that the problem of sustainability is one of demand; it is on the supply side. The Right Care programme believes that there are £11.5 billion of resources that could be switched from lower-value activity to higher-value activity. I have brought along one of our atlases of variation, which we publish to destabilise the professions, to show huge variation: a fourfold variation in amputation; a twofold variation in the percentage of people dying at home; a fiftyfold variation in knee ligament surgery; and a hundredfold variation in rheumatoid factor interventions—all by people who thought they were doing evidence-based medicine.

I could not produce the CCG report for Dundee, but I have brought along a *Commissioning for Value* pack for the Prime Minister's constituency. You cannot see it on its website. You can see a lot of detail about service provision but not about the fact that they are spending £0.5 billion a year. We have shown them where they are outliers and where the savings are. I will be speaking for myself. I have now handed this over to Paul Baumann, NHS England's director of finance, but I will be speaking mostly about what we have been doing in the Right Care programme or the last five years on the concept of value in healthcare.

The Chairman: Thank you very much. If you would like the Committee to have that as evidence, perhaps the clerk will be in contact.

Sir Muir Gray: I have brought copies for everybody.

The Chairman: Thank you very much for that. You are welcome. We worked together many years ago when you were in the different job of screening, so you keep reinventing yourself.

Sir Muir Gray: Like Dolly Parton, yes.

The Chairman: We do not need a song. Lord Ribeiro.

Q60 **Lord Ribeiro:** Sir Muir and Katherine, we are pleased to see you. I will come back to your map of variations, because I remember you coming to challenge us about that at the Royal College of Surgeons when I was president. What is your understanding of demand management in the NHS? In particular, what is the difference between demand management and rationing?

Professor Katherine Checkland: My take on that is that demand management focuses on users and need, and on trying to work out what healthcare is required. Rationing focuses on supply, so it focuses on what is offered. Obviously, those two things are linked and they overlap, but rationing is on the supply side; it is making decisions about what thresholds and what levels you are going to provide, whereas demand management is about looking at needs and the behaviour of users.

Sir Muir Gray: We decided fairly early on that the issue lay with the professionals on the supply side. It is not the public who lead to the fact that there is twice as much money spent on musculoskeletal services between the highest CCG and the lowest. That is something that we have inherited through 70 years of drift. We still cannot answer the question: how much do we spend on asthma? Is it £1.2 billion or £1.3 billion? The supplementary to that is whether asthma care is better in Somerset or in Devon. We can tell you about every hospital and every health centre to the nearest pound. We decided to look at it from the point of view that we have drifted after 70 years of growth into a position where we do not know what we are spending the money on.

We gave priority to programme budgeting, and certainly in primary care demand comes from the public, but if you look at the system as a whole there is what Jack Wennberg from the Dartmouth Institute called a culture of back surgery in one place or prescribing in another, often driven by the hospital specialist, and the GPs then having to respond because patients come with something that is generated. That is where

we say there is unwarranted variation; that is variation that cannot be explained by variation in need or explicit choice of populations or individuals. Demand is very important, particularly for GPs, but our approach is to look at the budget as a whole and to think of the programme spending—£5 billion in respiratory medicine, which is £100 million per million population—and think about the dynamic. Why has one place got into a certain style of practice and another place into another style?

For me, rationing is another word for prioritisation. They are two sides of the one coin. We are seeing CCGs doing things such as cutting hearing aids for people with milder hearing problems, but they are not looking at the fact that they are spending 20% or 50% more on one service than another. They are diving too much into the detail. Perhaps they are scared of the word “rationing”, but prioritisation is the key word that we have to face up to, as John said in his earlier presentation to you.

Lord Ribeiro: The King’s Fund in its report about rationing referred to “rationing by deflection”. At the time you came to talk to us, one of the big issues was the improving outcomes guidance on oesophageal cancer. Many surgeons at the time were very unhappy about the movement of services to other areas. We now know that the outcome evidence has suggested that was the right decision. Can you think of any other areas in healthcare, and there must be many, where this could be applied? With surgery it is very obvious—it is measurable and there are outcome indicators—but it is not quite the same for other specialties.

Sir Muir Gray: In 2003, a decision was made to introduce programme budgeting. I think Alan Milburn signed the paper. He cannot remember why he signed it, but he did. Programme budgeting is standard in industry. We want to know how much we spend on cancer and mental health. For example, when I am on the road I ask, “We spend £5 billion on respiratory, £4 billion on gastroenterology and £7 billion on cancer. How much do we spend on mental health?” I get the room to vote, and usually the answer is £1 billion to £2 billion. The correct answer is £11 billion. It may be that we should spend more, but we need to start people thinking that way. In relation to eyes and vision, for example—I do not think there are any ophthalmologists on this Committee—ophthalmologists are saying that they want more money for cataracts. Also, we have the fact they are using Lucentis when Avastin would be equally efficacious. They are letting slip in something I managed to stop: glaucoma screening. They do not actually know what the word “glaucoma” means. It is like blood pressure; there is no threshold. They are letting in many million invasive glaucoma surgeries; slipping little grommets into the eye while they are doing the cataract. We have been trying to say to all the ophthalmologists, optometrists and the patient groups, “Ladies and gentlemen, we are spending £2 billion a year, so what do you think is the priority for development? If you have some innovation, how are you going to find the resources by stopping lower-value activity?” We can see that in every programme budget; for example the laser treatment of endometriosis without knowing that it is really the cause of pelvic pain. I am pointing at the gynaecologists at the head of the table. The thing is to get the clinicians and the patient groups to understand that they can campaign for more money, but they then have

a responsibility for prioritisation within the programme budget. That is the approach that we have been taking through the Right Care programme.

Professor Katherine Checkland: I think of demand management as reflecting appropriateness within what we are already spending, and that is making sure that everything is the most appropriate. The other aspects of demand management are prevention and self-management. Part of the problem is that a lot of the expectations of demand management are overblown. There is the idea that by prevention you will save a lot of money or that doing things out of hospital will be a lot cheaper than within. The problem is that the expectations have probably been too high.

Lord Ribeiro: Do you imply that being more transparent about the figures and the costs would actually have a greater impact on demand? How are we failing to get that message across?

Sir Muir Gray: There is the example of the Windsor, Maidenhead and Ascot CCG. This is its *Commissioning for Value* pack. I would be very pleased to send all of you the geographically appropriate pack for your local population. This shows them that compared with the 10 CCGs most like them—so we are not comparing Oxfordshire with Tower Hamlets or Salford; we are comparing it with Cambridge and Hertfordshire—if they perform to the average, a lot of resources will be freed up. The average is not necessarily right. but then we also show them the outcomes in the pack; this is also online. Even though we do not have many outcomes, we show them what we call SPOT: the spend and outcome tool. We use the work of people such as John Appleby, if it is not available as routine data, and then we show people high spend, good outcome; high spend, bad outcome; low spend, good outcome. It is very simple stuff, but it has not been grasped. Partly, of course, it is the way in which we have split the budget.

If you take a CCG, that has only half the money going to a population. Oxfordshire's budget is £600 million, but the total budget for health and social care in Oxfordshire is £1.2 billion; specialised commissioning, prescribing, social care and public health. That is where sustainability and transformation plans in England are very important. Catherine Calderwood's work in Scotland on realistic medicine is fantastic, and I am going there next week. In Wales they have called it prudent healthcare. Northern Ireland has also taken this approach of saying, "Yes, we can campaign for more money", but, as John has said, it is not quite clear what you get for putting more in. Essential to controlling demand is educating the public about self-care. I always say that it is interesting how doctors use less healthcare than non-doctors; they are cautious about having their hip or knee replaced.

The key issue for the resources that we have is to say, "There is £115 billion on the table, there is a twofold variation in allocation of money and a tenfold, twentyfold, fiftyfold variation in activity, and we cannot see that explained by need or explicit choice". It is about thinking of programme budgeting and getting clinicians and patient groups together to think about whether we are making the best use of the resources we have for this population.

Lord Willis of Knaresborough: Excuse me for being rather simple, but

what we are saying seems obvious. Why is it not happening?

Sir Muir Gray: There is a split between purchasers and providers, and game-playing goes on. We know to the nearest pound what we spend in every hospital. I can tell you what we spend on car parking in the Oxford University hospitals trust because it is in the annual report, but no one you meet in Oxfordshire could tell you how much we are spending on women's health or on respiratory, because the GP prescribing is over there and the hospital over there. When Simon Stevens and the new board came in I made a presentation to the non-execs who were from a business background. I said, "It is like a supermarket, really. Every country you go to you see the same aisles: meat, vegetables, fish—respiratory, elderly people and mental health—and as you walk down the aisle you see the same bays: glaucoma, cataract, AMD and retinopathy, and we just think in that way". What we have done, and it has had advantages, is given greater priority to a bureaucratic approach of primary, secondary and tertiary, which is absolutely essential. We have been saying you need to have a matrix, so as well as saying that you know what is happening in every health centre and the CQC is visiting, to ensure good primary care, you need to be able to answer the question, taking quite a simple problem: is care for asthma better in Somerset or Devon? There is a need to have what we call a hybrid organisation, and that is what is coming in with the sustainability plan.

Professor Katherine Checkland: From my perspective as a GP, one of the issues driving demand is multimorbidity in the elderly. It is very difficult to split it up. You need to prioritise for each person. For a particular person their glaucoma may not be a problem and they are more concerned about their orthopaedic problems and their multiple problems. That is one of the problems with the idea of splitting it up into very individual pots. In practice I am experiencing populations of very elderly people with lots of different problems, and it is a matter of managing them and what matters to them.

Sir Muir Gray: We have also introduced programme budgeting, and if you were to ask, "How much do you spend on children?" or, "How much do you spend on elderly people?" no one can answer you. We have two types of programme: one is by disease category, such as cancer; and the other is by baby/children/teenagers, healthy men/healthy women/young disabled people/homeless people and—the most important—people in the last year of life, and there is probably £1 billion spent in the last year of life that does more harm than good.

Q61 **Baroness Redfern:** Katherine, do you see more helpful and more integrated work with GPs and local authorities—I am thinking of people with mental health issues—rather than the dishing out of prescriptions and green issues, such as getting people walking, losing weight and being less isolated, in a growing population of young children as well with obesity problems? Do you think that more integration can affect demand management and manage it really well?

Professor Katherine Checkland: The answer is that yes, obviously, there are lots of benefits to be had from functional integration; benefits from the patient's perspective and benefits as a practitioner. I am not

sure that big reorganisations that try to structurally integrate are necessary. Whether the functional integration of us working more closely together and across boundaries will save money or reduce demand is, I think, a very different question. There is not much evidence. A very good review by Nolte and Pitchforth found that improved integrated care increases satisfaction, but there is no robust evidence of cost reduction.

Baroness Redfern: Even in mental health illness where patients are occupying beds for a long time?

Professor Katherine Checkland: I do not know the exact figures in the mental health field. It is probably cost effective, but cost reduction is a different thing. A lot of things are cost effective but are unlikely to reduce costs overall.

Lord Scriven: I am absolutely fascinated by the fact that basically you have turned the clock upside down and said that the real issue here is supplier-led demand rather than demand from individuals. Clearly, if that is the case and there are huge savings and improved outcomes on the back of that—I think that is what you have been saying—based on this programme budget base, what does that mean for how health services are structured in the future? I do not mean the structure necessarily of the health service because it completely changes the whole basis of the autonomy of a doctor, the decision-making of doctors; I mean that it completely changes the way in which healthcare has to be delivered and, within that, the cultures and assumptions that have been made. What are the other implications, rather than for the structure, for following this type of model if it were to be introduced in the future?

Sir Muir Gray: I speak as a veteran of 22 structural reorganisations of the NHS, most of which have made no difference at all. I remember one where the chief executive of Oxfordshire said on the front page of the *Oxford Times* that he would like to reassure GPs and the public they would not notice any differences as a result of this reorganisation. Let us leave the structure, as you say.

That leaves two other issues: systems and culture. We have been saying, as you say, that the integration of structures is not important; it is the culture of the different professional groups and the patients. We have called it—and Public Health England is leading on this—population healthcare. That is healthcare that focuses on populations defined by whether you have a symptom such as pelvic pain, a condition such as asthma, or a characteristic such as multiple morbidity. You get people in the room, lock the door and say, “Ladies and gentlemen, this is what we are doing, this is how we are spending the money, this is where there is game-playing going on”, which is sometimes aggravated. Remember that Gandhi said that no structure will make a bad man good but the wrong structure will make good men and women behave badly, so there is the question of tariffs and referrals and those sorts of things.

Right Care has now appointed 20 people to take over from the team that I set up, because I did the development work, and they are now bringing every CCG together to say, “We have to look in a different way”. We are also thinking a lot about language. I never use the word “savings” with doctors, unless there is overspend, because it is about value

improvement. We have called this value-based healthcare. There are three types of value. Allocated value is how you allocate the money between old people and children or cancer and respiratory and then the clinicians; how you allocate the money between asthma, bronchitis and sleep apnoea; or how you allocate the money between prevention and treatment. Secondly, there is technical value, which is much more than efficiency, which the Americans write about, as John said. Technical value means that you also have to take overuse—are there people having operations who do not really benefit—and underuse into account. In the NHS the rate of knee replacement in poor people is a third of the rate of knee replacement in wealthy people. Then there is personal value. We have tried to change the culture. We have financial systems called programme budgeting systems, and they are not sensitive enough to multimorbidity yet, but that is shifting the matrix of the hybrid organisation, as Andy Grove called it. That is the approach that we are now trying to develop in NHS England.

Professor Katherine Checkland: It is probably not fair to think that CCGs are not sensitive to this thinking or not doing it. We do a lot of observational research in CCGs where we sit in on their meetings and watch what they are doing. They talk about this stuff a lot and they compare themselves with others, including their spend. One of the problems is that their spend is driven by PBR and it is very difficult to make these changes when your spend is delivered by individual referral decisions and the payments that follow those. I have looked at these packs. CCGs compare their spending with other people, and most of them will know where they are outliers, but making those changes happen is difficult in the current structure.

Q62 **Bishop of Carlisle:** Moving from that bigger picture more to the specifics, you threw out an absolutely fascinating comment—as an illustration of the general point you have been making about the possibility of shifting funding from one area to another—about end-of-life care, set at £1 billion, and funding being wasted on end-of-life care. Could you expand on that a little to give a flavour of some of the specific points?

Sir Muir Gray: We can have a good GP perspective on this too, but let me start. The word “waste”—this was very like Toyota when I was doing their screening programmes—means anything which does not add value to outcome. The Japanese word is “muda”. There is another great Japanese word, “mottainai”, which is a feeling of remorse for having wasted resources. I do not see much mottainai in the NHS. We have been interested in these words “waste” and “value”. Waste has won over value. What do we mean by waste? There are some things which most clinicians would agree are futile, but these are difficult ethical choices. If someone comes in with a bleeding aneurysm, and there is no advance care plan, there is a huge grey area for the anaesthetist, the patient and the relatives. I am working with some excellent people in the gold standard framework group, who are looking particularly at people in care homes. Often, however, because there is inadequate home nursing, the bank staff panic in the care home, they phone 111 and the resident goes into the ambulance and into hospital. This is starting to look at things such as people with multiple morbidities dying in intensive care. I am not saying

that no one with multiple morbidities should go into intensive care, but they may have slipped in there. It is tied in with people having explicit advance care plans at a much earlier age. That is the sort of area where economics moves into the ethics and these difficult decisions of clinical practice.

Professor Katherine Checkland: It is a moot point whether you could actually save that money. My experience is that we underspend massively on community care and care in the community. Community nursing is paid for in a block contract and my experience is that as community nurses' workload goes up they work harder and so no more money goes into the community care side of things. Research has been done, including a literature review by the Health Foundation, looking, for example, at the notion of virtual wards and whether, instead of people being in hospital at the end of life, it is cheaper to care for them intensively at home. The answer is that it is not cheaper; it is better but it is not necessarily cheaper because of the amount of care required at home. We talked earlier about the disappearing costs. Where have those 25% of people gone who are not getting publicly-funded social care? In my experience as a GP the answer is that they are paying for it themselves, but we have no idea who is paying for what. There is no way of capturing that because people pay for it privately from an agency; there is absolutely no way of capturing the amount of money that people are paying on private social care.

Sir Muir Gray: I am not advocating savings—we do not use the savings word. However, taking end-of-life care, we have to say that also in that budget is polypharmacy and hospital use. Looking at the idea of a population-based budget, that would mean you would have to either lock a hospital ward or pull the mattresses off—if you take the mattresses off they cannot admit people—and shift the money. We are starting to look at ways in which we do not talk about money but everything is expressed in the number of district nurses. For me, the two highest-value activities are district nursing and chiropody. That motivates clinicians. Clinicians are motivated by savings and by doing things differently. That is the approach of taking a very complex and ethically difficult area such as end of life and applying what we call a system budget and then thinking how to move the resources to give more district nursing and more home support.

Professor Katherine Checkland: That is very difficult in the current funding system.

Q63 **Lord Warner:** Can I bring us back to the funding gap? Ever since about 2010 the funding gap identified for the future has placed very high expectations on demand management. Much of that demand management has had a strong focus on patients and the gate-keeping function, and traditionally the GPs have been gatekeepers since 1948. From what we are hearing today, given the time it takes to get the physicians to change practice, how realistic are the expectations now being set nationally for making the books balance through demand management?

Professor Katherine Checkland: I do not feel that they are particularly realistic and that a lot of the things talked about as making cost savings

will not necessarily do so. For example, it is not necessarily cheaper to care for people in the community; it is not necessarily cheaper to look after people properly out of hospital. We all know that generally costs in the NHS are driven by proximity to death rather than by age per se, so however good you are at prevention, people will reach the point where they are going to die. There is no good evidence that you can save money overall. There is a lot you that can do on better allocation and managing people in better places, and you can get more cost effectiveness and better outcomes for patients, but the evidence is not necessarily that you can reduce costs overall. There have been quite a lot of literature reviews about, for example, doing more things closer to home. A lot of the work that Martin Roland has done—who I am sure has given evidence at various different committees over the years—showed that bringing things out of hospital, although it may be better for patients, is not necessarily cheaper. There are a lot of assumptions that are probably not true.

Lord Warner: Pursuing that further, once you get into hospital you are captured by PBR. Is the issue of demand management still, as it has historically been, back with the GP? You guys and girls are sending these people into the high-cost area where the PBR system starts to come into operation. I am trying to get a sense of how we break out of that cycle. Most people get into the system through you and your colleagues.

Professor Katherine Checkland: There was a very good review recently by Ray Pawson from Leeds for NIHR, which looked at demand management and planned care, and at referral management and how we keep people from being referred. I can send the report to the Committee. The conclusions are interesting. There are lots of ways in which you can do referral management and reduce referrals from GPs into hospital, but there is no one way that works because a lot of it is relational; a lot is driven by relationships between patients and doctors. For example, there is some evidence that if you have continuity of care you are less likely to refer on. If the doctor knows the patient and the patient knows the doctor, there is a reduction in emergency care, so people turn up less at A&E and there are probably fewer referrals. You can set up referral management centres where there is an intermediate step to manage the referral process, and that seems to work where there is professional buy-in and where people feel ownership of it, but it does not work if it is imposed top down. It is complicated but, yes, there are ways in which you can reduce the number of referrals. However, there are not necessarily clear cost savings to be made, because often those people need other things or they need them in different ways.

The other one that comes out a lot is giving GPs direct access to tests. That is quite an interesting one, because that can rule out a referral. You might do a test and then not refer somebody. There is some evidence that that tends to reduce the threshold, so you do more of them and you get this capture, because you do a test and the thing you were worried about is not there but you find something else, an incidental finding that needs to be chased down, so you get that technology-driven demand.

Lord Warner: Sir Muir, if we cannot stop them getting into hospital, what are you going to do to stop them getting the higher-cost interventions?

Sir Muir Gray: My question to the chief exec of a hospital is: are you in the real estate business or the knowledge business? We have a real estate business that is driven, as you were saying, by the Gandhi principle that there are things making good people behave badly, because you have to refer. You cannot phone a specialist; you have to refer. I see an organisation as three things: a structure, systems and culture. We have fiddled with the structure 22 times in my career, but we do not have systems. In Right Care, first, we published these atlases to destabilise that showed huge variation in almost anything you look at. This one is on elective breast surgery. We did them on paper because you cannot run away from paper. On the internet you can click away from them, but these are very powerful and written for emotional appeal, not for information-giving. Secondly, there is programme budgeting, to create a culture of stewardship and, thirdly, systems. I have brought along a copy of a handbook on systems. A system is a set of activities with a common set of objectives.

Let us take something that we did in Public Health England; atrial fibrillation. There would be 5,000 fewer strokes and 10% less dementia if you managed atrial fibrillation as well as they do in Bradford. The GPs in Bradford got together and sorted it out, but no one had written down what they were trying to do. We then wrote down a system specification. Based on Toyota, I did this with screening, but most healthcare is much more complex than screening, so we used a theory of complex adaptive systems. The ant colony is the best example. All the ants work together for a common aim. This has also been used in military thinking; the strategic aim is set once and then the operational command will deliver the service differently in different places. Atrial fibrillation was addressed very well by GPs and haematologists in Essex. You do not tell them how to do it; you set an objective. The key thing is starting to do it.

We have done this with quite a few things, including complex problems such as women with pelvic pain, and this has started moving to a new way of working. As I say, we never use the word "savings"; we ask, "Is there better value?" If you wanted to improve the system for people with atrial fibrillation, you would start within the present budget. Then there might be a case for switching money from neural or anticoagulants to other areas, or you might have to move money from heart failure into rhythm disorders. You start to think in a different way about how you do it. It is not structure, it is systems, and that is where it is starting to evolve now in the NHS.

Professor Katherine Checkland: It can work in very simple, practical ways. I have an excellent local cardiologist in Chesterfield, Dr Cooke, who is fantastic, and if I have a complicated patient I can ring him, I can get advice and I can manage the patient myself without referral. One of the difficulties with the system we have is that those direct lines of communication do not need structural integration but the ability for me to get the advice I need at the point I need it. However, that also needs me to have time. One of the problems in general practice at the moment is that we are so overloaded that that time element goes and it is quicker to refer than to take the time to get a consultant on the phone when you have queues of patients at the door. It comes back to some of what John was saying earlier: that if you have an overloaded system at the moment,

it becomes a less efficient system because you do not have time to do the things that would make it more efficient.

Q64 **Lord Warner:** At the national level, assumptions are being made about what demand management will produce for NHS expenditure. That is the political and public reality that we live in. How quickly can the kind of ideas you are talking about, on the supply side, produce measurable numbers that you can produce, for example, to the Chief Secretary to the Treasury?

Sir Muir Gray: I am being replaced in the Right Care team by 20 people. However, I worked with only a small number of CCGs. We have a team led by a chap called Matthew Cripps, and I think it would be good for him and Paul Baumann to tell you what they are doing. They are going to every CCG and showing them where they are. The health service does not manage knowledge properly, so if someone has managed atrial fibrillation well in Bradford there are also very poor ways in which other people learn that. We are setting up a casebook, as you would in any well-run organisation, where people can say, "Okay, we have a problem with emergency calls in Scunthorpe, and this is what the Blackpool Ambulance Service did". Learning from within the system needs to be accelerated greatly.

Professor Katherine Checkland: That will improve distribution and outcomes, but it is a moot point whether it will produce measurable savings that you could take to the Treasury, because I do not think it will.

Sir Muir Gray: But I am not in the savings business; I am in the value business.

Professor Katherine Checkland: I do not think there is any evidence that it will, because there are large parts of the system that are underfunded, such as district nursing and community care. If you are going to do these things well, the money needs to be moved. I think it is overstated that it can be saved.

Baroness Blackstone: I would like to ask a supplementary to Sir Muir's big macro question that is slightly more micro. Surely demand management should be partly about access to different levels of skill, training and cost as far as the workforce is concerned. To give an example, you say that GPs are terribly overloaded. Should work be done on how you filter out people with very minor ailments visiting GP surgeries so that they are not seeing highly trained and very experienced general practitioners but are seen by good but less expensive nurses, for example?

Professor Katherine Checkland: Some work has been done on that. My colleague, Bonnie Sibbald, at Manchester did quite a lot of work on skill mix and the idea of getting nurses or less highly-qualified people to see patients in primary care. They found that it is safe and acceptable to patients but not cheaper, for the simple reason that the less highly-qualified people take longer.

On the savings that you think you might get from changing skill mix in primary care, certainly the work that Bonnie did showed that they take longer to do it. The same goes for triage and having people at the front

door. There is some evidence that the more highly qualified the person the patient first makes contact with, the more efficiently the patient is dealt with. When I used to be on call at the Stockport Doctors Co-operative many years ago, we used to have GPs or highly-qualified nurses doing the front-line triage, and we saw far fewer patients than when you had less well-qualified staff dealing with an algorithm, as they have with 111.

Baroness Blackstone: Can that not be resolved by training? Are you not being somewhat defeatist?

Professor Katherine Checkland: That is the evidence of how it works in practice. Can you speed the nurses up? “I do not know” is the simple answer to that. However, when they have tried to do it, that is what they have found has happened.

Q65 **Baroness Redfern:** We have talked about demand management. What is the role of integration of health and social care in managing that demand?

Sir Muir Gray: The point has been made that changing the structure will not necessarily do it. I went to Northern Ireland many years ago with a single budget and there was the same problem: the doctor did not get on well with the social workers, the social workers did not like the nurses and the nurses did not get on with the doctor. It is a professional problem. We have to focus on culture; the culture of collaboration and identifying obstacles to common sense, as we were saying. Sometimes the consultant who speaks to a GP on the phone is given a row by their chief executive for not encouraging a referral.

Professor Katherine Checkland: Or for not charging it.

Sir Muir Gray: That means there is a disincentive. We have to stay away from yet another structural change.

Professor Katherine Checkland: One of the problems with social care is the huge unmet need. I am very sympathetic to the notion that we should think of overall spend but we do not know the depth of unmet need out there. I worry about the health budget being swallowed up, if you like, by some of that unmet need.

Baroness Redfern: You do not think there are any savings in acute services to have that joint working?

Professor Katherine Checkland: There is no evidence yet that there is. I would not say whether it is potentially possible or not. The integration pioneers have looked at that in the work that has been going on, but there is no evidence yet. A lot of people working on integrated care at the moment are using the integrated case management model and taking the most at-risk patients and putting together multidisciplinary teams for case management. There is pretty clear evidence now—in work done by one of my PhD students—that that does not reduce admissions to hospital. We know that now, but we are still pursuing that. Focusing just on those high-risk patients does not make a difference. There is certainly potential for improvement in patient experience, but I would be very sceptical about whether it saves money and reduces demand overall.

Sir Muir Gray: The proportion of people dying at home varies from 78% to 46%, so there is something going on at the local level that is very difficult to recognise. The question is getting people to start looking at where they stand in comparison to others. Both the 78% and the 46% of people will think that they are working their socks off. We have been trying to say to them, “Why don’t you go and see these other people and see how they’re doing it?”

Professor Katherine Checkland: However, it is not necessarily cheaper.

Sir Muir Gray: No, but it is the value. I have never used the word “cheap”. The word “value” is quite tricky, of course—remember that contaminated meat was on the value stand at the supermarket a few years ago. We are always using the word “value” for professionals: “You want to increase value, don’t you?” How can you shift resources? Often the professionals have a bit of resource hidden for the next pressure that comes along in the hospital; they hide away inefficiencies. We have to listen collaboratively—the ant colony again—to say that we all have to work together. You say that healthcare is what people do for themselves, and we need to think not just about changing professional roles but about the role of the internet. Why did a hairdresser tell me that hairdressers use the internet more than the NHS? I said that they have been to university for five years and then six years of postgraduate training and they are a member of the royal college of hairdressers. We are completely off the pace. We now have a new director of digital, Keith McNeil. I do not know if he is on your list. We have to think of ways in which we can start to look at reducing the pressure on clinicians. The internet is there and will increase pressure, but I do not feel that we have adapted yet. In my view, the mobile phone will have a bigger impact than the human genome in the delivery of healthcare. We need to think of how that is supported.

Lord Warner: I am sitting here thinking that you have done all this stuff on QIPP and you have all this data, so why do the budgetary flows not follow those findings? This hearts and minds stuff is all fine and dandy, but the reality is that the money is very short. The direct way to this is to say that you have done five years’ work and changed the budgetary system to implement that on a population basis. Does that not start to deliver?

Sir Muir Gray: Yes, we have to go for programme budgeting, not just for conditions. There are about 30 programmes such as elderly people’s morbidity, and in the sustainability plans in England at the moment there is a bit of a battle between the provider and commissioning sides. They have to work together with a single budget, and that does mean a change in the bureaucracy of the budget as a cultural change.

Q66 **Lord Kakkar:** All this has been covered with regard to the sorts of demand management that the NHS should be implementing, but perhaps you would like to comment on that. Specifically, is there a role for devolution and much more community-driven and community-based approaches towards the question of demand management? Baroness Blackstone also raised the issue of the relationship between the demand for healthcare and what that will do for workforce demand.

Sir Muir Gray: The paper I have prepared for you shows that there is a twofold variation in spend in mental health, a twofold variation in spend on musculoskeletal, a 1.8-fold variation on almost everything. That is what we have inherited. You cannot lay down nationally that you should be spending this on eyes and vision and this on cancers. It has to be at the level of the population. I should know; there are 44 sustainability plans. Scotland is moving to seven populations, and Wales, too, is moving to four or five. We have to focus on populations, probably ones that are a good bit bigger than the CCG populations, of maybe 1 million or 1.5 million, put all the money on the table, lock the door and get people to work together. It has to delegate to that level. In England, the FPP is at about the right level at about 1 million to 2 million.

The Chairman: Do we have any examples of where this is working?

Sir Muir Gray: Yes, I think we do now. I can see it happening in Manchester, obviously, and there is something called the Oxford Value Improvement programme. The key issue is one of trust and collaboration. Still, the providers are under understandable pressure and trying to defend their position in the hospital budget. Look at the spend in general practice compared to specialists in the last 10 years.

Professor Katherine Checkland: It has gone right down.

Sir Muir Gray: It is this issue of getting people into the room and locking the door. Put the map on the wall and look at it.

Professor Katherine Checkland: Also, the current rules make it quite difficult. There is a lot of working around going on with everyone pretending.

Q67 **Lord Scriven:** It is becoming clear to me that you are saying that demand management is a concrete approach to dealing with value in healthcare; getting the biggest bang for the buck. Do you think that demand management is going to work by itself? Do you think that demand management is not the solution? It is quite a fundamental question, because it is where we are going.

Professor Katherine Checkland: What do you mean by work?

Lord Scriven: The objectives: working to drive out inefficiencies, dealing with sustainability and making sure that outcomes are improved in the long term.

Sir Muir Gray: This is the most complex business on earth. War is comparatively simple, because at least someone drops a bomb on you and you have to respond in some way. This is the most complex thing. There is no single panacea—call it what you want: commissioning, demand management or whatever. We found that we need to move on from quality and safety because you can have high quality and low value. The approach that we are taking is population and personalised value. Demand management is one of the interventions for that. The question, as Lord Warner said earlier, is: what is the outcome? You have to have outcomes that relate not just to the patients being treated—that is quality—but to the whole population.

Professor Katherine Checkland: You can certainly get better outcomes for the money that you are spending, but I do not think it is a way to save money.

Q68 **The Chairman:** We have had quite a broad-brush discussion. This Committee is focusing on the sustainability of the NHS to 2025 to 2030 and beyond, and we have different sustainability projects, which have been referred to. What would be your suggestion for a change that this Committee could recommend to support the long-term sustainability of the NHS?

Sir Muir Gray: I would recommend that you ask every part of the country to get people together who will be leading the health service in 2036 and set them the challenge: here are the resources, the resources are finance, carbon and time—the time of professionals, the time of patients. Expecting old people such as me and the 50 year-olds to come up with these longer-term solutions is not the approach. If you get together GP trainees, specialist trainees in their final year of training, nurses doing massive programmes and finance trainees, we need to take a longer view, as John Appleby was saying. We are looking specifically at getting the 2026 and 2036 leaders on the case. They come up with much more radical and inventive solutions than the people who are managing the service at the moment.

Professor Katherine Checkland: My prescription would be not to have an overblown expectation of what can be delivered by demand management. Prevention is an interesting one. There was a report for the Scottish NHS by a guy called Ian Craig, a health economist, who suggested that if we are thinking about prevention we should not be thinking about NHS spending but about things such as reducing income inequalities and reducing unemployment—so thinking about spend across the piece. Many of the things that we know would work or that would make a difference are small things such as continuity of care and good local relationships. Give people time and the autonomy to re-engineer their processes, because people want to do that. One of our difficulties is that everyone is running like mad to stand still, so we should build in space in the longer term so that people have the space to think about what they do. Functional integration is the aim, not structural integration; there is no point in pinning your hopes on structures.

The Chairman: We hear that in the long term we need more healthcare to be delivered in primary and community care, we need to reduce the pressures put on acute services, and we need to change the model and have more skill mix in the workforce. That will reduce the demand both for people going into care and acute services and therefore reduce the cost.

Sir Muir Gray: Changing the culture is more important than changing the model. In Derbyshire, we asked how many people there were with type 2 diabetes, and no one could answer. We asked them what the deficit was and they said £16 million. These are clinicians. Changing the culture is the function of leadership; it is partly behaviour but it is also the language.

The Chairman: Who should provide that leadership?

Sir Muir Gray: Leadership is a combination. In our estimation there are about 400 people per million of population, not just the top management, which would include perhaps 60 or 70 GPs and 70 consultants. The military are very good at getting the language clear: words such as value, savings or efficiency. Everyone uses this in a different way. The military would be much tighter on doctrine.

Professor Katherine Checkland: Better care in primary care and the community will not necessarily save costs. You can pull things out of hospital, but it is not necessarily cheaper. It is important to be aware that the evidence is that it is not.

The Chairman: Thank you both very much for a most interesting discussion, and thank you for coming today to give evidence. If there is any material or other information you wish to send, please feel free to do so.

Professor Alistair McGuire and Ian Forde – Oral evidence (QQ 69-75)

Evidence Session No. 6

Heard in Public

Questions 69 - 75

Tuesday 13 September 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Professor Alistair McGuire, Chair in Health Economics, London School of Economics, and Ian Forde, Programme Lead, Health Systems Quality and Outcomes, OECD.

Q69 **The Chairman:** Good morning. I first of all say to everybody, Members and witnesses, that this session is being broadcast, starting now. Thank you for coming; we appreciate very much your coming today to give evidence. As you know, most of this session is to do with funding, different funding models—the pros and cons of different models—and, importantly, the long-term sustainability of the NHS and social work. First of all introduce yourselves. If you want to make an initial statement about anything, please do so.

Professor Alistair McGuire: My name is Alistair McGuire. I am Professor of Health Economics at the London School of Economics. I have been involved in the analysis of healthcare both in the UK and abroad for about 30 years.

Ian Forde: Good morning. My name is Ian Forde. I am one of the senior analysts at the OECD in Paris, responsible for health system performance assessment. I was the lead author of the quality review of the United Kingdom, which was published about six months ago, and I have been involved in performance assessment of various health systems in Europe and Latin America.

The Chairman: Do either of you want to make a statement?

Professor Alistair McGuire: No.

Ian Forde: No.

Q70 **The Chairman:** We will start with the first question then, which is: how does the UK compare with the OECD and other EU healthcare systems in terms of its funding and performance. How are the two things linked and

is it likely that the UK will maintain its position over the next 15 to 20 years, so long term, whatever its position is now?

Professor Alistair McGuire: Personally, I think the UK lags behind most northern European countries, if you take them as a comparative group, in terms of expenditure judged by percentage spend per GDP. We are about 8% to 8.1% per GDP currently. Most of the northern European countries—by that I mean France as well as Germany, Denmark and Sweden—are now up at about 11% of their GDP. That comparison becomes slightly better if you do a healthcare expenditure per head of population comparison and take account of prices, exchange rates and purchasing power parities, so taking account of relative prices, but even then, in comparison to northern European countries the UK is slightly below healthcare expenditure per head, even adjusting for our lower costs within the NHS. Of course, about 70% of the costs are labour costs and therefore we have basically lower wages in the NHS compared to our northern European comparator countries.

In terms of performance, it is difficult to compare, because you are comparing across countries which define health and social care expenditure in different ways, so comparisons are obviously difficult on the expenditure side, but they are very difficult on the performance side because you have different structures and different starting points across countries. Nevertheless, I personally think the performance within the NHS is deteriorating if you look at health outcomes. If you look at cancer survival rates over five and 10 years, we are again lagging behind our northern European comparators. That is pretty well documented by a number of European studies or surveys. There was a fairly well publicised study by Chris Murray et al. I do not always believe his figures but it was published in *The Lancet* and they were looking at how the UK generally in terms of health outcomes compared to other countries in Europe. Again, the UK was in a fairly weak position—not very good performance compared to other countries in terms of age-adjusted mortality rates for a number of diseases, including cancer and cardiovascular disease.

From our own internal performance indicators on the process aspects of the NHS, such as waiting time targets, we know we have been missing them quite badly for a number of years now, going back about three or four years now; in particular, the cancer wait times have not been met for the past two years. I think expenditure is relatively low, in summary, compared to northern European countries, and our performance is deteriorating.

Ian Forde: I would agree broadly with Alistair's summary of the spending picture. The UK historically has relatively underspent compared to OECD averages, and certainly compared to the G7 there is less spent on health in this country than in any of the G7 countries apart from Italy. In relation to the more relative comparators, it would seem the UK NHS slightly underspends. As Alistair said, countries such as France, Germany, Switzerland, Sweden, all spend considerably more.

It is worth noting though that growth in spending is well controlled in the UK, which is a positive aspect. Over the last 10 years, annual rates of growth have only been around 1.8% compared to around 2% across the

OECD. That is a positive statement: growth in spending is better controlled in this country than elsewhere.

In terms of performance, I think I would be more optimistic than Alistair's summary. There are some areas where we perform well compared to OECD comparators. Primary care is a good example of that. The OECD publishes various indicators of performance in our *Health at a Glance* publication. The 2016 edition will be out in six or eight weeks. If you look at the indicators of performance across the OECD, in primary care the UK does well. We have fewer hospital admissions for things that should be managed in primary care, conditions like chronic heart failure or CAPD; we prescribe better in primary care compared to other countries in terms of generics, in terms of appropriate medications for diabetes and so on; and we are good at vaccinating elderly people against the flu, for example, so that is reassuring. We are less good on other aspects, however, particularly secondary care. As Alistair mentioned, our survival rates in this country for cancers are less good compared to OECD comparators, although they are improving and the rate of improvement is promising. We are less good in terms of survival after heart attack or stroke, so people in the UK are less likely to survive a month after having a stroke or heart attack than people elsewhere in the OECD. Unfortunately, we in the UK—I say “we” because I am English, as you will have picked up—are also less good at prevention. Obesity rates are higher than the OECD average, and worsening; alcohol and smoking are going down, but they are still worse than the OECD averages; so we are poor on public health prevention.

One area where the UK is outstanding is in the policies and institutions which are put in place to improve performance, efficiency and sustainability. Across the OECD it is very rare to see the level of transparency and accountability, the depth of data, the granularity of data, that is available in the UK; that is rarely replicated across other OECD countries—the institutions in place such as the National Institute for Health and Care Excellence, the incentives in place and so on and so forth. Therein lies a slight paradox: although the UK is outstanding in terms of its policies and institutions to drive performance and efficiency, somehow its performance is average at best.

The Chairman: You said we are better than some OECD countries in terms of preventing admissions to hospital and that primary care was better, yet our hospitals are chock-a-block, full.

Ian Forde: That is a question of resources. The UK has fewer hospital beds than the OECD average; it has fewer doctors and nurses than the OECD average as well.

The Chairman: Also, we often hear stories about our access to primary care not being that good; people cannot get an appointment to primary care.

Ian Forde: That is not borne out by international comparison. If you look at data on unmet healthcare needs, the UK does very well; it is well below the OECD average. Also, in terms of equity, if you measure that indicator by wealth quintile, for example, there is a very narrow distribution, so we are very good at making sure people with fewer resources as well as

those who are better off have the same level of access. On an international comparison, I would not say the UK health system struggles on access.

Lord Mawhinney: Out of the average for northern European countries of 11% of GDP, what proportion comes through the Government spending taxpayers' money and what proportion comes from taxpayers paying themselves, either through insurance or directly? What are the comparable figures for this country?

Professor Alistair McGuire: As I said, it is difficult to compare. Health in most countries in northern Europe is publicly funded, so the vast majority of the funding will come from public funding. For example, in Germany public funding is about 95% of the expenditure, with a very small private sector, for example. However, it is a completely different funding model. It is funded through social insurance, which is employer contribution-led rather than tax-based. A group of countries have followed that German model of social insurance rather than a public tax-based model, as it were, but the vast majority are public expenditure-dominated. The comparison is not like for like on taxation but I think the idea that we have a tax-based system is quite important, for example.

To pick up on something Ian said, the UK has been relatively good at constraining expenditure growth. I use the term "good" in a pejorative sense because, obviously, if expenditure is too low, constraining the growth of the expenditure is not necessarily a good thing. Over the past few years, for example, the Government has ring-fenced the NHS spend and said that the real resourcing going into the NHS will be level funding but, to acquire that level funding, the NHS has to maintain between 3% to 4% of what they call productivity savings—we can come back to the term "productivity" if you want—or efficiency savings per annum over the next five years. Historically, the UK NHS has really only attained at best 1% and on average 0.5% productivity savings per annum over the life's course of the NHS. This 3% to 4% is a big ask, just to stand still, and in standing still, that is the constraint element in terms of keeping the expenditure level. But note that our expenditure is tax-based, and we have a number of expenditure departments that have a claim on the taxation that is raised by primarily income and other, indirect forms of tax. Assuming that this Government hold to their public sector borrowing requirements—we have extended those requirements and targets a bit—taxation will have to fund partly the public sector borrowing, but with the NHS being held at the level form of expenditure, even incorporating the productivity/efficiency savings, other government expenditure departments will lose out by about 6% per annum in expenditure. That is a hard choice.

Lord Mawhinney: If we as a Committee were to ask you for your advice on how we go from 8% to 11%, would you reply that we should simply increase taxation, or should there be more individual payments and, if so, on what? I would be interested in both of you answering that.

Professor Alistair McGuire: I am not a big fan of co-payments, of individual payments. I think the responsiveness of the volume of services to co-payments is inelastic; in other words, you can put co-payments up by 10% but utilisation only increases by about 2%, because it is a very

inelastic response, so I am not a big fan of that. I think there has to be a political will among politicians and others to increase expenditure in the UK. You have to have something like Tony Blair's expensive breakfast, where he announced on breakfast TV without any discussion with his Cabinet, it appears, that they were going to move from under the OECD average to the OECD average expenditure level. There is nothing great about averages. We could ask everybody in this room to stand up and obtain the average height. It does not really mean much; some are below, some are above, but it was a political will to move us to that average, and they funded that by an increase in national insurance taxation. It was not a hypothecated tax at all but it was an increase in national insurance.

We would probably have to raise taxes, but let me emphasise that there is no true figure in this game; it is a normative statement about how much people in the country want to spend on healthcare. The Americans spend about 20% of their GDP on healthcare and are also a fairly bankrupt country—in other words, they have a big public sector borrowing requirement and debt requirement on the private sector as well—but their citizens seem to want to spend that high level of expenditure on health. It is a normative question; there is no fixed level which is true and good, but I believe currently we are underspending. If we are going to increase our spending, it is best done through taxation.

The Chairman: Mr Forde?

Ian Forde: I broadly agree. There are various options if you want to raise national levels of spending on health. One option is to ask people to pay for it directly out of their pocket when they see a GP or when they purchase medication. The evidence does not support that as a policy option. It is bad for equity, because it damages people on lower incomes, and it is bad for health, because in the long run it increases health costs because people forgo primary care and preventive care when they need it and wait till they are sicker further down the line and end up costing more money. There is good evidence that increasing dependence on out-of-pocket payments is not a good option.

You have the option of voluntary health insurance, as widely adopted in France, for example, where you encourage people to take out their own private health insurance plans, which could top up or supplement what is offered by the national health insurance. There is not particularly good evidence that that is a good idea either. It is inefficient, and it can damage equity. That is not a broadly recommended option.

Finally, you have the choice of either raising contributions from employment-linked insurance, the German model, or general taxation. The OECD has a clear position that the best option is to finance spending on health or growth in spending through general taxation. We think that is better than employment-linked contributions, for two reasons. First, as you know, the population is ageing and there will be fewer people in work compared to those working in the future, so the base for revenues if you go for employment-linked contributions will be shrinking. Second, there is this notion of the "Uberisation" of the economy, with the economy shifting to a more informal basis—the "gig" economy, whatever you want to call it—so the revenue base in that sense is also likely to shrink or certainly

become less stable. The OECD's general position is to go to general taxation for increased funding of health and social care.

Lord McColl of Dulwich: You mentioned the figure of 8.1% of GDP, but if that were adjusted it is better. What is the figure?

Professor Alistair McGuire: Adjusted for what? Roughly 8%, just over 8% of GDP of our healthcare expenditure, so adjusted for what?

Lord McColl of Dulwich: You said if you adjust it for all the other variables, it is better. In terms of what?

Professor Alistair McGuire: Ian, do you know that?

Ian Forde: The OECD figures are UK figures. I do not know whether it is quoting English figures but for the UK spending as a fraction of GDP is something like 9.8% of GDP.

Lord McColl of Dulwich: Thank you.

Lord Warner: Can you go back to this issue of employer-based systems for raising the money? Is there any evidence that they become a tax on jobs, and unemployment shifts disadvantageously? I am thinking in particular of the experience of General Motors in America, which went down the tube not just because it made lousy cars but because of its healthcare costs.

Professor Alistair McGuire: That was a private insurance base. The employer was buying private insurance as a secondary base. The German system is completely different from that; it is not based on any actuarial basis of insurance, which the premiums were for General Motors when it contracted with its private insurers. It is a social insurance scheme which has fairly large cross-subsidies built into it to overcome problems associated with high-end users. It is slightly different and does not operate so much as a tax on employers, but obviously there is an additional cost embodied in that. The cost is partly passed through to the employee, because there is an employee contribution as well. It is not a full cost to the employer.

Lord Willis of Knaresborough: I am more interested in what you get for your bucks rather than the total amount, though I accept that that is important. We saw a huge amount of money put in during the last Labour Government and, in terms of productivity, what resulted in terms of patient outcomes was not significant. I wonder if there are any indices anywhere which correlate the amount that is spent with actual outcomes in a set of principal areas of care. Is there such a table? The second part of this question is: on public health, how do we fare compared with our OECD partners, or even G7 partners, on the amount we put into preventing poor health rather than pouring money in to mend it when it has gone wrong?

Professor Alistair McGuire: Can I pick up on your first observation, which was that we did not obtain very much through the last Labour Government? Remember that it takes five to six years to train a doctor and about four to five years to train a nurse. Essentially they doubled expenditure over an eight-year period, but it takes five to six years to train a doctor, so it takes at least that time to start seeing the return. You

are not going to see a very quick return. I would suggest that there is evidence to say that for a very short time there were some promising indications that that money was being put to good use in the system, around 2011-12, 2012-13. That is debatable. That is my perception.

In terms of expenditure, we know there is good correlation regardless of what it means between expenditure and GDP levels—national income levels. We know there are certain confounding elements which help to explain that relationship between GDP and expenditure. There is a less well correlated association statistically between expenditure and mortality rates, and that is partly because you have to wait some time before the expenditure returns a benefit on mortality. There is some—better than 50%—correlation between a range of indicators on mortality that public health would have to regain.

Ian Forde: The question you ask is a very basic one: can you demonstrate health gain per pound spent? Unfortunately, that is extremely difficult to do. There have been myriad studies trying to develop indicators of productivity efficiency, and not one has taken hold as an internationally validated benchmark or comparator across systems, so although the question is an obvious and a simple one, it is not something which is in common currency. There is a correlation at lower levels of spend—you can see a clear correlation between spending levels and life expectancy, for example—but in the G7 or the European Union that relationship is completely flat. It is hard to demonstrate an important correlation between spending levels and health outcomes.

In terms of the level we spend in the UK on preventive health, the OECD measure breaks down how money is spent within a health system. There is a category called “collective services”, which covers public health but also captures other things such as administration and governance costs. It is not a precise measure of what you were asking, but on that indicator the UK spends 9% of its health budget on these collective services, which is the same as the EU, the 27.

I would like to make an important point that on prevention we should not just think about classic public health, vaccination, health promotion campaigns, and so on. It would be important for this Committee also to consider spending on social care and long-term care, because that is often left out of the equation, and if the spending in that domain is cut, there is an immediate impact on greater demand and pressure in the health service.

Professor Alistair McGuire: As there has been in the UK, quite dramatically.

- Q71 **Lord Lipsey:** Across the OECD there is quite a range of spending on health as a percentage of GDP. There is also a great variety of systems: Bismarck in Germany; Bevan here; Adam Smith, if you like to call it that, in the US, although curiously American public spending on health is comparable with that in the rest of the OECD; the Americans just do a lot of private spending on top. My question to you is this: if you think about the variety of different systems, is there any evidence that one of those systems is systemically better than the other systems, or are other factors much more important in determining the efficiency of health gains

for a given level of spending?

Professor Alistair McGuire: I would say no, but Ian might differ.

Ian Forde: No, I would say no as well. The first point to make is that although the distinction you make between different types of funding structure used to be very real, nowadays functionally those types of systems are very similar. Even within an NHS-type, tax-based system, you have competition between providers and you have division in to purchasing and providing, geographic units and so on; and even within the Bismarckian model that you described, you have national values, national guidelines and so on. Functionally they look very similar. If you stack up OECD health systems, the ones that tend to have a higher spend as a share of GDP tend to be the Bismarckian-type systems, to use your terminology—the social insurance type models. We think that is simply because they are more complicated. You have lots of insurers; people can choose between them, choose which one they want to join. That generates a lot more administrative costs, so they cost more if you rank the OECD health systems up. They seem to have perhaps slightly better health outcomes. That may be because more money is going in or it may be because they have better developed competition between providers. It is very ball-park stuff and it is a very simple glance at a set of bar charts which leads to that conclusion; it is not a sophisticated analysis by any means. My bottom line would be to agree with Alistair that you could not confidently say that a tax-based system is more efficient than a social insurance-based system.

The Chairman: Although you seem to be in favour of a tax-based system, saying that it is as good as any of the others, or better, is it not a problem that a tax-based system can be manipulated in how much the Government from year to year will allocate to health expenditure, as opposed to other systems which might increase with an increase in costs and therefore are more sustainable?

Professor Alistair McGuire: A tax-based system is good for raising funding, I would say. I think private insurance is completely inefficient, for a whole host of reasons. Social insurance can work as well but, as Ian points out, there are maybe more administrative costs in that. It is very difficult to measure the administrative costs, of course. Because tax-based systems move away from an actuarial base and allow explicit cross-subsidisation across populations, they are very efficient in raising funds. In terms of what happens to these funds and what level of funding is attained, they are obviously open to political manipulation and, as I said, if we continue with this level funding based on productivity savings, somebody else loses in the public pot somewhere unless we put up taxes, which nobody likes. So yes, it is open to those manipulations and those political decisions but I believe political decisions have to be faced up to.

Ian Forde: I think it is an advantage in fact if a tax-based system is open to political manipulation, which is the word that you used. As I said, an employment-linked basis for funding carries risks going into the future because of the worsening dependency ratio with an ageing population and the way the economy is shifting to a more informal basis. As we face the future, a tax-based system is probably a more sensible choice. A point Alistair made earlier on is that populations tolerate higher spending on

health through tax; whether it is Sweden or Switzerland, populations, through political process and through political agreement, have shown themselves to be happy to spend more on health. That can only be negotiated through a tax-based system as opposed to an employment-linked system.

Lord Bradley: Very briefly, Mr Forde, I may have misheard you. I think you said at the beginning that we are poor in preventive work compared to other countries. What are the key features of where we are poor? What are the major weaknesses in our system in preventive care?

Ian Forde: On activities or on the outcomes that result?

Lord Bradley: Both, very briefly.

Ian Forde: On the outcomes, as I mentioned, obesity is worse than the average, and worsening. Alcohol and smoking are improving but still worse than OECD averages, so we have a less healthy population.

Lord Bradley: What are the drivers that make them better?

Ian Forde: Primary care is very important, and the OECD has shown that the most effective intervention is quite resource-intensive. It is a one-to-one discussion between an individual and a clinician, a nurse or a doctor. That is the most cost-effective way of tackling these risk factors, but it is an expensive intervention. More broadly, there are public health measures, such as increasing taxes on alcohol or sugar, or minimum unit pricing, for example, or stronger regulations around labelling. The UK's preferred model has been for responsibility deals with industry to achieve those public health goals. It is still too early to decide whether that is an effective approach or not.

Professor Alistair McGuire: There are a lot of differences across countries in tastes and behaviour of course, which are difficult to control, so you need to put in place incentives. On expenditure, it is not just levels; it is what you do with that expenditure. Some systems have started operating bundled payments to try to promote co-ordinated care, particularly for things like obesity or diabetes, and give a payment to a chosen medic, usually, to try to co-ordinate across a range of services that these people with chronic diseases need. There are incentive mechanisms you may put in place as well.

Baroness Redfern: You mentioned outcomes on cancer. Do you think it is because people present themselves late, and do you think more money should go into public health, particularly with obesity? My area has very high rates of children with obesity. Obviously, that is linked to cancer and cancer outcomes as such. Do you think more money should go into public health and health and social care to try to prevent that?

Professor Alistair McGuire: I definitely think there is scope for improvement in screening programmes, for example, particularly for cancer, but of course, cancer is partly led by other issues. It is one of these diseases that is becoming more and more specialised across the disease spectrum, with very rare cancers being picked up now as well. The screening programmes themselves have to be considered in a cost-effective manner.

Baroness Redfern: Do you think we should have more screening programmes?

Professor Alistair McGuire: Yes, but we have to have cost-effectiveness tests to say whether these programmes are appropriate or not, because some are very ineffective, with very high false positive rates, for example.

The Chairman: Yes, you have to make sure that screening programmes are cost-effective, otherwise it costs a lot. Secondly, with the ageing population, the numbers of people with cancer will be rising. Also, people with cancer will live longer because they will be able to manage. That has to be costed in.

Q72 **Lord Warner:** Can you move us on to the evidence about different funding models for health and care? The OECD seems to have changed its definition of healthcare to include in effect some things which were previously regarded as social care. Is there any evidence that different funding models improve the performance or sustainability of the system? What I mean by that is: is there any linkage between the way you collect the money and the way it ends up being distributed? Could collection systems affect the way you use the money?

Professor Alistair McGuire: Let me preface this by saying that we are obtaining more and better data on health outcomes all the time but we do not have the ideal datasets to answer these questions yet, particularly on measuring morbidity, because a lot of long-term care is associated with morbidity rather than mortality. It is easy to count the dead but it is difficult to count chronic illness in a morbid sense. The short answer would be, no, I do not think there is any evidence to show that different funding typologies lead to better outcomes or even that the funding itself is more or less efficient.

Let me backtrack and defend the OECD. The OECD did not redefine health and social care; a number of individual countries have redefined what is in their pot for health and social care and so on. Some of the social care elements have gone into health in the OECD definitions. The British Government through the ONS tried to follow the OECD definitions but found it very difficult, both because there are four constituent countries in the UK and because different local authorities were measuring social care in different ways. There is a vast variety of measuring of social care in the UK at this point in time; there is no standard measure as such, but we know that the level of expenditure on long-term care in the UK is about half of the OECD average, and we also know that it is worsening by the moment, as local authority budgets have been cut by about 25% over the past five years.

Lord Warner: Can I just be sure I have understood that? Are you saying that the method of collecting money for social care can have an adverse effect on the outcomes for the healthcare system?

Professor Alistair McGuire: The measures of how the money flows are going can have an adverse effect but, more importantly, the measures of need, and need in long-term and social care, and how you measure that, can have an adverse effect. As people grow older and more chronically sick, their needs go up, but the local authorities are also adjusting the

needs base on which the entry criteria for people to come in to the system to use the money is defined.

Ian Forde: I just emphasise the point that there is very little evidence that the way you choose to collect the money makes any difference to performance and sustainability. It would be a mistake, I think, for this Committee to focus too much on that. Much more important is how you spend the money once you have collected it, which really determines performance and sustainability. In that regard, there is good evidence that a health system needs things in place like a health technology assessment agency such as NICE; it needs price control in place, like national tariffs; it needs lots of transparency and data in place to look at variation across the country in rates of hip replacement and so on; and it needs close performance management at the clinical level, so that units and doctors and nurses can see how they are performing day to day. It is much more important what you do with the money and how you spend it than how you raise it.

The Chairman: Currently we hear every day about crises in the health service. We hear of crises on the public health side and on the social care side, and it all seems to be about money. If we are spending what you say we are spending, clearly something is not working.

Professor Alistair McGuire: Yes. Let us take a look at this money issue in another way. Roughly 70% of healthcare spend is labour costs. Let us assume you all have a real job.

The Chairman: Are you suggesting we do not?

Professor Alistair McGuire: I am just making an assumption. Let us assume we all have a real job. How would your wage be determined? It would be determined by your productivity, your add-on output to that firm or whatever job it was. In terms of productivity—and remember I used that term earlier—the productivity/efficiency estimates are part of the levelling off of the expenditure in the NHS. They have to make a 3% to 4% productivity gain just to stand still. Also, part of that productivity gain has been essentially a fall in real wages. We are in a time of depression generally, so I do not have a huge problem with that, but we have seen falling real wages. It is becoming more and more difficult to attract people in to the NHS, the 70%, let alone social care, and so the volume of people going through, having to service this higher productivity need just to stand still, is currently, I would suggest, not in equilibrium. I think there are probably all sorts of pressures in the system, because we do not have enough people in the system to service the system. One of the problems with that statement is it is very hard to go back to the data and prove it, because the data and labour statistics in the NHS are not widely publicly available.

The Chairman: Why not?

Professor Alistair McGuire: There is all sorts of confidentiality. If I asked you how much you earned, you would not be very happy about that question. It might be that you would put it in the public domain but not everybody wants to do so, and so there are confidentiality issues in getting people to report. We could get around that through anonymity IDs, but to do that and then to go through all the security issues is not a

trivial task. My suggestion would be that labour costs should be tracked to productivity outcomes rather than the productivity/efficiency savings being used to keep our expenditure lid down. In that way we may see more volume. I think we have a real volume crisis in staffing in the NHS just now.

Ian Forde: The NHS is broadly efficient. It delivers broadly the same outcomes of other health systems with fewer doctors, fewer nurses and fewer beds. If there are reports of crises in the papers, a lot of that could be due to the cuts in the social care sector impacting directly on hospital A&E departments and GPs' waiting rooms. We know that in the UK, as a result of austerity, local authority funding dropped by around a fifth or a quarter for old peoples' services, and that will directly impact on the health service. It would be an interesting study to try to quantify that and to explain to what extent these reports of crises or this perception of crisis originates from outside the health sector.

Professor Alistair McGuire: I should add that some studies have said somewhere between 10% and 30% of the growth in expenditure on healthcare is attributable to new technologies. Usually in a sector a new technology would come in if it lowered the unit cost. That happens in healthcare. So PTCA, angioplasty for heart disease, is about a third of the open heart surgery, the old coronary artery bypass grafting. It is about a third lower and you would expect that to save money but it did not; it raised money in that group of patients who were just on the cusp of getting open heart surgery. Once the lesser intervention came in, it widened the patient group who could have surgery, and therefore the costs increased. The use of technologies is quite important in terms of servicing the patients as well. We have some evidence that there is a lower uptake and a lower rate of diffusion of new technologies across the NHS, and therefore the outcomes are suffering because of that, so we are in a catch-up.

Lord Kakkar: If I may just return to the point of the relationship between what is provided in social care and the ultimate effectiveness and efficiency of healthcare, would it therefore seem most intuitive to have a single mechanism of funding that is driven principally by focusing on the population need across those two domains and defining it in that way? Would that ultimately lead to a more effective and efficient delivery of healthcare?

Professor Alistair McGuire: That is partly what these bundled payments which have been tried in some of the northern European countries, mainly France and Germany, are trying to do, to try to integrate through financial incentive those pathways across different providers. They are not using it in Germany for social care but there is no reason why they could not. Certainly what you do not want is to take money out of the NHS budget and give it to the local authority, as was done in the past, and say "Get on with it". In short, yes, I think you can use financial incentives in a better way.

Ian Forde: A priori, your suggestion is absolutely correct because, at least from a patient point of view, there is very little distinction between health and social care. When someone falls over and breaks their hip, their need for immediate medical care and ongoing rehabilitation and

social care and adaptations to the home and so on and so forth, to them, it is the same episode of care. A priori, it absolutely makes sense and, as Alistair said, there are some experiments to try to bring those two streams of funding the services together. The challenge is that historically they are very distinct sectors. The social care sector in particular is much less used to performance management, to accountability, to transparency, and so on and so forth, simply for historical reasons and because of the professional culture in place. That is not to say it cannot adapt and become more like healthcare. Indeed, that I think would be a very ambitious and challenging but very pertinent recommendation for this Committee to make.

Lord Kakkar: I have just one further question, Lord Chairman, if I may. You talk about these experiments—has anybody in the world been able to demonstrate that in an objective way?

Ian Forde: Do you mean reduction in costs?

Lord Kakkar: And more effective delivery of care across that spectrum, considering the whole.

Ian Forde: Yes, there are some examples, particularly in Germany. Germany and the Netherlands are the most advanced in terms of integrated care models. The most famous is called the Kinzigtal integrated care model, in a small valley in Germany, small enough that they could integrate further services relatively easily. That was shown to have reduced costs and improved outcomes. Also in the States there are some moves towards integrated care models, bundled payments and so on, which have been shown to be more efficient and to deliver better patient outcomes.

Lord Kakkar: I should declare my interest as Chairman of UCLPartners.

Q73 **Bishop of Carlisle:** I think you may have just answered my question in the question that was asked of you a moment ago. We have talked about different funding models, and you have made it clear that it is not always easy to make comparisons between different countries. You have also said that in terms of sustainability what really matters is how you spend the money you have, and we have talked a bit about the linking with social care, but is there any particular country which you would want to single out when it comes to sustainability, which is what we are talking about in this Committee, where there have been particular reforms or the performance has been really outstanding, that we can learn from? If so, what have they done? You have mentioned Germany and the United States but I wonder whether you want to stick with those or mention anybody else.

Ian Forde: Within the OECD, two countries, at least for me personally, really stand out in terms of their reforms, and that is Portugal and Israel. They are much less studied than the classic examples but they are both extremely dynamic, ambitious, responsive systems capable of fairly far-reaching reform. In each case what you will see is, again, a deep investment in data, and in transparency and accountability. In Portugal, anybody—a doctor or patient—can go on to a website and find a whole range of indicators for their local health service, benchmarked against all

the other peers in Portugal over time, to see how it is performing. They have done lots on integration, they have done lots of reforms on strengthening primary care, reducing dependency on the hospital sector, and lots of innovation on financial incentives as well. Israel, particularly the Clalit insurance model, is another example. One thing that the OECD is very keen on is learning from other systems. In fact, that is the *raison d'être* of the OECD. If you were interested in looking at systems to compare the English system to, I would definitely recommend Portugal and Israel.

Lord Bradley: I declare my interest with Pennine Care. Would you extend the integration model to the integration of physical and mental health as well as health and social care?

Ian Forde: Again, a priori, yes. There should be no distinction between a person's needs for care and we know there is a very close correlation between physical well-being and mental health well-being. The two drive each other. Again, the reason that they have not been more closely integrated is probably historical more than anything else. It is probably a result of historical legacy rather than intentional design, which is just to say that I think integration will be difficult but a priori should be sought.

Lord Bradley: Are there good examples elsewhere where that has been done?

Professor Alistair McGuire: No.

Ian Forde: Few spring to mind. Mental health is still seen as a very distinct system, for better or worse.

Professor Alistair McGuire: There is a general rise in payment for performance but that of course means you have to define performance, and that means defining both the indicators and the timescale over which you are working. Some of these chronic diseases are not easily managed within an annual budget setting. That is a problem. For sure, you can shift your financial incentives in terms of payment structures within systems, and I think we have done that very successfully within England with the HRG payments for hospitals—case payments, basically—and for some of the GP practice payments, for their standards of care, which were a one-off payment for upping their screening activities essentially. But to get performance indicators and to get the appropriate timescale for mental health is extremely challenging.

Baroness Blackstone: Just now, when you picked out Portugal and Israel, you mainly focused on primary care. Am I right in assuming that both those countries stand out because their primary care is so good, but is their secondary care equally good, or is there a tendency for some countries to focus on one sector, primary, and not so much on secondary, and vice versa in other countries? If that is the case, which countries have really good secondary care?

Ian Forde: You are right. Portugal and Israel are particularly good in their primary care reforms, but that is not to say that they have left their secondary care sector alone. In both countries there have been several initiatives to improve performance sustainability in secondary care. They are worth studying across both sectors.

On countries' general tendency to focus on one sector or the other, in fact the general tendency is to focus on hospitals and primary care is often forgotten. That is because it is much more difficult to understand primary care. Hospitals are much more visible in what they do; they are much more procedural and things can be counted much more easily in secondary care. The things we value in primary care are continuity, comprehensiveness and co-ordination, and these tend to be invisible to data systems, which means they tend to be forgotten by reformers and planners. When I talk about leading countries in health reform, the most challenging reforms to achieve are in primary care. That is why, again, Portugal and Israel sprang to mind. If countries have a preference for reform, it is always in the hospital sector. It is more grip-able.

Lord Warner: Can I bring us back to the answer Dr Forde gave a little while ago about Germany and the Netherlands being in the lead on trying to integrate systems of health and social care? Is there an issue around the way you collect the money for those two systems that is very difficult to align if you collect the money for those two systems in fundamentally different ways? At the moment we seem to have a totally different budgetary system for raising the dosh for social care and for the health service. They do not all come out of general taxation. How have those two countries grappled with that? Have they unified their way of collecting the money for the services?

Professor Alistair McGuire: They are both very different, but yes, Germany has bundled it into its social insurance system, tax system, and the Dutch have an experiment going on in private insurance and public provision where the public provision contracts with the funders. I would suggest that the private insurance experiment is not really working. There is not enough cross-subsidisation, but that is a different question. I think the contracts are specifying much more complete crossovers between hospital and social care. However, it is not working particularly well because their hospital sector is in deficit at present. There are other problems. Every system in every country has problems, unfortunately.

Lord Warner: If your two funding systems for raising the money are diverging—in social care we now have local authorities raising precepts—this is going to make integration intrinsically more difficult.

Professor Alistair McGuire: It does not make it easier, that is for sure. Also, I think that the annual budgeting process does not help within the NHS. If you are dealing with chronic care over a long period of time, and trusts are focused on balancing their books at the end of March, as are local authorities, it does not help address these issues.

The Chairman: Mr Forde, did you have any comment?

Ian Forde: Yes. In Netherlands and Germany both health and social care are funded broadly from employment-based revenues, so there is an immediate coherence, as you mentioned in terms of the funding base, without the kind of complication that would exist in this country.

Q74 **Lord McColl of Dulwich:** Based on international experience, what should the UK focus on to make the health and care systems sustainable?

Professor Alistair McGuire: I was not really clear on the term “sustainability”. That is quite easily answered: £380 million a week, is it not? I was not really sure what “sustainability” meant. If you meant broadly achieving given targets and objectives, that is one thing, but if you meant dealing with the rising demands and costs within the NHS system, that is another thing. The IFS came out with a fairly good report a few years ago saying that, even if we were keeping our expenditure level in real terms, the demand increase associated with chronic morbid conditions would add about 1.5% per annum to expenditure, and new technologies would add a further 2% to our expenditure in predicting out the per annum cost. If you take their figures as real, you are looking at a 3% increase in current budget per annum to keep matching their predictions of demand and technology uplift. That is even beyond the Simon Stevens figures that say just to keep still by 2020 we need £20 billion if we are going back to historic 0.5% per annum productivity increases.

Ian Forde: We have already discussed many options for putting the NHS on more sustainable funding. The option to rebalance to private sources of funding we have already crossed out. There is an option clearly to rebalance the public, government budget more towards health, and that has been historically done over recent years by spending less on defence, for example, less on infrastructure, and more on health. That is clearly an option which could be pursued further.

The main answer on the spending side of the equation has to be about striving for greater efficiency with the money that you have. The UK does a great deal in that sphere already but there is still more that could be done, in particular around variation of care across the country. We know that, for example, hip replacement or procedures on the heart after a heart attack, CABG and PCI and so on, can vary threefold across the country in ways unrelated to need. Despite having national guidelines, despite having national tariffs, despite doing our best to have a national health system, there are still these variations across the country. That is clearly one area to tackle.

There are lots of other areas of waste in health services that need to be tackled as well. Beyond efficiency, there are still other steps and recommendations which I think would be important. Paying adequate attention to social care spend is clearly fundamental, and we have discussed that at some length. The other element that is often forgotten in this conversation as well as social care is the role of the patient him or herself. It would be a useful recommendation to try to bring patients more into the conversation, to try to orientate more information to the user of the health service about how much things cost so they are slightly more aware of these things, and also, where care is low value, to try to moderate demand. There is a very good initiative called Choosing Wisely, which has been rolled out across Canada, the United States and some other countries, where they take national guidelines, the things produced by NICE, for example, which run to several hundred pages, and reduce them to a single side of A4, and they are written for the patient, so that the patient in conversation with his or her doctor can understand what care is appropriate and what care will be effective and what will not. For example, Choosing Wisely tries to discourage patients from asking for

scans of their back when they have simple back pain. It tries to discourage patients from asking for antibiotics when they have a cough or a cold. It is trying to move the conversation in the patient's direction so that it is not about cuts, the Government saying no or the NHS saying no or the doctor being difficult; it is about what is good for you and what is good for the health system in the long run. Bringing the patient into the conversation I think is something we have not done sufficiently and should be explored more. The final area is around prevention, which we have also discussed at some length.

Professor Alistair McGuire: I broadly agree but I think the pinch points in the NHS now are the volumes of staffing levels. I think there are concerns over those. The NHS is often compared as an employer to the Red Army in terms of size, but the Red Army has one in six at the front line, and there are six behind them doing all the administration and other tasks. There is a very great need to improve management within the NHS. The management structures and management intake are poor. Whilst there is variability of outcomes across the UK—quite marked variations—the variations in management are appalling.

Lord McColl of Dulwich: I like very much this Choosing Wisely. Is it having any effect on the gross obesity epidemic?

Ian Forde: It is a very new initiative, having been up and running for three to five years. There are some studies, and they show that it has an effect on the things which they try to disincentivise—for example, antibiotics for coughs and colds. There is no study looking at the effect on obesity yet but it has been shown to be an effective programme in other areas.

Lord Ribeiro: You both said earlier that general taxation in your view was a better way to achieve sustainability in the NHS, but if public funding was limited, what evidence is there that private funding can fill the gap? Given the objections you have both raised to co-payments, even though we have evidence that the public have accepted prescription charges and dental charges, how do you see this being taken forward?

Professor Alistair McGuire: If you have a capacity-constrained system, which leads to waiting times, for example, for elective surgery, there is some evidence that a complementary system of private funding can take some relief out of that system, but it may be it is only temporary relief, because it may be that capacity grows in the other sectors, so it is a dynamic question. Generally speaking, it is the same surgeons and clinicians operating both systems, so it may be that you have to regulate the system quite extensively if you introduce complementary private funding. I have less of a problem with private healthcare provision being allowed to compete for resources which are financed publicly. I think that can, under certain circumstances, with suitable regulation, also be used to improve efficiency, but with the funding you have to be careful that you are regulating the two systems appropriately, and of course there is a massive issue about equity.

Ian Forde: Apologies if I was over-simplistic when I said that we had discussed rebalancing to private sources and we had crossed that one out. I did not mean to be over-simplistic. Clearly, every health system has

a blended source of revenues, and clearly there is a place for private sources of funding within that. The UK currently has around 15% coming from out-of-pocket sources. It is an option to expand that to try to shift more of the costs on to private individuals but, as we said, there are risks associated with that. It is an option but one that should be taken carefully. It is not really being pursued by other health systems.

Lord Ribeiro: On that basis, do you think that the introduction of the concept of independent sector treatment centres, which initially was introduced so that NHS surgeons and anaesthetists would not be taken out of the system to work in it, was a success or not?

Professor Alistair McGuire: Broadly speaking, I would say they have been, but you have to be aware that first of all the treatment centres have largely been merged into the NHS now, as a source of revenue generation. I think initially they were largely broadly a success to increase the efficiency within the system, but that was at a time when money was growing quite markedly. Also, you have to have, as there was, considerable regulation to ensure that there is no cream-skimming.

Q75 **Baroness Blackstone:** If you were to make one key recommendation or suggestion for change that the Committee might recommend which would promote the long-term sustainability of the NHS, what would it be?

Professor Alistair McGuire: There were always going to be two bites at this cherry. My main recommendation would be improved management in the NHS. The second one would be improved data. I have to come back to the labour data, because it is not just about the cost of that data. We have very poor data of who does what and the turnover rates, for example, of nursing staff within the NHS. So data but primarily management.

Baroness Blackstone: Can I just ask you what you mean by management? What level are you talking about—central government, NHS England, hospital trusts or what?

Professor Alistair McGuire: Picking up on something that Ian said right at the beginning, I think the regulatory structures within the NHS are, broadly speaking, very efficient and very good. At the central level, particularly NHS England but also NHS Improvement, as Monitor now is, I think that there are excellent people there. The centralised structures are fine. Where you have much more variability is within the hospital trust sector, within the CCGs, as it were, and probably as are going to be but in a different manifestation, and at GP practice level. We have no history in this country of promoting management as a career structure within the NHS. We have been very lucky with some of the NHS managers who are outstanding, but the variability is massive.

The Chairman: Mr Forde?

Ian Forde: I completely agree with Alistair, so I will take the opportunity to build on his response by saying two different things. My two responses would be, first, to be ambitious on prevention. Seventy per cent of NHS spend is on long-term, communicable, lifestyle diseases. This country is not healthy, and in some respects is becoming unhealthier over time, so there is a need to be ambitious on prevention through legislation,

taxation, advertising and regulation, as well as the clinical one-to-one stuff. The second recommendation would be around the health and social care budget, to take that difficult step to unify the service. That would be more patient-centred as well as being more efficient, and would better match the needs of the population going forward. It is an extremely difficult thing to do. However, that is not to say that this Committee should not make a difficult recommendation.

The Chairman: Thank you both very much. We have taken a lot of your time. Thank you for coming. If you have any additional material or something you may think about that you would have liked to answer but you did not have a chance, I encourage you to send that in.

Ian Forde: When I said lots of things were above and below average, and so on, the data itself is in this document, so I will leave this with you. You will find the numbers in there.

The Chairman: Thank you very much indeed.

Professor Andrew Street, Professor Nick Black, Reform and NHS Improvement – Oral evidence (QQ 76-86)

Evidence Session No. 7 Heard in Public Questions 76 - 86

Tuesday 13 September 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

[I](#): Professor Andrew Street, Professor of Health Economics, Centre for Health Economics, University of York, Professor Nick Black, Professor of Health Services Research, London School of Hygiene and Tropical Medicine, Andrew Haldenby, Director, Reform, and Jeremy Marlow, Executive Director of Operational Productivity, NHS Improvement.

Q76 **The Chairman:** Thank you very much, gentlemen. Welcome. Just to warn you, this session is being broadcast. If you see that sign, it means we are live. If you speak, it might be picked up, so be careful. That applies to Committee members too. Thank you for coming. If you want to introduce yourselves first for the record, your name and your background, and if any of you then want to make an opening statement, feel free to do so. Can I start with you, Professor Street?

Professor Andrew Street: Yes. Thank you very much for inviting me here. I am Andrew Street. I am a health economist. I work at the Centre for Health Economics at the University of York.

Andrew Haldenby: I am Andrew Haldenby, director of Reform, which is a cross-party think tank that looks at productivity in public services in the UK.

Professor Nick Black: I am Nick Black, professor of health services research at the London School of Hygiene. I also chair the National Advisory Group on Clinical Audit & Enquiries, which advises NHS England.

Jeremy Marlow: Hello. My name is Jeremy Marlow, recently appointed executive director of operational productivity at NHS Improvement, and before that I spent a year working with Lord Carter of Coles on his review into the same subject.

Q77 **The Chairman:** Thank you. Do any of you want to make an opening

statement? No. Then we will kick off straight away then with the first question. I would like to explore with you the NHS and social care system as we have it now. Is it sustainable over the longer term beyond 2025-30? How are we going to make the systems sustainable, and what reform of the funding system will be needed to bring about the sustainability of that long-term agenda? What funding increase might be required year on year to make it sustainable, without which it might not be? You might disagree. As you have been working with Lord Carter of Coles, but others too, what increased productivity levels might be required for controlling overall levels of funding for both systems? That is a broad brush question.

Professor Andrew Street: I was born in Coventry, and Coventry was completely destroyed after the Second World War. There were no factories, no houses, no food in shops—shops that did not exist—and there were no schools. Three years after the end of the Second World War every household in Britain received information saying that the National Health Service was to be created, free at the point of use, funded through taxes. Of course, there were many priorities for funding at that time. The whole of Europe had been destroyed. My grandparents' generation did not say, "We cannot afford a National Health Service" in that situation. They said instead, "We cannot afford not to have a National Health Service." That system of course has been sustained for almost 70 years, and its fundamentals remain.

The crisis we had with the recession in 2008 is nothing compared with the crisis we had after the Second World War; it is nothing like as deep. I think the fundamentals of the national health system remain the same; it remains a sensible way of funding for now and for the future. I think it is still the case, as my grandparents' generation would have said, that we cannot afford not to have a National Health Service, because the alternatives are going to be more expensive and they are going to leave us worse off.

Andrew Haldenby: If the question is whether the NHS and social care systems are sustainable over the long term—I will try to say this quickly—at one level, as Professor Street has said, the NHS will definitely be here in 2030 and it will be funded through our political system. Parliament raises funds for the NHS and social care, and if the NHS needs more money, it will raise more funds to do that, and if there is a sense that the NHS budget has to be controlled down, it will do that too. In that sense, does the political system that we have today mean that the NHS and social care will be there in some form? Yes, it certainly does.

The force of the question, though, is: are we going to have a good NHS and social care system in 2030? I would say that there is optimism and pessimism. On the optimistic side, much of our work now dwells on the opportunities of new technology to improve the way public services work and the way they address the problems of citizens. I met a company yesterday, Cerner; I am sure they will not mind me saying so. They are now working with 20 hospitals in England. They can combine data on patients both in the hospital and from primary care. They can join up those systems, which has been difficult to do before. From that they will be able to identify so-called frequent fliers, patients who have a lot of contact with the NHS. Those patients can then receive special attention,

with the aim of preventing further ill health in the future. That is one example, but the technology revolution is real and should enable much more productive use of healthcare resources in the future, and that will only improve.

Briefly, on the pessimistic side, from our evidence from our discussions—I do not have a metric—we would say that the current NHS productivity programme under the *Five Year Forward View* is not on track to meet its targets for 2020. Simon Stevens, in his article for the *Daily Telegraph* in the summer, said that the share of the NHS budget that is going on hospitals rather than other kinds of activity—prevention and so on—is rising, not falling. That is an indication that the NHS is not changing for the better. I would say that broadly Ministers do not make the case for NHS productivity; they make the case for more spending, more inputs, more doctors, nurses and so on, but they do not make the case for sustainability and productivity.

I think I have answered that question in three ways. I am saying that the NHS will certainly be here in 2030. The technology revolution should be significant support in its performance over the long term, but given where we are today I would say that the movement towards greater productivity seems to be slower than government targets would want.

The Chairman: In brief, on the question I asked about whether productivity would be important you are saying yes, but on the financial question on funding you are saying that funding also needs to be—

Andrew Haldenby: There will always need to be a vote for a sum of money for the Health Service, and the NHS will always have to do the best it can with that money. At different periods, the funding side and the productivity side may need different emphases, but in other public services where there is a guaranteed spending level—in defence, for example, there is a target of 2% of GDP spend, and in aid it is 0.7%—those spending targets do not in themselves guarantee good services. There are major reform programmes going on in those departments, and major efforts to ensure value for money, so perhaps I am saying that we need to think about both sides of the equation.

Professor Nick Black: Yes, the health and social care system as a publicly funded system is absolutely sustainable. This is a political question. You have lots of technical know-how in front of you and other people coming to see you. We can provide a certain amount of ideas and advice—I hope helpful—on how we can do it better at the micro and meso levels, but the macro level—sustainability—is a political question, and politicians have to answer two questions for society. One is how much do we want to spend on health and social care as a society? That is an explicit discussion. The second is how fair do we want the distribution of those services to be? Those are two political questions. I have my strong views on both of them, as has probably everybody in the room. They may not all be the same, but we have to have a much wider political discussion.

How can we move forward? I think there are three priorities. One is engaging the public in an informed discussion. That does not mean that at the end of it the public will agree to rationing, because there will always

be rationing. There is rationing in every country in the world, and it is inevitable given the brilliance of our biomedical industry, medical profession and nursing profession to come up with new things that we all want, but we have to have an adult conversation so that the public understand that you cannot have everything. We need much greater courage from politicians to address the really tough questions. Second, the one thing that has to change in the system—we can perhaps talk later about the details of governance, commissioning, management and so on—is that we have to make the NHS and social care system much more comfortable about risk taking; it is far too risk-averse. You have lots of brilliant ideas bubbling up, which is vital because sustainability is going to be solved from the bottom up, not the top down, but managers risk losing their jobs if they go ahead with something that does not fit the national mandated way of doing things.

Those are the three things: engaging the public, the courage of politicians, greater tolerance of risk taking and not punishing those when some of those risks turn out to have been a mistake.

Jeremy Marlow: On the question of whether it is sustainable over the long term, I do not believe it is as it is currently configured and the way it performs. There are three areas that I know you are looking at and that you need to think about here. One is the quantum of the funding. As colleagues here have said, and I know you have looked at it, questions about what is affordable for the public finances are critical to that. You cannot look at that in isolation; they are big political decisions that have to be taken as we look at that time horizon.

The second is how the funding is distributed. We have a mix of ways of doing that at the moment. They are not at all optimal in the way they drive productivity and the outcomes that we have, but there is a blend that we need to look at in relation to those long timescales. Thirdly, what I am most interested in the job I do is what we obtain for the money we allocate, and the way we allocate the funding.

For me, there are three main areas that we need to think about over the medium and long term. The first is to address the unwarranted variation in the system. I know you have heard a lot about that; it is a common theme in the system, and you see it in other systems around the world, but I think we have a long way to go in how we address it, particularly using the wealth of data that we have out there to do that, but we are just not very good at using it at the moment.

The second is how we go about improving the productivity of our clinical work force—the non-clinical too but particularly the clinical—what they are doing, how we deploy them, how we motivate them, and how we best obtain the clinical results from what they do. The third and final area we need to think about is the way we scale up our services, primary through to tertiary care, to address what we see in some areas as the fragile and unsustainable services that we have out there in an environment with increased technology and increasing specialisation, particularly in acute, in the care that we give.

Q78 **Bishop of Carlisle:** I would like to come on to new technologies. You were talking about new technologies and the huge possibilities that they

offer. At the same time, earlier on we heard that new technologies are adding considerably to the cost of the NHS. I wonder how those two balance out.

Andrew Haldenby: Indeed, there will be both a cost and a benefit, and the technology has to be paid for. The example I pointed to was the benefits of new technology coming online today and providing particularly better information on patients, which we have not had before, and enabling greater targeting of resources on certain patients in order to treat them more quickly and to prevent costs down the track, but technology is indeed also a cost. The witnesses in the previous session talked about management, and part of the management challenge of the NHS is to be able to invest correctly in technology, understanding that it should be able to make a return. It would be a tragedy if new investment in the right technology was not done because it could not be afforded today, if there was a sense of that.

Professor Andrew Street: New technologies need to be seen in terms of the costs and the benefits that they produce. Something may be more expensive, but if that means that people live longer and live with less disability and less discomfort, investing in those new technologies may well be worth the cost of their procurement. In the United Kingdom we have a very good committee, the National Institute for Health and Care Excellence, which was set up to establish the costs and benefits of new technologies and new medicines, and the UK has been at the forefront internationally in setting up that type of arrangement and those ways of evaluating the costs and benefits of new technologies so that we can assess whether new technologies are worth investing in in terms of the benefits that they secure.

Bishop of Carlisle: That is very helpful, thank you.

The Chairman: Does anybody else have any other comment to make? Going back to the funding issue, in the long term—I do not know that you have all had the opportunity to comment on the long-term funding issue beyond 2030—what funding adjustments to the current system would be required?

Professor Andrew Street: We have a funding crisis now. The *Five Year Forward View*, which Andrew alluded to earlier, summarised some of the evidence on what the funding gap would be at the end of this parliamentary term were funding levels to remain flat, and that suggested that we would face a £30 billion funding gap at the end of this parliamentary term. That had been estimated by a number of independent organisations in order to work out what we need to meet the demands on the healthcare system over this parliamentary term. The question is how we meet that funding gap.

The *Five Year Forward View* put out three key things that need to be done. One was that the NHS needs to meet annual productivity gains of 2% to 3% a year—I will come back to what productivity means later and whether or not the NHS has been meeting that. The second thing that was said was that the Government needed to increase funding in 2020 by £8 billion over 2015-16 levels. It has not done that. The Government are instead increasing funding by only £4.5 billion, as the Health Committee

said in its report previously. The Government said that they were going to provide £8 billion; they are not doing so. The remaining gap between what the Government are promising in increased funding was to be met by efficiency savings produced by the NHS as a whole, and those efficiency savings in the *Five Year Forward View* would have been £22 billion. Because the Government are not meeting their commitment, that rises to £25 billion. That is simply not achievable, and because the NHS is not receiving the funding it needs and on top of that social care cost funding has been reduced, that is one of the reasons why we are seeing so many problems in the health service now.

Professor Nick Black: I am glad Andrew added social care, because it is in the nature of the beast that healthcare is always the one that captures the public's voice and the politicians' ear, for obvious reasons. Social care is not as sexy; it does not make the headlines. If I were putting more money into this field as a Government today, I would put it all into social care. I would not give the NHS any more money. The majority of patients are elderly and very elderly, and most or many of their needs could be dealt with much better through social care than healthcare, and that is one of the crises. I would be really tough on the NHS. That is where the courage of politicians has to come in—looking very radically at our current provision and talking to the public about their expectations. Dilnot started to address sustainable funding of social care but that seems to have been kicked into the long grass. We have still not, as a society, addressed the issues of social care, end of life care, or the needs of the very elderly. That is where I would focus.

Q79 **Lord Warner:** This question is probably to Andrew and Nick Black. Underpinning the Five Year Forward View was a very clear statement by Simon Stevens that there had to be adequate funding of social care, so all the figures that you mentioned, Andrew, also had underneath them adequate funding of social care between the time of the Five Year Forward View and 2020. Has any work been done to show how the gap has become worse as a result of the trend line for the funding of social care, in so far as we can discern it, up to 2020?

Professor Andrew Street: Yes, there has. The Health Committee reported in July on the spending review, and as part of that evidence they looked at the funding requirements and promises for the NHS and for social care. A number of studies and evidence have been presented to that committee, which were summarised in the report, on the growing funding gap for the social care sector. We see that there are fewer people now receiving social care support than used to be the case, and that is having knock-on consequences for the NHS. If people are not receiving the support they require to live independently, they are more likely to fall into crisis and they are more likely to show up at A&E departments, and that puts more pressure on A&E departments. Similarly, if social care support packages are more difficult to arrange for people who are already in hospital, that leads to delayed discharge, and essentially the health and social care system as a whole runs less efficiently because constituent parts that are designed to support people on a timely basis in the optimal location are not now being delivered.

Lord Warner: Can we put a number on it? What is the gap? Is it £2

billion, £3 billion? How much worse is it by 2020?

Professor Andrew Street: The figures are all in the Health Select Committee report, and the gap has been calculated for each year over the parliamentary term. I cannot remember off the top of my head what it is, but the gap is in the billions.

Andrew Haldenby: Briefly, on social care and a word on the previous question on funding, I think the fact that the current Government introduced the new precept on social care in the Autumn Statement indicates that they know that cuts in social care funding have gone too far. That does not answer your question on the future, but it shows that the Government know that.

I wanted to make an obvious point. No doubt everyone would like to spend more money on the NHS but there are trade-offs, and at a time when the public finances remain in an unprecedentedly difficult position, at least in recent decades, with net debt at 80% of GDP, still in deficit, as we know the new Prime Minister has said that the likelihood of the new finances going back into surplus is not going to happen in this Parliament. It will be at some point after that, so the public finances are extremely difficult and it is hard to find new areas of public spending that can be easily transferred to health.

What is the public appetite for greater taxation? In a poll last year, we asked the public "Would you support an increase in income tax to pay for the NHS?" Sixty-seven per cent of people said no, a third said yes. The other thing is the trade-off between departments. The NHS is so big that, as my fellow witness pointed out, the NHS was only going to have an increase of £4.5 billion compared to the £8 billion that it had been promised. If the police service were here, it would say, "Goodness me, £4.5 billion is a third of our entire funds for the year." You have to be a bit careful. It is a small amount of money for the NHS but it could wipe out other public services. I am just trying to put context around it. It is not easy at the moment, at least in the short to medium term, to envisage big spending increases for any public service.

Q80 **Baroness Redfern:** I think we all agree about the health and social care and how we would like to see more money go in; more money has gone into the acute sector. Can I go on to the capital side on fixed costs? We have a very expensive NHS estate. Do you think there is any mileage in looking at how we utilise our buildings as we work with other partners?

Professor Nick Black: Yes, absolutely. We have estate in the wrong place, as every healthcare system does, because we inherited a historical legacy. Facilities were where they were for all sorts of good reasons at the time, which are no longer. In a nutshell, the key change needed is a reduction in the hospital secondary care estate and an increase in the primary and community care estate.

Baroness Redfern: Have we started that work? I am getting at the thinking.

Professor Nick Black: Very slowly. Your colleague Lord Darzi suggested something along the lines of polyclinics. It may not have been quite the right model. There was debate and discussion.

Baroness Redfern: There are some serious efficiency savings.

Professor Nick Black: The danger for those of us in London—it is true of all my colleagues and perhaps all of you—is that it is a very different in London to the rest of England. One of the mistakes that government has made is to try to come up with solutions for London and the rest of England, but they are different challenges. I spend quite a lot of time in Kent, where there has been fantastic primary care and community service development over the last decade or two—stuff that you would never see in London. That is one issue: that we do not try and solve the problem that we see within five miles of this building. It needs a different approach from the rest of the country.

Professor Andrew Street: I think we missed a big opportunity over the last 10 to 15 years in trying to think about the configuration of the healthcare system. We had a time of income growth, and lots of hospitals developed PFI schemes and had major rebuilds, but they all did those in isolation without thinking about what the system as a whole needed to look like for the future and how their new build would impact on and be influenced by the new build happening in the neighbouring city or down the road. Essentially, we overcapitalised, particularly in the hospital sector, and we are now living with a legacy of an overcapitalised healthcare system, which is not at all easy to sort out because of course the payoffs for new capital build are over a 30 to 50-year time horizon. We lost a great opportunity to think about the configuration of the healthcare system, not just in the secondary care sector but as a whole, over the foreseeable time horizon. It is very difficult to row back on that.

What can we do? Some things happened in that period that were quite useful. You mentioned in the previous session the development of treatment centres as a different model of delivering care; small, self-contained, specialising in particular treatments, and although they were expensive to set up in the first place, they now tend to deliver high-quality care at a lower cost, with lower lengths of stay and better outcomes for patients, than they would case if they had gone through the normal run of the hospital sector.

Lord Willis of Knaresborough: The discussion was about whether the NHS and care system sustainable beyond 2030. Mr Marlow, I was particularly interested in your three points. One of them was fundamental, because if 70% of the costs of the NHS are in staff, you said that the clinical work force basically has to change. I have read the Carter report, and I see little evidence in it of those solutions. It is silo-laden, hierarchical, steeped in the past, and if that does not change what hope do we have of a sustainable healthcare system? What ideas do you have? This is your job now.

Jeremy Marlow: It certainly is, and I relish it. I think you are right; it is very siloed. I have been a user, also known as a patient, of acute hospital care. In that setting you cannot help but see it. I recently had the privilege of an undesirable customer journey to have my hip replaced earlier this year, and I saw for myself the silo nature, the baton changes that happen in the system.

The theme throughout the report and my theme in life at the moment is that that does not happen everywhere. There is unwarranted variation in that it can be appalling, and it leads to the inefficient use of the people, it demotivates people when they do not feel part of a team, it costs money, and it is bad for the patient—sometimes really bad for patient safety. However, there is cause for optimism here in that work is being done on the diversity of the skills mix in hospitals, with healthcare assistants working alongside qualified nurses, physicians' assistants, nursing practitioners in clinically-led teams, and how they deliver that care in the emergency setting and in the elective setting—in the acute. There is cause for hope in that that can be done. I do not underestimate the professional interests and the protectionism that we might see in doing that, but I passionately believe that the vast majority of clinicians are there for the good of the patient and that they will see, especially when you use the data—because they are also scientists by background—that there is evidence that working differently, doing things differently, delivers better results for the patients. As I say, you do see that in some settings.

Q81 **Lord Mawhinney:** Can I take you back to the funding of social care, which is largely through local authorities. Should it be, or are they dealing with so many pressures that it would be better handled through an entirely separate, freestanding organisation? If so, what would you recommend that we recommend?

Professor Andrew Street: I would recommend the recommendations of the Dilnot review.

Lord Mawhinney: Which specifically?

Professor Andrew Street: They explored a variety of different ones and suggested a number of different funding models. Essentially they suggested a social health insurance model whereby people are obliged to make some sort of commitment to their future costs, with some cross-subsidisation across the population.

Lord Mawhinney: But should the cross-fertilisation be local authority-based or separate?

Professor Andrew Street: The solution at the moment is the social precept, as Andrew mentioned. Most local authorities are implementing the social precept for social care. The concern is that they are not all doing it, and that those that are tend to be better off local authorities. That means, if they are in those local authorities, that the social care support of the people most in need of it is likely to be underfunded. The social precept is a bit of a fudge and it might accentuate inequality.

Lord Lipsey: Dilnot said absolutely nothing about the provision of social services. It is all about who paid for it, the balance between the individual and the public provision. What we are talking about from the health point of view is how much of this social care we should provide in order to complement and work with health provision. So Dilnot cannot be the answer, with great respect.

Professor Andrew Street: No, but the question was how it ought to be funded. There is another question, how the social care and healthcare

systems need to work in integration, and that has been an ongoing problem historically. For years we have been grappling with that problem, and different parts of the country are trying to deal with that. One of the suggestions in the *Five Year Forward View* was that we need to have a less fragmented health and social care system, but of course to do that we need to invest and we need to think about different ways of ensuring that we have different arrangements between local authorities and local NHS commissioners. Different parts of the country are doing that. I am working in Somerset, where they have been thinking about integrated care arrangements. Some of those have been frustrated by contractual arrangements and other difficulties, but the recognition is that there is a problem and there is a will to move towards a better system.

Lord Mawhinney: Can I make one more attempt to have you answer my question? My question was: should we stick with the local authority or should we look to a different type of framework? Your answer was that the precept works but primarily with the rich ones, not the poor ones, so it is the people in most need—which does not answer my question.

Professor Andrew Street: Which is why a social health insurance type of system, where people are paying in on a social health insurance basis, might be preferable.

Lord Mawhinney: And we should get rid of the local authorities?

Professor Andrew Street: That would be the implication, yes.

Q82 **Baroness Blackstone:** All of you touched on productivity in answer to questions about funding, but I wonder if we could focus a bit on efficiency now. Perhaps you could say what you think about whether the NHS is efficient, whether it is becoming more or less efficient, and what the evidence is—whether more competition would drive up efficiency or not.

Professor Andrew Street: I think we should have clarity first on what productivity and efficiency are.

Baroness Blackstone: Do you want to define them in ways that you think are helpful to the Committee?

Professor Andrew Street: Productivity is the simple accounting arrangement of trying to see what the relationship is between the outputs that the system produced compared to the inputs used to produce it. For a given amount of input—staff, machines, equipment and so on—an organisation is more productive if it produces more output than another. We obtain productivity growth if the growth in output is increasing faster over time than the growth in input. Efficiency is somewhat different, but they are complementary ideas. Efficiency requires us to appeal to our understanding of best practice. Is this the best way of organising care? Are we managing care according to the best clinical guidance? Are people receiving high quality, timely care at the time they need it? Efficiency is about best practice. Often those go hand in hand. The more productive you are, often you can be more efficient. It is a bit like thinking about what our achievements are. They are partly about hard work, perspiration, 99%. Some of it is about inspiration, 1%. It is the same sort of idea; you achieve better productivity by working harder, you achieve

better efficiency by smarter working. We need to think about better ways of working smartly.

The Chairman: The question was also whether the NHS is becoming more productive.

Professor Andrew Street: It has become more productive over time, but there is still scope for efficiency. Let me just make it clear. We have said here that there are problems with productivity, but the NHS can celebrate the fact that its productivity has been improving over the last 10 years or so. If we look at productivity gains in the NHS up to the recession in 2008, productivity growth in the NHS pretty much tracked that for the economy as a whole. After the recession the economy as a whole has stagnated. In contrast, year on year productivity growth has been positive, improving year on year since then. The latest figures were that we have annual productivity growth of 2.2%, so the NHS is becoming more productive over time and it is outperforming the rest of the economy.

The Chairman: Do any of the rest of you want to answer that? Before you do that, Lord Willis, you were going to focus on productivity. Do you have a comment?

Lord Willis of Knaresborough: My question has been answered.

The Chairman: Can we continue with the question that Baroness Blackstone asked.

Professor Nick Black: To focus on healthcare for a minute—I certainly do not have expertise on efficiency or productivity of social care; others will provide that for you—the NHS could be more efficient and more productive, no question about it. There is still a huge variation in costs. We tend to focus on variation in outcomes. This is what I spend most of my life on. Variations in outcome are very slight. It does not matter which hospital in this country you go to for a hip replacement, the outcomes according to patients do not differ. What differs is the cost. We have just done a study of a small bit of healthcare, memory clinics. Only £200 million a year is spent by the NHS in England. We have found that the basic costs of assessing and diagnosing the new referrals for dementia vary. The range is 17-fold, a 1,700% variation. Even if you take out the outliers, the majority still vary 6-fold, a 600% variation. When we are looking at outcomes we are excited if there is a 5% difference, so this obsession with outcomes, which of course I share—measuring outcomes and developing measures is how I earn my living—but efficiency is mostly driven by cost and we do not know very much about variation in cost.

Worse, I do not think that most boards of provider trusts are fit for purpose. I say that because I do not think that most of them have people on them, either executive or non-executive, with the ability to take something like data on variations and to work with the clinicians. They are the ones whose behaviour has to change. Boards need to look at how they are producing a hip replacement, how they are producing a birth, and look hard at the staffing levels, at the costs, because there is huge potential for efficiency gains. That is just the hospital sector. We have even less data on general practice and primary care. We do not really know how efficiency varies in primary care.

Jeremy Marlow: I agree that the variation is enormous, which is what Lord Carter and I looked at. Another question is what we do about it in that context. You are absolutely right that the prices that trusts pay for everything, from paper through to the hip implant, for the same thing, can vary enormously across that piece. I forgive trust execs and boards a little more than you in that they are not aware of it. They do not have the information in front of them so that they can know that they are paying considerably more than someone else in the system. We have the benefit of such a large system. It is not unprecedented. There are other health system provider networks the size of ours, but we do not use that information smartly at all, and we do not give it to our execs and non-execos on the boards so that they can know that this is happening.

We have to do something about that, which is what I want to do. We have to bring that data out there and share with them the fact that if their costs and their commissioning behaviour is such that they are forcing their procurement teams to buy things they should not be buying and that there are cheaper products out there that give exactly the same outcome, and sometimes probably better. Orthopaedics is an area that we have looked at a great deal. I have two clinicians working with me, one of whom, Professor Tim Briggs, has led a fantastic piece of work over the past three years looking in depth at orthopaedic practices, and he has drilled right down, absolutely mined the data that is out there, in all sorts of places. It is not easy to get at, and one of the things I have to do is make it easier to get at. This is not patient-level data, this is aggregated data that is out there to use.

You are absolutely right that in infection rates for hip and knee replacements alone there is a range of 0.5% to 4% across the system, which is big, and it affects patients, I can tell you. I did not have an infection, thankfully. If we could reduce that to 1%, 6,000 patients would suffer less and it would save the £300 million cost of being readmitted across the system, but we have to make both the administrators and the clinicians aware of when it is happening in their system, and then help them to do something about it. That is what we have to scale up and do in NHS Improvement. It has to be clinically led when we do it, and I am pleased to say that the work that Tim did in orthopaedics is now expanding into 11 of the major surgical specialties, and we are going to expand it again into the same amount of medical specialties as well, supported by my colleague sitting behind me today, Professor Tim Evans.

Baroness Blackstone: Are you saying that the regulators now need to do very much more in relation to both productivity and efficiency, providing more information to providers on what the costs of what they are doing are? It is difficult to do this, coming back to your remarks, for every separate trust, because they do not have the benchmarking data in order to understand better which areas of their activities need more attention from the point of view of efficiency. I am asking should this not, at least in terms of the data available, come from the centre, and that data be more widely disseminated, to make the pursuit of efficiency easier?

Professor Nick Black: I disagree. There is plenty of data and the boards have access to that data. I do not buy that the problem is they do not

have access to it. Over the last 10 years—all credit to CQC and other bodies—we have greatly enhanced the quality of data both about the quality of care and to some extent on costs, though Andrew knows more about that than I do. The problem we have is that most of it is falling on stony ground. That is why I come back to my point, which might sound over the top, that there are a few exceptional trusts in this country but the majority do not have an executive or non-executive board member who knows how to handle that information and to have the really hard discussions. It is not easy—and I am aware of various eminent surgeons in the room—to go, say, and talk to your senior surgeons and say, “Why do you have two nurses in theatre during that operation when other places do it and achieve the same results with one?” That is a really tough thing to do. I do not believe we have on most hospital boards people with the confidence and the know-how and the skills, the relational skills, to handle and manage the change that needs to take place. Whilst the cost of the bits and bobs and widgets is important, it is a tiny bit compared with the staff costs of who is doing what and the decisions that clinicians make on who is admitted to hospital, what happens to them and how long they stay. Those are the big cost drivers.

Baroness Blackstone: Can I just come back on that? I should declare an interest because I chair a hospital board. I think what one needs to understand is that there are huge pressures which come from politicians, regulators, NHS England, on quality, and you constantly get push-back in terms of, “If we did this in the way that you are suggesting, we will not meet the quality requirements of what we are doing in terms of our output”. You have to look at the counter-pressures on achieving what you are proposing, which I identify with, in all these many institutions.

Professor Nick Black: I recognise and accept that, which is why one of my three main opening comments was that we have to change the relationship between the centre and the periphery so that the periphery is not in fear of taking risks and making radical changes.

Baroness Blackstone: Well, they are.

Professor Nick Black: That comes through NHS England, NHS Improvement, the CQC and the Secretary of State for Health. We have to take that pressure off to allow you and your board to say, “We are going to do things rather differently, because we have seen something in Spain or America, and they do it quite differently.” You should be allowed after a year to say, “Ah, it didn’t work”, or, “Things are worse. We are now going to try something else”, and not be punished for it.

The Chairman: Nick, in our conversation you remember that we are talking about long-term sustainability of the NHS and not trying to fix today’s problems. Mr Haldenby wanted to come back.

Andrew Haldenby: I thought Lord Rose’s report on NHS leadership, published last summer, was very relevant to this conversation. Coming in as an outsider, he was gravely concerned about the kind of bureaucratic goo that was gumming up the NHS, in his view. He had a phrase for it—“The NHS is drowning in bureaucracy”. Members of this Committee may be wondering, “How can it be? We have an NHS where there are headlines every day about financial deficit, but here we are presenting

evidence that the NHS does not think properly about its costs. It is missing the wood for the trees". But I think that that is what is happening. I think the volume of central guidance and requests for information from the centre to your trust are giving you plenty to do but are not encouraging you to look, on the productivity side, at some of the things that really matter.

Q83 Lord Warner: I should declare two interests. First, I am a member of the advisory board of Reform and—listening to some of the earlier conversation—I was a member of the Dilnot Commission. I have talked to Andrew privately. I think he may have got hold of the wrong end of the stick about what the Dilnot Commission was about. It was capping individuals' responsibility for funding their social care.

I have been twitching here, listening to this discussion about efficiency and productivity. When I was a young civil servant, like Jeremy, in the fast stream, I was taught the difference between efficiency and effectiveness. Lord Carter of Coles, who is a personal friend, has produced a brilliant report, but even if you do everything, it produces £5 billion, which is a long way short of plugging the gap. Let us do it all, and I agree with everything that has been said about trust boards and all the rest of it, but it produces £5 billion.

Let us then talk about productivity, and have a go at that. Andrew was very positive about NHS productivity. The lion's share of that productivity was achieved through pay restraint. Of course, if you cut the cost of your inputs, you will achieve a productivity increase. It is arithmetically impossible not to. We are being asked to back a couple of horses, productivity and efficiency, which does not produce sustainability on the levels that we need. The game in town that is discussing effectiveness is the Five Year Forward View. The Five Year Forward View is trying to change the models of delivery. My question to you is: let us do productivity, but not necessarily the way it was done before, and let us do efficiency; but how do we return to the sustainability of an effective NHS funded through taxation? Starters for 10. Where are the answers?

Professor Andrew Street: The *Five Year Forward View* set out a productivity challenge but it also said there needs to be investment in new ways of doing things—of making the system more efficient. We need to have more-effective public health and prevention; we need to develop new models of care and new arrangements to deliver care. Those are the types of investments that will secure longer-term efficiency gains. The problem is that the NHS is having to deal with deficit situations, which means that the investment funds that were to be used to transform the service are not available to do that, so the efficiency challenge will not be met; and as you rightly say, the productivity gains that we have seen over the last few years have really been about dampening growth in inputs and, of course, keeping wages low. That is not a long-term solution either. The update of the *Five Year Forward View* that Simon Stevens produced in the summer said the plan for the future growth in wages would be 1% over the parliamentary term annually. They are going to grow by more than that in the economy as a whole. In that situation, it is going to be very hard to retain and recruit the staff that the NHS needs, and that will make it difficult to maintain the productivity gains that we

have seen in the past, and it will undermine the efficiency ambitions of the *Five Year Forward View* as well.

The Chairman: Do any of the others wish to comment briefly?

Andrew Haldenby: As I tried to say at the beginning, the *Five Year Forward View* has, as I think people will agree, a lot of good ideas. The question is: is it going to achieve them any time soon, certainly before 2020, which is the target? One of its big ideas—and I do not have all the answers—is prevention, to prevent ill health before it happens. People tell me that we might need to pay NHS providers differently in order to encourage them to do preventive activity rather than responsive activity, and that those changes in funding have not happened, so there has been little progress on prevention. On new care models, in primary care there are new and very big primary care operations covering 100,000 or 200,000 patients done in completely different circumstances, such as GP surgeries, from those we might have in mind. So there is some care there, but at the hospital level there has not been the pace of change that people would have expected.

Lastly, on pay and numbers, let us compare it to the police. The Government no longer argues that there have to be more police officers to have lower crime. It has an outcome target—“Lower crime, please”—but it says to chief constables: “What you do with your work force is up to you.” Still in the Health Service it says: “We want better health, thank you; but you absolutely must employ more nurses and more doctors.” I am not advocating massive cuts in the NHS, but what is the question Ministers are asking of the NHS, and what are the constraints they are putting them under to deal with issues of work force and pay?

Professor Nick Black: I agree with you. Things like the Carter proposals will make a useful contribution but they are quite marginal—£5 billion is unlikely but £2 or £3 billion might be possible. On prevention, looking at 2030, even if we started today, it is not going to have much impact on demand for care in 2030. That is not an argument against prevention, but it is not an immediate thing. Therefore there are two things that have to happen. I think there needs to be more resource—more money for health and social care. As I said earlier, I would focus it mostly on social care at the moment, at least for the next five years, because social care has been so reduced and the impacts on healthcare are enormous. We also need to look at radical change in how healthcare and the NHS are organised. The STP model of getting to 40 health economies that are managed will work only if all the players at the table—be it local government, foundation trusts, CCGs or whoever—will come to the table and drop their sectarian interests. Will a foundation trust chair or chief exec accept that the outcome for the public in that million population might be a reduction in the budget for their hospital, and will they go back and deliver that to staff? That is where I come back to the politicians’ courage, because I would extend politics here to non-execs and chairs of boards acting politically with their local population. If that does not happen, it is a rather gloomy outlook.

Jeremy Marlow: I am sure you would expect me to disagree with Nick on some of what he said there. There are two fundamentals that we are doing in the next five years that are going to be really important to the

long term. What we are doing in the delivery of Lord Carter's report is, yes, about short-term cash savings in some areas, such as the consolidation of pathology. You will be aware, Lord Warner, of the long ambition to get that done. We have to get on and do it. There are other areas that will deliver some improvements in productivity but are fundamental to the long term, which is the clinically led area of work, where we have to standardise and remove the variation in the system. That is not going to be done in five years. That is a decadal or possibly generational thing where it has an impact on junior doctors going through med school at the moment, in the way they operate and behave in 15 to 20 years' time.

The other is the innovations, the thinking that is going on out there, in terms of the way we configure our health system, and with social systems—such as what is being done in Northumbria and the innovation and courage being shown in Greater Manchester to integrate services across the health and social care spectrum. That will shine a light on the way forward for the long term. It is not all going to be delivered in the next five years. We are not going to see massive, universal change in the way that our health service is provided in the next five years, but it will set out the path for the longer term if we are successful in doing that.

Q84 Lord Kakkar: I remind the Committee of my interest as Chairman of University College London Partners. I would like to turn to the question of NHS Improvement and how it is contributing to the efficiency and productivity of the NHS in the long term, and in particular focus on a couple of issues: first of all, what progress has been made with the Carter review? We have touched on this but it would be good to have clarity on where you think it has got to. Secondly, is the single definition of success which NHS Improvement has provided a contributor in terms of the long-term sustainability question? Thirdly, who is actually in charge of the strategy and taking forward the delivery of these efficiency and productivity potential gains within the NHS? Is it NHS Improvement or, as we have heard, the multiple other regulators and arm's-length bodies that exist in the NHS currently? Finally, how would this Committee and others be able to determine whether NHS Improvement is really delivering?

Jeremy Marlow: I had better answer that one. Regarding Lord Carter's report and the progress in implementing it, many of the recommendations in the report were directed at NHS Improvement. When it was written and published back in February there was no such thing as NHS Improvement. It did not formally start until April. Any machinery of government changes, any public sector changes, cause a huge amount of upset and turmoil that has to be gone through. Such is the nature of things. Certainly, from where I sat then and where I sit now, we have gone through that at a fair old pace but it has meant we have had a couple of months where I would have liked us to have gone faster had we had the capabilities there to do it, but we were not able. However, I am now building up the team and we are on track with most of the recommendations in the report. There were 15 big recommendations, broken down into 87 sub-recommendations. I have a plan, which is to deliver that. You are right—£5 billion of savings is what we have to do over the next five years, cashable and non-cashable.

There has been good progress in areas. Because of the work that Sustainability and Transformation Plans and footprints are bringing together in the areas of pathology and back-office consolidation, we are out there helping people do that at the moment. In the clinical space, as I have said, I have the funding to scale up the programme in that work across 22 clinical specialties in that sector. We are recruiting senior clinicians to lead each of those strands as we do that.

In terms of your question about who is in charge of the overall productivity and efficiency area, it is the NHS, so it is complex. That is the answer to that. The *Five Year Forward View* has obviously a set of objectives which are more than just about efficiency when it comes to closing that £20 billion gap. It comes down to prevention and crude pay restraint, as you say. There are various organisations responsible for delivering their part of the overall package. What we are responsible for at NHS Improvement is the operational productivity side of things. How do you remove the unwarranted variation that is there among providers in the acute community and mental health sector? How do we shine a light on it in the first place to help boards and chief execs do their bit? How do we give people the standards, the best practice that colleagues talked about here, in a way that is meaningful to people working out there? That is why, in my view, it is so important that it is clinically led—that it is not just me, a civil servant. Everything I am doing I am trying to do jointly. Something I learned in the States when I went there a few weeks ago was that they always deliver improvement in what they call a dyad, where they always have a very senior clinician partnered by a senior operator and always deliver it in that way. You cannot do it without both of them. That is the model I am trying to build.

Lord Carter himself is a non-executive on NHS Improvement and will be chairing a sub-committee of the board to keep my feet to the fire and make sure I am delivering. He is also going to be working with me from next month to look in depth at community health and mental health providers, which we did not look into during the first review but we are aware we have to do. There is about £30 billion spent in that area. It will be very tricky. It does not have the wealth of data that we had available in acute, especially in the community sector. I know you have taken evidence from people on that before. It is an area we must look at because I am sure we will find just as much unwarranted variation, if not more, when we have an in-depth look at that.

Andrew Haldenby: Part of that question was who should be responsible for driving NHS productivity? A large part of the evidence this morning focuses on the boards and leaders of individual NHS organisations. We have to emphasise that. Taking it right up to the political level, the policies of Ministers and, indeed, the Prime Minister do matter. Just thinking very briefly about the politics of the health debate in recent years, the previous Prime Minister, David Cameron, did not push the arguments for NHS efficiency and productivity particularly hard. That was not the main part of his pitch to the electorate on the NHS; it was much more about protecting it, protecting its budget and so on. Interestingly, after the last election, when he obtained his majority, he toughened up his language. His first policy speech in this parliament was on the NHS and is well worth reading. He spoke about the need to deliver both high-

quality care and efficient care, and the fact that those two things could go together, not be in opposition. That was a toughening of his rhetoric—and now he has gone, as we know, and we wait to see. I do not think the new Prime Minister has said anything on healthcare thus far. I am just trying to say that for all of NHS Improvement and any of the agencies' efforts, inevitably they work within a broader policy framework. As I say, Ministers and, indeed, Prime Ministers need to set a direction towards productivity, if that goal is to be achieved.

The Chairman: Does anybody else want to comment?

Professor Andrew Street: I do not think just providing information and encouragement is enough to change behaviour. We need behavioural change at board level and within organisations. A lot of the attention in Monitor and NHS Improvement, particularly at the moment, has been around the hospital sector, because we are dealing with the deficit situation. I do not think that the things that are being put forward to change that, unless they change behaviour, will be sufficient to deal with the problem. There is a mentality in the hospital sector that the way to get out of financial trouble is to grow your income, which means doing ever more activity—so you do more activity, your income grows. That will not work, because the income you receive is based on average cost minus a 4% efficiency target. If you are above cost, you will not get out of financial difficulty by growing your income; you will get into worse financial difficulty. Since the annual 4% efficiency targets were introduced in 2011, hospital deficits have been growing worse and worse, because hospitals have been doing more and more work.

How do we change that mentality? As Nick said, we have to think not just about the income implications of doing more work; we have to think about the cost implications of doing that work, and hospitals need to make a decision about what work they do and how they expand or contract their services on the basis of both the income consequences and the cost consequences. The problem is that very few hospitals look at cost information, and very few hospitals have decent cost information to look at. Only 50% of hospitals have invested in patient-level clinical-costing systems in this country. That is almost 14 years after we introduced national tariff arrangements. Without that information you do not know how income is going to impact on your deficit or surplus.

Hospitals have to change their mentality and they have to do that themselves, and it is not enough to give them information and encouragement; they have to be incentivised properly. It is NHS Improvement's job to encourage them to do that, but ultimately it is going to rest with management and boards within hospitals to change behaviour and mentality.

Lord Kakkar: How then would NHS Improvement most effectively incentivise that behavioural change at institutional level to contribute to sustainability in the long term?

Professor Andrew Street: It is clear that the 4% efficiency target has not worked because hospitals have not responded to that. What has happened with that 4% efficiency target is basically that it has just gone into deficits. I suppose it has paid off for hospitals because they can now

say, “Bail us out.” In terms of a long-term strategy, that is fine; they have been able to get away with running up deficits, because they just could not meet a 4% efficiency target. That was impossible. The efficiency targets that need to be set need to be not just across the board; they need to be focused on specific areas where there is variation and where there is evidence that in this area there is much wider variation in costs, in length of stay, in outcomes, than in another area. The incentive regime needs to be more sophisticated and more targeted at where we think there are gains to be made. If it is across the board, you will have an across-the-board response, which is probably detrimental to the system as a whole.

Professor Nick Black: On NHS Improvement, I think the shift of culture and approach from Monitor and TDA to quality improvement is welcome, and Ed Smith and Jim Mackey are genuine in that they see it as not so much to regulate as to support and help. There has to be that shift. The role of NHS Improvement should be to help those boards do what they should be doing and are not currently doing. The problem over the last 5 to 10 years is we have recognised at the centre a problem with the calibre of managing our resources locally, and instead of trying to enhance and improve management, we have reached for regulation. You do not run an organisation, certainly not of this size, through regulation. Regulations are very specific, and regulation has grown and management has withered slightly. We need a wholesale change, and I think NHS Improvement is genuinely supportive of that. It has lots to do to help and support boards, so they do not feel, “NHS Improvement is on our back” but that, “It is holding us up and helping us.”

Lord Bradley: Just on that point, I again declare my interest as a non-executive director of Pennine Care and having had a hip replacement operation. Is there not a tension currently with NHS Improvement, with a very blunt instrument of annual control tariff claims which undermine the ability of boards and management to look at innovation, to look at how they can change the way in which they practise? They have this short-term financial pressure to deliver on a control total which NHS Improvement cannot justify in any rational way. It is a mechanism to reduce deficits rather than looking to the long-term changes that need to be made within the NHS and social care.

Professor Nick Black: It is this eternal issue of control and command from the centre versus local autonomy. As you will have gathered from most of my comments, I would favour much more of the latter and let go of the control and command, take risks, allow mistakes to be made in certain places. Looking back in five, 10 or more years, we will have achieved much more, which we are not achieving with so much control and command at the moment.

Lord Bradley: Do you think the so-called devolution of health and social care, say, in Greater Manchester, is an opportunity to break out of that?

Professor Nick Black: Yes, very much so. If Devo Manc does not achieve half of what we hope it will—it will be great if it achieves half—the outlook is quite gloomy, because that has to be the way.

Lord Bradley: But as Professor Street said, you need that injection of

resources up front to change the pattern of care.

Professor Nick Black: You need more money, yes. It cannot all be done with existing resources.

Lord Warner: What is the danger that the poor old NHS out there, down at the local level, is a bit confused as to what they should do? You have Jeremy and his colleagues pushing down the NHS Improvement route, and you have Simon Stevens and NHS England saying the future lies with STPs, which is a kind of “control your own destiny” type of model. Having sat in Richmond House and sent signals down to the NHS and then found that my colleagues had sent another lot of signals down to the NHS, I wonder whether there is not a risk, looking at 2030 and not 2020, that we are giving confusing messages to the NHS as to what they should do?

Professor Nick Black: Absolutely, yes. It has come about partly from the fragmentation of the centre since 2012. That is not to say that, in the Department of Health, all the parts spoke to each other. We all know there was fragmentation despite being in one organisation, but it has not been helped. You have clashes and fragmentation at the centre, which is not helpful to the periphery.

Jeremy Marlow: However you configure this thing, whether it is 136 acute trusts or 44 STPs, whatever, ultimately there will be wards and out-patient departments and in-patient departments working. I and my team can help at that operational level, whatever configuration you are in, to know whether what you are doing is optimal or not both for the patient and for the cost of what you are providing. As I say, one advantage that we sometimes do not think about in the scale of our system, with the wealth of data and understanding we have, is that we have fantastic experience and pockets of excellence out there. The tragedy is we just do not identify it and share it with others and get them to do the same. We are too afraid. I agree the fragmentation that has come about has meant that we have not had the capability to do that. However you configure this going forward, you are always going to want to do that. People often say that with our NHS we are the envy of the world. I am not sure, but in that regard, everywhere I go, people are envious of the amount of data and knowledge we have across one system. They look at me quizzically and say, “Why on earth aren’t you using it?”

The Chairman: In this session and the previous session we have concentrated on efficiency and productivity and all of the issues on the hospital activity side, but why do we not have data on the primary care side, or is it efficient?

Professor Nick Black: The sad thing is that we were on the cusp of getting it with the GP systems and you and others round the table will know about the various issues and concerns genuinely held by some people about confidentiality, access and misuse of the data. If we had been having this discussion five years ago, I would have said, “Yes, we are starting next week and we are going to be able to drill down and have information on 50 million people in England on their GP records”, but that has not proved possible yet. Until we can, it is very limited. There are things that can be done. The Health Foundation, the Nuffield Trust and others, as Andrew is referring to, are trying to look at segmentation of

populations in primary care, but it is desperately slow because of the problem of access to data and use of that data. That has to be resolved within this building as soon as possible.

Professor Andrew Street: I would echo those sentiments entirely.

- Q85 **Lord McColl of Dulwich:** Can I go back to preventive medicine, because it seems to me that the only certain way of reducing the costs is to get the millions of obese people down to a normal weight. I was a bit alarmed to hear it said that it was going to take 10, 20 or 30 years. In fact, it would be possible within a year or two for an obese person to reduce their weight. The problem is that the Department of Health and NICE misled Parliament and misled the people by saying it was due to lack of exercise. It is nothing to do with exercise. Exercise is good for other things. The Government, the Civil Service, NICE and all these organisations need to give a clear lead. You do not tell people what to do, just tell them the facts—that the answer to obesity is to eat less. It is nothing to do with exercise. What does the Department of Health do? It tells doctors they must not call patients obese. It is nonsense. It is judgmental, they said. It is not judgemental; it is simply accurate diagnosis. We need that.

The Chairman: That is a message you might transmit more widely.

Professor Nick Black: The point about the health costs is yes, somebody could start losing weight tomorrow and by the end of the year have lost weight. The health implications of all the young being obese are not going to be felt for 20 or 30 years, because they are not actually going to become sick in their 30s, 40s, 50s. It will come later. They are not going to need bariatric surgery until much later. That is why I said, even if we were successful in prevention starting tomorrow, it is not going to have much impact on the 2030 perspective. Of course I am all in favour of people losing weight. I share some of your personal views on that.

- Q86 **Lord Willis of Knaresborough:** Could I first of all declare an interest as a consultant at Health Education England and the NMC, and I have not had a hip operation.

The Chairman: Yet.

Lord Willis of Knaresborough: Do you know something I don't know?

I am staggered after this session. I go back to my point about 70% of the budget being spent on staff, yet none of you seem in any way to see this as an acute need to change the way that staff work. If in fact you have these new proposals, whether they are coming from NHS Improvement or anywhere else, or individual trusts, unless staff can work in a very different way, be differently skilled, be multi-skilled, be able to break down these barriers, quite frankly, this is pie in the sky. None of you seem to have any real urgency about tackling the particular issue of the work force.

Andrew Haldenby: I think we may have slightly taken it as read but, just to give one piece of evidence, our last paper on primary care pointed out that of all the GP appointments taken in the country, only 62% now

are taken by an actual GP. The remaining 38% are taken by other members of clinical staff—nurses, pharmacists in some cases, physiotherapists and so on—and there are greater opportunities to further reduce the proportion seen by GPs. That is an example of a much greater skill mix in primary care enabling better use of skilled and more expensive staff.

Lord Willis of Knaresborough: The biggest fundamental barrier, particularly in nursing care, is the use of drugs and to be able to either prescribe or deliver. At the moment all that is restricted to registered nurses. The idea we proposed in 2014 of the nursing assistant is still going through the system, even though Ministers agreed it, people agreed it, in order to have those capacities. If the speed of change is so slow, you cannot make the sorts of changes that you need in the whole system.

Professor Nick Black: I think you can make a lot of changes despite that.

Lord Willis of Knaresborough: You cannot, because the rules say you cannot. The regulation says you cannot. The Royal Colleges say you cannot.

Professor Nick Black: I agree all of those are factors but if you take my example of memory clinics, where they have a 600% variation for the majority, leaving the wide outliers out of this, that is because of the staffing; that is driven almost entirely by the numbers of doctors, nurses and what they are doing. That is about looking at the most efficient way of providing a memory clinic. The expensive ones have more doctors. Do they need to be there? Patients seem to receive just as good a service when it is a much more nurse-led one. Absolutely, that is part of the solution. The same with STPs, looking across the whole sector, whether it is in primary care or secondary care, redesigning clinical pathways, and inherent in that is what our individual professions do. I agree there is some limitation from central bodies which have other agendas—like Royal Colleges, I quite agree—which may not be in the interests of the NHS and the public. It might be too much in the interest of the profession, on the grounds of maintaining good standards. We have to get that balance right. I agree it is not right now.

Professor Andrew Street: There are two ways to look at this. One is at the national level and one is at local level, and we need a strategy at both levels. At national level, in a report earlier this year the Public Accounts Committee was scathing about the lack of work force planning for the NHS over the last few years. We need good work force planning. It takes seven years to train a doctor, three or four years for a nurse. You have to have a good work force plan in place to ensure we have the right numbers and they are specialising in the right areas. Our work force planning over the last few years has been very poor, and that needs to be rectified, because if we do not have the work force in place, we require recruitment from overseas and we will be spending more on agency staff.

There also need to be incentives at local level for organisations to work out what the best mix of staff is and what the best mix of capital and labour is. It is organisations, clinical teams, at the local level that are the best to do that. What we need to ensure is that the incentives are in place

for them to work out the best way of organising care—to work out what that is and to implement it locally—and to ensure they have the resources available to be able to do that. We need a work force strategy at national level, so we have the work force in place, but with incentives at local level to ensure that organisations are incentivised to pursue efficient ways of organising care.

Lord Kakkar: Just to pick up on a point of Professor Black's, is the system that we have for commissioning sufficiently robust to drive down those changes and variations in practice? Quite frankly, should not a commissioning system be able to look at this and define clearly what needs to be commissioned, and then providers have to provide at a local level and meet those requirements?

Professor Nick Black: No, I do not think they are, for a number of reasons. One, we have far too many commissioners. With all respect to some wonderful staff in CCGs—that is not true of all of them—we could probably staff 40 local commissioners around the STP footprint and have really high calibre, and my comments about the shortcomings of provider boards I would also apply to the shortcomings of commissioning boards. Again, I think the know-how, the skills and the calibre—it is an incredibly difficult task we have given them, and a lot of it is just rubber-stamping what we paid for last year in a sort of accountancy practice, rather than addressing and pushing the local health economy to implement better clinical pathways that meet all these requirements we have talked about.

Lord Warner: If NHS Ltd was a FTSE company facing an existential threat because it had the wrong product lines, its board would probably say we need both a strategy and an investment plan. Where is the investment plan?

Professor Andrew Street: The *Five Year Forward View* set out a strategy for investment and prevention in public health, recognising that we have an obesity crisis now and in the future.

Lord Warner: Sorry, let me just stop you. It did not say that on the investment plan. It sent out a wish list for money.

Professor Andrew Street: Yes, but you need a vision, and that vision was supposed to be set out by the Sustainability and Transformation Fund. As I have said before, at the moment that has been swallowed up by sustainability, not transformation, and without that we do not have investment. The vision set out by the *Five Year Forward View* needs to be backed up by investment. Without it, we are going to be muddling through from one crisis to the next, which is what I feel the NHS is doing at the moment.

Andrew Haldenby: In this case, unhelpfully, in the Sustainability and Transformation Plan "sustainability" does not mean the sustainability that you are talking about in this Committee; it just means breaking even. The NHS is focused on sustainability, just not the sustainability that you are talking about in this Committee.

Professor Nick Black: Like you, I am hoping—perhaps this is a forlorn hope—that the STP plans currently being developed and produced are actually investment plans that say, "This is where we want to get to, but

to get there we will have to change some of the facilities and buildings as well as the relationships and clinical pathways—the lot”. That should be the investment plan, whether or not it is funded or sent back to the drawing board to work on further. Yes, I share the model you are suggesting.

Lord Warner: But there is no bank, is there? We have no bank for this. If you are a company, you go to your investors to try to produce the money to get you from A to B. What I am trying to understand is whether you guys think there is an investment plan. There is a vision possibly.

Professor Nick Black: With those 40 investment plans put together, if they are going to require an investment of £10 billion, NHS England has to go to the Treasury and No. 10 and say, “That is what the investment plan will be”. That is the bank. If politicians were courageous, they would then go to the public and say, “This is what is going to be required. Do you want an NHS? We are going to have to raise that money.” Income tax is only one form of tax revenue. We have to raise the money and pay for it. I am not suggesting you take it from the military or the police, who are all squeezed even more.

Jeremy Marlow: I just want to come back on some of the work force points that Lord Willis raised. I am sorry if I have not expressed the degree of urgency that I and the organisation are giving particularly to this. Job planning is a really important part of this for the work force we have now. Do we know what they are doing and are we using them as best we can? That is not just doctors. It is nurses, healthcare assistants and other allied health professionals.

I agree completely about the role that regulation plays in sometimes stifling the innovation and what we can do with our work force. We plan our work force, as others have said to you before, in a very Soviet-type system where, because we have such a specialised work force, to think we can plan it 15 to 20 years out, which is what we are going to do, is rather optimistic. Maybe if we try to create a more flexible, adaptable work force, we will not need to plan it 15 to 20 years out down to the degree of specialisation that we do at the moment.

I do not know why I am defending the Royal Colleges but I think I might for a moment. There are about 1,000 physicians’ assistants in the country, and the Royal College of Physicians is hosting the first event for those to get together in a few weeks’ time to think about some of the regulatory aspects to what they do. There is hope again out there, regarding the way we have always worked, that there is fresh thinking and an acceptance that we have to do this. If we are to use our resources more effectively and more flexibly in future, we have to plan for that now, because, as I say, it takes 15 or 20 years to get people in place in the first place.

The Chairman: Thank you all very much for coming today to give evidence. It has been most helpful. In questioning you may have thought about some other issues or answers. We are very happy to receive any further evidence from you, so if you have any, please send it. Thank you for coming today.

NHS Providers, ADASS and NHS Confederation – Oral evidence (QQ 87-97)

Evidence Session No. 8

Heard in Public

Questions 87 – 97

Tuesday 18 October 2016

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Bishop of Carlisle; Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; and Lord Warner.

Examination of witnesses

Chris Hopson, Chief Executive, NHS Providers, Margaret Willcox, Vice President, ADASS and Rt Hon Stephen Dorrell, Chair, NHS Confederation.

Q87 The Chairman: Thank you all for coming. Just a few administrative matters: the whole session is on record and when the “Broadcasting” sign is on we are all being broadcast. Any private conversation may be picked up so please be careful. That goes for Committee Members as well. Committee Members will declare any particular interests when they ask questions, even though it might already be in the register of their interests. At the end of the session you will be provided with a transcript. You cannot change it but you can correct it, if you so wish. Before we start, please introduce yourself and if you want to make an opening statement please feel free to do so on any aspect of our inquiry. Can I start from my left?

Chris Hopson: My name is Chris Hopson. I am the chief executive of NHS Providers. We are the membership organisation for the 238 acute, community, mental health and ambulance foundation trusts. I will say five very quick things. First, it seems to us that if you look at the future projections for demand and disease patterns, there is a spike in demand that the NHS faces which, to be frank, our perception is, it is wholly unprepared for. The second point to make, linked to that, is that there clearly is a set of workforce demands that that extra demand will create, which again we feel the NHS is wholly unprepared for. The third is that we cannot see how the NHS can meet those challenges and the wider social care system within the existing model and we therefore need to move to new care models much more rapidly. We are concerned, although that process has started, about the ability of the NHS to get there quickly and consistently enough. The fourth point to make is we believe we will need to increase funding and that current funding levels will be insufficient to meet that demand. The final point is that if we are to keep a taxpayer-funded system we feel very strongly, if there is to be increased funding, it

will require public consent and if we are to gain that public consent we need a much better quality of debate about the NHS, its funding and its outcomes.

The Chairman: Thank you very much. It is nice to have a previous Secretary of State here.

Rt Hon Stephen Dorrell: Not everyone in the room may agree with that, my Lord, but thank you for the invitation. Can I introduce myself as chair of the NHS Confederation, which has members from the provider side, from the commissioning side of the health service and has associations with the Local Government Association? We seek to develop a broad health and care view of the health and care economy. I should declare two interests, if I may, to the Committee. The first is that I am an adviser to KPMG, and the second is that I chair LaingBuisson. I refer to that because I want to refer briefly to the report published by the ONS on the total size of the health and care economy, which relied, to some extent, on work done by LaingBuisson.

There are two points I would like to make in an opening statement, agreeing with everything Chris has already said. The first is to refer to the total health and care economy, which the report I have already referred to assesses as 9.9% of the UK economy—this is a reassessment published by the ONS earlier this year—and, to some extent, draws the fire on those who draw attention to, allegedly, how small our health and care sector is by international comparison. We are still, incidentally, 1% behind France and Germany but at significantly higher levels of spend on health and care services than some of the earlier numbers suggested. It allows me to make the more important point than the “moment in time” comparisons on the size of the health and care economy, and that is to refer to trends.

I very much welcome the work of this Committee, which, if it is focused on the long-term sustainability of our health and care sector, is presumably focused on trends—where this is going over the next five, 10 or 15 years. There is a tendency when people talk about the health and care sector to regard it, because it is largely tax-funded, as a kind of national overhead and a burden, and we are worried because we devote a rising share of our national income to delivering health and care services. I would like to invite the Committee to look at it exactly the other way round. As society becomes richer, of course, it is true that the elements of our society that deliver health and care services to the sick and the elderly take a rising share of our economy. Why would they not? It is Maslow’s famous hierarchy of need that, as societies become richer, in this country, all over the world and throughout history, these services take a rising share of our rising national wealth.

The question for this Committee and for those concerned about the future of this sector, it seems to me, should be how to ensure that that expressed wish of consumers in this and every other country throughout history is not obstructed by the fact that we choose to fund the majority of our services through the tax system to secure equitable access. It is that policy challenge which is at the heart of good policy-making in health and care services: how to facilitate the growth rather than, as the Government’s current plans suggest, restrict that growth—I would argue

artificially—during the whole of the current decade. That is the core question.

The second question I would like to touch on briefly during the evidence, if the Committee is interested, is not just the quantum of money but how we ensure the money is properly spent to deliver the objective of improved life experience for the consumers I have been talking about. We tend, again, because we think of them as services, to think about medicine and the service we deliver over a period of years, rather than the outcome we deliver and the experience of the people who rely on these services. That is a theme I would like to come back to.

The Chairman: Thank you. We will come back to some of the comments you made in the first question.

Margaret Willcox: I am Margaret Willcox. I am currently the vice-president of the Association of Directors of Adult Social Services, so we represent the directors and assistant directors, both past and current, in the country. My opening remarks would be that we are very well rehearsed on the ageing population that the country faces and, in particular, the fact that many of us are living longer, with more complexities. The number of those aged over 85 in the population has seen a very significant rise. We urge people to consider the fact that there are other groups also in that rising group. There are more people with learning disabilities now and we are predicted to have 21% more by 2030. There is a rising number of people with mental illness. We have made more Mental Health Act assessments and more deprivation-of-liberty assessments in the last few years, and they continue to rise year on year. We are seeing dementia in people with learning disabilities—situations we have not seen before. Regardless of whether they have a mental health problem, a learning disability problem or indeed a physical disorder, people are likely to have more complex needs because of the nature of the advances we have seen in medicine and, to a certain extent, in social care.

I urge the Committee to think about the fact that for people to have a fulfilled life for as long as they can, we need a range of services across health and social care and into broader areas such as employment, so that people can have a fulfilled life and contribute to the economy. The services and providers we have are a form of taxation, but it is important to remember they also contribute huge numbers to the economy. The social care workforce in this country is bigger than the NHS workforce; people often forget that and the contribution they give back. The situation we currently face, which I am sure will come out in the debate, is about where that future workforce is and what sort of model we can expect for people to live at home for as long as they possibly can, or at least in their own community with the right support—not too much support, but enough to be motivated and enough to keep them safe and as healthy as possible for as long as possible.

The Chairman: Thank you all for that opening statement. Much of what you have all said comes out in my first question, which was related to the funding issue for future sustainability and the use of the money. If I go back to that, you may all wish to comment: how do we make spending on all these health aspects part of the public service agenda? Margaret

mentioned the housing issues and we have also heard about integration of social care. Do you have any comment on either of those questions?

Chris Hopson: Stephen should go first because he is very strong on this issue. I will follow behind you.

Rt Hon Stephen Dorrell: You might wish to manage expectations. If I may say so, my Lord, this is at the heart of it. I would like to dive straight into a short-term issue, which is the sustainability and transformation plans, but enlarge that to show where an important part of the longer-term answer lies. Last December, NHS England initiated the STP process. It is variable as it has been, in the famous cliché, built in flight and it is certainly imperfect but I am absolutely clear that it is the right direction of travel. It is insisting that you cannot deliver what I talked about, outcomes for citizens, if you see the NHS either as a single silo or, more accurately, as a group of silos. The NHS is not a city on the hill. That is the simple way of putting it. It is a public service and you can deliver effective outcomes and good value, high-quality services for citizens only if the NHS is part of the broad range of public services delivered in a place.

STP is the NHS route into the devolution agenda that was pioneered by Sir Howard Bernstein in Greater Manchester. One of my roles is as an independent chair in Birmingham and Solihull STP. We are seeking to insist that NHS acute hospitals, NHS primary care community health services, social care services, social housing services and education services are all part of a continuum of public services. If you cut, for example, mental health services in schools or you cut independent living through the DWP or you cut extra care housing through the housing budget, the public service economy as a whole shrinks, the outcome delivered to citizens shrinks and people become unnecessarily ill. People express this as an economic argument but the real challenge is the social policy point that if people are not able to live independently they become unnecessarily ill and then present in GP surgeries, A&E units and emergency admission wards.

Chris Hopson: The evidence is very clear. Michael Marmot's work is absolutely crystal clear: effectively, the determinants of health and wellbeing go much more broadly than just focusing on health. They are determined by issues such as: are individuals in secure employment? What is the quality of their housing? Stephen tells a great anecdote: at the NHS Confederation conference, the chief executive of New York Medicare came over and said the single biggest intervention that had improved health outcomes in New York was the installation of air conditioning units in low-cost housing. In the summer spike in the heat, old people were becoming ill because they had inadequate housing and air conditioning. There is a real opportunity here, as Stephen was saying, to place health in its appropriate set of wider determinants. For example, Salford Royal acute hospital trust is developing a much closer relationship with its local authority and not just having a conversation about, "Yes, we are very happy to take on social care", but looking at how it can relate much more closely to the housing department, the leisure department and the education department so that we can put health in this much broader set of determinants.

The reality, it seems to us, is that we have a national illness service. We do not have a national health and well-being service where we use the full range of public services to support people to have healthy, independent lives for as long as possible. All the money, emphasis, management bandwidth, capacity and capability seem largely focused on treating people who are ill, whereas, as Wanless showed 15 years ago, we will not be able to cope with that demand unless we focus much more effectively not just on prevention and health promotion but on putting health in that much broader range of public services.

Margaret Willcox: I would concur and add that because of the restrictions in funding and the drop in funding that everyone is familiar with, a lot of the funding we now have is focused on that acuity end. It is all about sorting out today's crisis; it is not about sorting out tomorrow's solutions. If anecdotes are acceptable, one of the things we see regularly on every acute ward is a point at which a patient has been admitted and reaches the stage of realising that their isolation, lack of independence, loneliness and miserable housing means they do not want to go home. Their family has reached a point where it does not know how to look after them any more and you have a desperation point where people make poor choices. Instead of us thinking, "How can we get this person home?", we should be looking after their carers—personal carers not paid carers, although they have a role, too—to keep that family together in an extended way, if possible, and give them things which are quite small and relatively inexpensive but will stop them using the A&E front door, which, as Sir Keir would say, is its own success as it is always open. That is where people go when they do not know what else to do, but it is not the right place.

Rt Hon Stephen Dorrell: Can I support the narrative with some specific statistics on the balance of spending within the health and care system? Between 2005 and 2015, a ten-year period, NHS spending in total went up 25% in real terms, social care spending flatlined, primary care spending went up 3.5% in real terms and spending in the acute sector went up 31% in real terms. The evidence is clear that, despite ministerial rhetoric—I have been responsible for it myself and I see some faces round the Committee who have also been responsible for it—we have all said how important it is to channel your resources into the community and into primary care, but what has happened is they have gone to the acute sector and not to the place where Ministers say, quite rightly, they need to go.

Q88 **Lord Warner:** Stephen, you made a very helpful comment at the beginning about the proportion of GDP realistically being estimated and updated now, but within that sum I suggest there has been huge variation year on year over time between what goes into the NHS and, certainly at the beginning of the year, what it can expect to spend in the 12 months further forward. As you rightly pointed out, there has been huge variation. There has been no synchronisation between the uprating of NHS expenditure and social care expenditure. What do you think we should be saying as a Committee about what more should be done to synchronise that over time so that we do not have this random system of uprating year on year, and it is a guesstimate on the part of managers in

both systems as to how much they will get next year, particularly if you want to go down the path of the STP model? What are your ideas for synchronising those spending patterns over time?

The Chairman: Before you answer, may I say that your comments have produced a lot of excitement? I have a whole series of people before we even get on to the second question, and there are another six questions. Can we have a quick-fire response and a quick-fire question session before moving on to the next one? Please go ahead.

Rt Hon Stephen Dorrell: The Committee will know that I proposed, together with Alan Milburn and Norman Lamb, at the beginning of this year that there should be a commission which looked at some of the issues your Committee is looking at precisely to provide a longer-term context to address the issues Lord Warner mentions. I emphasise that none of the three of us thought this was to take the health sector out of politics—the health sector is intrinsic to politics in a democratic society—but it was to try to provide a longer-term context to the different funding flows coming into the sector. Incidentally, it is worth drawing out to the Committee that the piece of work Lord Warner referred to made it clear this is 10% of all economic activity in the UK, but only 80%—only—of the funding for it comes from the taxpayer, so it is not exclusively a taxpayer issue.

The Chairman: Could we go quickly now to Baroness Redfern, Baroness Blackstone, Lord Mawhinney, Lord Bradley and Lord McColl?

Baroness Redfern: I have two very quick questions, one for Stephen. You mention devolution and STPs. What are your views if the STPs are not coterminous with a devolution deal? It is vitally important that people in that area know their subject. As the leader of a local authority, I have views on health and social care. The second one, to Margaret, is that only 44% of disabled people have health checks. We debated that last night in the House. How can we get more GPs to support increasing those health checks so they can have a personal plan and move on?

Rt Hon Stephen Dorrell: The short answer to Baroness Redfern's first question is simple. I refer to the fact that STPs are in process and being built in flight. I have already said that in Birmingham and Solihull I do not think it is appropriate for an outsider to be chair of this board and I propose to sign off my report to the proper governance processes tomorrow. There needs to be governance that allows decisions to be made, which clearly is not the current state of the STP process. Having said that, I give significant credit to NHS England for having initiated the process of ensuring that the NHS is part of that broader devolution agenda. It clearly needs to be. The boundaries issue needs to be addressed, but if we argue about boundaries we shall never get any work done at all. It is a process not an event.

The Chairman: Does anybody else have any quick-fire response to add?

Margaret Willcox: I suggest there are parts where we have made good progress here, particularly for people with learning disabilities, whose health check levels have gone up, and the diagnosis of dementia, which is vastly improved; and it is learning from those. It is also trying to have a relationship with primary care that says the health check is more than

about whether this person's physical condition has deteriorated or not; it is about how are they employing themselves in their daily life, and what they are contributing to it. It is about trying to make it more rounded than just the diagnostics. Then it is of much greater value to the individual service user and their family.

Baroness Redfern: They can support them.

Baroness Blackstone: I want to follow on from what Norman was saying about the need for more synchronised spending from the figures you were giving, Stephen. If we are to have the integrated social policy that you are proposing, can we continue with a system where local authorities are quite separate from NHS institutions and organisations? Should we think very radically about this and consider whether, to achieve this, we should go back to a single form of governance via local authorities; rather as was proposed not that long ago by the then-Chancellor, when he was trying to develop ideas about the Northern powerhouse in Manchester—that there should be proper devolution of health to either regional or local authorities? Only then will we have some sensible decisions made about how funding should be allocated and more joined-up thinking on the relationship between education, social care, housing, et cetera.

Rt Hon Stephen Dorrell: If I was pushed for a one-word answer it would be yes, but may I enlarge on it a little? The debate between central and local is as old as the NHS itself—indeed, it goes back, before the NHS, into the Cabinet minutes before the NHS legislation came forward. My very strong view, first of all, is that there is a role for the “N” in the NHS—an important role in defining standards, ensuring it is a transparent service where you can see what is being delivered in one part of the country by comparison with another, and looking at sharing resources, in particular in specialised areas. There is definitely a role for the “N”, but the balance has gone far too far in favour of the “N” and away from the local. Not only has that created unnecessary and deeply damaging fissures within local public services, it has also reduced the accountability of the health service to local communities.

It was an argument I remember having with Ken Clarke in 1990 when we first introduced the purchaser/provider split—commissioners for providers, as it now is. I was in favour then, as he was, of removing councillors from trust boards on the grounds these were enterprises that needed to be managed as professionally as possible. He was also in favour, and the legislation reflected this, of removing councillors from what we now call the commissioning side of the health service. I argued with him then that that was wrong, and I still think I was right then, and that policy is being put into reverse in this respect, which is a good thing.

Lord Mawhinney: It is good to see that your clarity of thought and expression has not decreased over the passage of time.

Rt Hon Stephen Dorrell: That is kind of you.

Q89 **Lord Mawhinney:** That was an excellent summary of public service, where you took six or eight different things and rolled them all into one entity. The budget for public service would be astronomical. My question is: how do you think we should write a report that persuades the

Government, which operates on the basis of 20 silos, roughly, to forget about silo-ing health and social care and put them all into one ginormous, economic entity called public service?

Chris Hopson: If you put health and social care together, it is not a massive increase in terms of the budget. Again, Stephen, you will know the figures better than I do, but we are talking about a £110 billion NHS budget. We were not necessarily saying that you would lump all of those budgets in a single place.

Rt Hon Stephen Dorrell: I am.

Lord Mawhinney: I am just quoting Mr Dorrell.

Rt Hon Stephen Dorrell: Let me answer Lord Mawhinney because I absolutely do not think it follows from what I was arguing that there should be one organisation delivering housing services, education services and hospital services. The reductio ad absurdum of that, which is the anecdote I tell in Birmingham, is this does not mean that University Hospitals Birmingham runs the primary schools in Smethwick. That is barmy. It illustrates that this is not about changing the boundaries of managing the acute hospitals or the primary care system, or the schools system; this is about creating a commissioning process that looks across the range of public services and insists there are proper digital exchanges of information, proper professional exchanges and proper resource exchanges.

Lord Mawhinney's question is: what is the key argument to the Treasury short of money to justify this? The Treasury is interested in efficiency. We endlessly hear how the health service could be made more efficient, and nobody disagrees with that. We usually hear about agency staffing ratios and about procurement, and every Health Minister in the room will have made speeches about both subjects. Health care is just like any other sector in the economy; this is a sector of the economy we are talking about. How do you create transformative efficiencies in an economy? It is by rethinking what you are trying to do. We are no longer trying to deal with a world where communication is paper-based and people present with a condition for diagnosis, treatment and cure. We are dealing with a range of services where success relies on a joined-up service to the citizen. If that is the exam question, let us start with the right question and we will have a greater chance of delivering the right answer.

Chris Hopson: It is also important not to forget Lord Warner's point. There is a degree of frustration in the present government about the inability of the members we represent to deliver the efficiencies being asked for. One of the problems is there is no credible, medium-term financial strategy for the NHS. This year is the year of plenty, where we have a 3.7% increase, which just about keeps up with demand and cost. When we all saw the settlement last year we said, "How on earth is the NHS meant to deal with a year in which funding increases by 1.4% next year, 0.3% the year after that and 0.7% the year after that?" It becomes incredibly difficult to run the system effectively when you do not have an evenness, a consistency and a smoothness of funding increase but also a funding increase that reflects the underlying cost and demand.

As one of your former colleagues, Lord Lansley, said to our annual lecture about three or four weeks ago, everybody knew we were due a five-year squeeze between 2010 and 2015; nobody expected we were going to have a second five-year squeeze between 2015 and 2020. My argument to you would be that the unevenness of having a front-loaded year but then years which, to be frank, are miles off in the increase needed to keep up with demand, makes it much more difficult for our managers to run their hospitals, community mental health and ambulance services effectively because of the unevenness with which those funding increases are flowing.

Q90 Lord Bradley: I should declare my interest: I am an executive director at Pennine Care. Perhaps I should also declare I lived in Manchester because that is relevant to the conversation we are having. “Devo Manc” is about setting joint commissioning arrangements across place and people. Crucial to that, in my view, as a first step, is the recognition that you are trying to integrate physical and mental health into one commissioning arrangement. I absolutely support everything you have said, Stephen, and the STPs are a mechanism for that change, but the problem, as Chris has identified, is in the short term. Because of the financial situation, it is more sustainability that those plans are looking at, rather than transformation. How do we shift to have that long-term sustainability and the funding transformation that is not being absorbed into ensuring current services are maintained across health and social care, physical and mental health?

Rt Hon Stephen Dorrell: That is a challenge for any manager at any time in any economic sector. It is a particular challenge in the health and care sector. At the moment, the figure Chris was quoting for the spending profile in health in the NHS budget, narrowly defined, is true in spades, incidentally, in social care, where there is significant resource planned for the last two years of the spending plan, 2019-2020 and 2020-21, but in the short term there is a significant further reduction planned in social care. This is the sector that the CQC last week described as “approaching a tipping point”. Lord Bradley’s point is very well made when looking at the health and care sector as a whole. There are two levels of answer. First, to Lord Mawhinney’s point on efficiency, it is not efficient to use an acute hospital as a care home, which is the practical result of the world we are creating. Bringing forward some of the funding planned for social care at the end of the spending profile is an immediate fix that could certainly create some headroom for the kind of change Lord Bradley is looking for.

While the health and care sector, as a whole, in the lifetime of every person in this room—and of our children and grandchildren, I hope—will be largely a public sector-provided service, a good commissioner of public services applies Lord Adebowale’s principle that a public service is a service to the public. As a commissioner of services to the public, the key question is how we bring parties to the table who are able to facilitate the type of change Lord Bradley, quite rightly, says is needed.

The Chairman: I am managing the time in this session extremely badly, because we have not moved past the first question. Lord McColl, a quick question from you and then we will move on.

Lord McColl of Dulwich: Margaret Willcox, you mentioned all the causes of the increasing expenditure in the NHS but you did not mention probably one of the greatest, which is the obesity epidemic.

Margaret Willcox: Absolutely.

Lord McColl of Dulwich: Do you have any figures on exactly how much this grotesque increase is costing?

Margaret Willcox: I do not but we can obtain them. They may have been in the original evidence submitted. This goes back to the previous argument. One of the concerns we have, as Stephen has mentioned, is if we concentrate only on the acute end of when the obesity crisis is here or when the person has had a fall and is in a crisis when they are elderly then we are looking at it from the wrong end. The answer to obesity, from all the public health arguments we have seen, is about people's lifestyles and social parts; about education and good learning and about exercise. They are about our children and getting the young people of this country to take some responsibility for themselves, but to do it in a way that is also enjoyable and sustainable rather than a quick fix.

One of the things I would add about the integration of funding, whether at commissioning or at any other point, is that if we concentrate the funding on the acute end we will never treat the problems we are building up. We need to come much further forward into how we deal with the prevention end. We know from history that whenever finances are tight, it is prevention that goes first because we have to make the quick fixes for the acute situation. It is about trying to redefine it and about moving away from a medical model and a medical solution to everything when there are alternatives.

The Chairman: If you have those figures we would be pleased to have them.

Margaret Willcox: Certainly.

The Chairman: A lot of the issues have been covered so hopefully we can keep the questions and subsidiaries to the original one and be quick fire because we have a lot of material to cover. Baroness Redfern, can I start with you?

Q91 **Baroness Redfern:** My question has almost been answered. I agree with the panel: funding acute beds as residential beds is not the best place to spend scarce resources. I am interested, as I say, in the health and social care end. If there is additional funding after 2020, where would you see that funding being targeted?

Chris Hopson: If you take a short-term view, one of the interesting things at the moment is that the entire NHS seems to believe that if you were going to put more money in it should go into social care, which is a very interesting statement.

Baroness Redfern: In the past more has gone into the acute sector.

Chris Hopson: Correct. We identify that if you want to sort out the issues that, for example, acute hospitals are currently dealing with, probably the best place to spend the money is on social care to ensure we

do not have 30% of people on older people's wards occupying beds when they are better off with care being provided close to home because they are medically fit to discharge. Stephen has also pointed out primary care where, if you look at what is currently happening, the 6% increase in demand coming into A&E in the first quarter of this year, both in presentations and admissions, is a function, partly, of the fact that primary care is completely overwhelmed and is unable to cope.

There is an illustration of a wider point here. We spend a lot of time talking about the need to transform the system, and we tend to talk about the money. The bit we do not tend to talk about is that, if you want the system to transform, we have to incentivise our leadership teams to focus on transformation. If you ask our members what they are most incentivised to do, you effectively lose your job as a chief executive or a chair if you cannot make today's money work—if you cannot pass today's CQC inspection, if you cannot ensure that you are meeting your 95% four-hour target and if you cannot ensure you are providing the right quality of service, all of which are very important. No chief executive or leadership team has ever lost their job by failing to come up with a long-term transformation on their local health and social care economy.

One of the arguments I would be making to you is that if we want the system to transform we have to achieve a much better balance between the focus on today's performance targets and today's money and balance it appropriately in the way that we do in most other systems, but not in the NHS because of the operational pressure it is under, and say to management teams, "We want you to focus on long-term transformation". All we are doing at the moment is running faster and faster and harder and harder inside a broken model, and one day we will wake up and realise that we have not spent the management time and capacity on moving towards a transformed system. That is where we are, partly, to be frank, because of the pressure the existing system is under.

All our members say they are spending their whole time trying to prop up this increasingly fragile system, and they simply do not have the management capacity or bandwidth to do the really complicated bit of bringing everybody together in their local health and social care economy and plotting a path to a sustainable future. One of the reasons for that is perfectly understandable; they have spent their whole time being measured against today's targets, not against, "How well are you doing to deliver the transformation?"

Margaret Willcox: May I add to that? We would ask, in respect of the finances but also the way the STPs work, that we are trusted with the money. Local government has demonstrated it can make the cuts needed to bring local government into some form of balance. To always passport money through another route to us, as has been demonstrated by the Better Care Fund, is not the greatest confidence builder if you are working in local government. We know how to prioritise things, we understand how, as I said before, the impact of things such as housing and employment and equipment can transform people's daily living and make such a difference to the level of demand they put on other services. We need to be trusted to do it.

Rt Hon Stephen Dorrell: May I add a point here? I absolutely agree with what Chris and Margaret have said and would link that to the STP process, because that is exactly the issue the STP process is supposed to be trying to address; to encourage people to think slightly longer term. I have already mentioned his name once but let me mention it again. If Sir Howard Bernstein was sitting in this chair now and was asked how he would achieve the kind of transformation we are looking for, when he makes his presentations on this he always starts not by talking about the deficits in the hospital service but about employment and liveable cities and green spaces, so that people have a fulfilling life. The great mistake in the health and care world is to imagine that demand is a given and then to reduce it to money. Demand is people's healthy living, and if they have employment then, as Lord Bradley pointed out, there is a direct link between mental health and physical health. There are libraries of evidence demonstrating that roughly 20% of demand for physical health services can be traced to mental health causes—mental health problems caused by isolation and all the social conditions we are concerned about.

We should not imagine that the rest of local government is somehow divorced from, different from and unrelated to the hospital deficit. The failure to deliver those services and to deliver a joined-up version of local government is one of the key underlying causes of the hospital deficit.

Q92 **Lord Mawhinney:** I very much appreciated Mr Hopson's analysis; I thought it was spot on, but you stopped at exactly the wrong time. You got to transformation and then left us hanging on a branch. If you want to have serious reform of health and personal social services, do you continue to leave it with local authorities but not ring-fenced so they can decide how to spend the money however they want; do you wrap it up with the NHS into a new body; or do you set up a special health and personal social services commission which works in parallel? All those would be transformational. Could you give us the second paragraph of what you said earlier?

Chris Hopson: What we are trying to do in the NHS is achieve this process through the sustainability and transformation plans that Stephen has already talked about. Yes, you could try to do a top-level structural reorganisation. My sense is that the NHS does not have a particularly strong history of effectively moving around organisational blocks. This has to be a bottom-up process where you have different workforces, different leadership teams which are currently separate. I can tell you five or six places where this is beginning to work, and there is a single thing that underlies all of them, which is that the local authority chief executive has sat down with a hospital chief executive, the leaders of the local GPs, the accountable officer of the clinical commissioning group and they have hammered out between them an agreement about how they will do things differently. They will completely ignore all the stuff raining down on top of them from NHS England, NHS Improvement and everywhere else and say, "We are going to do the right thing for our local population".

The key, for me, is not necessarily a structural reorganisation but about local people—local leaders working together effectively to do the right thing for their local populations. That is happening in Manchester, Yeovil and Northumbria, and it has been achieved without primary legislation to

create brand new structures. It is bubbling up from underneath, encouraged and supported from above, not mandated from above in a structural reorganisation.

Lord Mawhinney: GPs talk to me about being forced into new GP structures for 30,000 people and about how concerned they are for their patients. Will all that pass in the night and not be a factor that anybody needs to worry about?

Chris Hopson: If you said to us, “Where are the tensions likely to be?” one of them, clearly, is in a primary care structure that, in some places, still feels as though it is a 1948-created cottage industry. I would observe that in places such as Birmingham and Salford we are seeing the growth of GP federations, where GPs are willing to come together to create organisations of a critical mass that are then capable of interacting effectively with these much larger organisations, such as mental health and acute hospital trusts.

The Chairman: Are you saying the current model of primary care needs to be changed?

Chris Hopson: I am saying there is a widespread agreement that the 1948-bequeathed structure of a bunch of single-handed practices led by individual GPs is unable to provide the kind and scale of primary care that we now need, and there is a rapidly growing development where people are coming together in GP federations which make it easier and more effective to then link up all these different parts of health and social care.

Lord Warner: There seems to be a general agreement that we should have more direction of money towards social care, if there was more money to be directed. What are the processes for how you would redirect the money from the centre to achieve that objective? Bottom-up is fine, but at the end of the day money flows down from the centre.

Chris Hopson: The immediate answer is in the submission we have made to the Treasury about the Autumn Statement. Effectively, what we have said is that already laid out in the Government’s plans are two ways of increasing money to go into social care. The first is a back-loaded increase in money in the Better Care Fund, where this time the Government will put money into the Better Care Fund. The second is enabling local authorities to raise more through the precept; taking away the 2% cap and raising it to 4%. Our argument in the Autumn Statement is both of those should be brought forward.

The combination of the two is important because we know that the precept is potentially discriminatory on the grounds that there are local authorities with lower tax bases which will not be able to raise as much money through the precept. If you are a relatively less well-off northern council, such as Gateshead, for example, you will not be able to raise as much through a 4% precept as you would if you were leafy Surrey. Hence the need, in our view, to balance the increase in the precept with the opportunity to cross-subsidise using a Better Care Fund that is there to make up the gap.

Lord Warner: That is a short-term fix.

Chris Hopson: I accept that it is a short-term fix.

Lord Warner: We are dealing with after 2030. How do we change this system? What should we say in our report to change this system for the next 15 years? That is to all of you.

Rt Hon Stephen Dorrell: I heard Lord Warner's question as directed at the short term and I agree with what Chris said, in particular, about the Better Care Fund. That is money that the Government have committed to social care. It is in the budget for 2019-20, 2020-21 and it is necessary, as the CQC was arguing last week. The broader question, as Lord Mawhinney referred to, of how this joined-up version of public services is to be financed fundamentally comes down to a question of financing local government and, in his second question, the relationship between local government and the NHS central budget. I do not think anybody is suggesting there will not continue to be a nationally voted, parliamentary vote to the NHS; the question is the relationship between the NHS central commissioning authority and the local commissioners of service within a place.

If we are looking beyond 2020, there is absolutely no escape, nor do I look for one, from the point with which I started in response to Lord Patel's initial question about an opening statement, which is that health and care services are a growing part of the economy. If we seek to manage the structure of public policy or public finance to restrict the growth of the public sector—for all the reasons with which I, as a lifelong Conservative, am fully familiar—we have to reconcile the ambition for manageable tax burdens, small state and all that with an explicit commitment to allow the health and care sector to grow in a way that reflects the ambitions of the society it is there to serve.

Chris Hopson: If you are right, Stephen, it seems fundamental, if you are going to increase funding in a taxpayer-funded system, you must have a quality of debate with taxpayers where you set out the options for them and the consequences, for example, of carrying on with flat funding or reduced funding, and the consequences and potential benefits of increasing those funding levels through increased taxation.

I did an interview for ITN last night. They had done a poll where, effectively, they said that 70% of people interviewed would be prepared to see 1p extra on income tax and 50% would be prepared to see 2p extra on income tax. My argument would be that in a taxpayer-funded system, if we are to have the kind of debate that Stephen is talking about whereby we say we are going to increase public funding, you will only do that by building public consent. I have to say I do not see a quality of public debate at the moment that enables us to have that proper discussion and to gain that consent. It is urgent that we find a way of having that proper debate with an appropriate level of underpinning evidence to enable an informed debate, rather than the quality of debate we had in the general election, which tends to revolve around things such as the "War of Jennifer's Ear" and such like, as opposed to the real fundamentals that underlie this.

Margaret Willcox: We appreciate the precept and, as you know, a large percentage of councils took it up. There is an irony about it in that if you have a high level of self-funders in your particular local authority and you are more likely to raise the precept, you are also less likely to have the

need that other areas have where the precept is very difficult to collect because there are lots of people below that threshold and their level of need will be the same. Clearly, the north/south divide is an example, but it is there between particular councils as well. There are perceptions that this is a local tax and, therefore, local people are paying for what they can locally afford, as opposed to having a national scheme for everybody to meet a level of eligibility criteria and service. There is a balance to be had between having a local tax and saying, "This is the level of qualification we want for the country; this is what you should expect to pay in return for your major taxation".

The Chairman: This discussion leads very well to your question, Lord McColl, about funding issues.

Q93 **Lord McColl of Dulwich:** If more money is not forthcoming, what exactly should be done? Should alternative types of funding, such as charging for some services, encouraging greater private spending and limiting what the NHS provides be considered? What alternative funding models do you consider viable alternatives to the present arrangement?

Rt Hon Stephen Dorrell: May I link that to Margaret's last answer? There is an important point that is quite often lost in the discussion of funding health and care. The Government, quite rightly, say they are committed over the lifetime of this Parliament to additional spending of either £8 billion or £10 billion, depending on your point of view. What it does not then do is add the yield of the precept as additional funding. By opening the precept as funding available to the health and care sector, the Government unlocked a significant level of additional funding to which, in our view, access should be brought forward through the Better Care Fund. As I have said, in a sector where we are talking about £180 billion, of which the total taxpayer contribution is about £139 billion, roughly £40 billion already comes from other sources into this single sector. Going beyond the debate about the NHS to a debate about health and care, and preferably to public service more generally, puts you into a world where there is already more than one funding stream. The question is how you secure the objective of equitable access to high-quality services without changing the free offer of the health service but in the context of a broadly funded public sector with sufficient resource to deliver the outcomes we have been talking about.

Lord McColl of Dulwich: Do you want to increase the £40 billion from other sources?

Rt Hon Stephen Dorrell: Given that the whole basis of my argument is that, as societies become richer, all of us, as citizens, choose to spend more on the services delivered by the health and care sector, we should be looking for ways of accessing the widest possible revenue sources without changing the free offer. The question Lord McColl is hinting at is should we go for a revised funding basis of core NHS? My answer to that is no; it is a question for Parliament, not for NHS managers. My answer to that is no, because it misses the point. The point is that this sector already has diverse funding streams, and what we are doing at the moment is relying unnecessarily on the tax-funded core because we have

not set up a structure that attracts sufficient funding into the sector more broadly defined.

Chris Hopson: I accept, quite rightly, that we are talking about the wider health and care sector but you would expect me to bring an NHS provider-specific focus to this. We went on record about four or five weeks ago to say that we have now reached a tipping point where the NHS is being asked to deliver a set of services that it simply cannot carry on delivering for the funding available. We would make the observation that, yes, it is perfectly understandable that the Prime Minister and the new Chancellor should be saying to the NHS, "You have the best settlement of the public services; you have had extra funding, go and deliver". The reality is what has happened to most other public services faced with similar pressures: we have had more money but the demand we are experiencing is much greater and staff numbers have been reduced. We have 450,000 people who are no longer eligible for social care because the social care eligibility criteria have been changed; bins are now being collected once a fortnight rather than once a week and libraries are closing.

The key point we are trying to make to the Government at the moment is that the NHS is unable to adopt any of the strategies adopted by other public services because we have an NHS constitution that specifies what the performance standard should be, specifies the targets for four-hour waits in A&E and has a bunch of recommended staff ratios that are enforced by a very rigorous inspection regime. Our members are saying very clearly, "You can't have your cake and eat it. You cannot expect the NHS to deal with 4% or 5% increased demand every year but increase the funding by only 1% and then not allow us the service flexibility that other public services have had to change the offer, change the eligibility criteria or reduce staff numbers. The NHS has now reached the point where it cannot carry on meeting those formal criteria on the funding available.

Rt Hon Stephen Dorrell: Particularly, if I may emphasise the point, when the effect of many of those other changes in other public services is to divert demand into the NHS.

Margaret Willcox: Also, to distract the people we rely on, such as the informal carers. If we had a better offer for informal carers we would have a broader capacity of workforce available to us. We have spoken very little today about how the future workforce across health and social care is seriously under pressure because we are all fishing in the same pond for staff. The status of carers in the voluntary sector has dropped dramatically. The public do not have the respect for them they used to have. We have a retail market that is now far more attractive to what would have been the unqualified workforce than social care can achieve. In areas where you have low unemployment, it is absolutely impossible to recruit to those posts. We have a whole sea change which is much broader than just the delivery of the acute service; it is about how we change the way we run our community service and what sort of models of expectation you should have if you want to stay at home. Who do you think should be coming through that door to look after you? How should they do that? The days of having a routine four visits a day by four

different people is not what the public expect and it has not been satisfactory. To some extent, some of that has led to the need for acute care when people lose confidence in being able to manage for themselves at home. They become frightened.

Q94 **Bishop of Carlisle:** From what you have all consistently said, your answer to what I am about to ask is fairly predictable. I would like to pick up on this issue of tipping points. It is an expression that has been used more than once in the conversation. May I focus the question around the recommendations of the Dilnot commission? As we all know, the implementation of the recommendations has been deferred until 2020. Do you think, if that happens and they are not implemented sooner, as seems likely, we will have reached a tipping point and the implications for long-term sustainability of health and social care will be severely damaged?

Rt Hon Stephen Dorrell: My view of the Dilnot recommendations is that they ask the right question, which is the one we touched on in the earlier answer: how you get more private funding into the delivery of a more broadly funded service. I am not entirely convinced that the Dilnot recommendations achieve the objective of more private funding. They certainly have the effect of targeting taxpayer funding at people who probably would not be at the highest end of the urgency list if we are dealing with urgent pressures in the system. The Dilnot process probably needs to be rethought but was addressing precisely the right question.

Margaret Willcox: We were hopeful that if, by deferring it, we would have had access to the £6 billion allocated for that, we could, at least in this particular time, have tested out what those opportunities would have been and may have been able to find some solutions. From an ADASS point of view, some of the figures still look a bit understated on the volume for the future. We would have had a longer lead-in time to be able to know what it is. The longer before we know whether the implementation of the legislation will come in 2020—not in respect of the money because we are still optimistic that some of that may come forward—then the longer it is before we can test out those issues.

Chris Hopson: What is particularly worrying as well is that, since the Dilnot proposals were put forward, the social care market and sector has become even more fragile. In other words, the funding gap has grown. I point to one other thing. One of the things the CQC pointed to and that we are very concerned about is the number of private providers who are saying they are struggling to see this as a viable proposition. If you look at the number of big organisations and medium-sized and small organisations withdrawing from the market because they are no longer able to provide and earn a sensible, commercial return, you can see, even if we were to have Dilnot Mark II quickly, some of those underlying market factors have fundamentally changed and worsened, making things even more difficult than they were when Dilnot was making his report.

Bishop of Carlisle: Is anybody revising or looking at a revision of the Dilnot proposals?

Margaret Willcox: I do not know at a national level. I certainly know, because I work in the south-west, that Bournemouth University has done

some very interesting work looking at the predicted figures. ADASS will pick those up in the new year. If my memory was good enough I would be able to tell you who it was, but it has just shot out. They have certainly done some work on it and are coming up with slightly different calculations.

Bishop of Carlisle: Without more money in the near future we will have real problems.

Margaret Willcox: As the CQC pointed out in its report, we know that small organisations in private care provide better quality, as a generalisation. Some of the big ones do, too, but those small, local organisations provide very good services for their local community and they are the least likely to survive in the current climate because they are too near the margins of sustainability. That is a great loss because we do not want everybody to be treated the same; we want a local flavour for what is, at the end of the day, community care and not institutional.

Lord Lipsey: I want to make a clarification on Dilnot, which Norman Warner knows about very well. Dilnot made one set of recommendations. They were not adopted by the Government. The Government adopted ones with a much higher threshold and those are what have been postponed, obviously having much lower cost than the Dilnot proposals. We ought to be absolutely clear about that.

Q95 **Baroness Blackstone:** I turn to the very big variations that exist in social care services in particular. I wonder whether you have any suggestions as to how to deal with these variations.

Rt Hon Stephen Dorrell: My answer to that would be to emphasise the importance of national visibility in the experience of citizens in need of social care. It is often said that, as an overcentralised service, the National Health Service is supposed to deliver the same to everybody. Increasingly, as anyone who has ever worked in it knows perfectly well, that is not true. Increased transparency of patient experience within the NHS is making it more obvious that that is not true. That is a good thing because it focuses attention on where variation does occur. Exactly the same principle should apply across the range of public services, not just specifically in social care, so that—to use the jargon—the place-based services we have been describing this morning can see both the experience of quality of service delivered to a community and, ultimately, much more importantly, the outcome achieved for the residents of an area. The thing that really matters is the measure of life expectancy, morbidity and the way people lead their lives.

All this debate, so often, as we have inevitably seen this morning, is about funding mechanisms and structures, not about the difference of citizen experience as compared in east and west London, London and Berkshire, Berkshire and Northumberland, and so forth. If there was more visibility and discussion about that, we would have more genuinely accountable public services.

Margaret Willcox: There is also an issue about certainty. The market is so uncertain about where it is going: it is uncertain about its migrant workforce; it is uncertain about future pay structures; it is uncertain

about the types of qualifications available to people and how we develop new models of care. It is uncertain about the future strength of the GP workforce because they are clearly not coming forward. It is not the career it used to be so there is a new model there. It is uncertain about future funding, either through local government or through social services, or indeed, from self-funders. Therefore, the growth in that market we saw 20 or 30 years ago has completely subsided. Then you have the geographical variation, which I have already alluded to, whereby richer communities will have more sustainable services—as it has greater demand for them, it is easier to create them—whereas an area with greater poverty has few self-funders, has local levels of government funding which are lower than its neighbours and, therefore, to a certain extent, there are lower expectations among that community because they are not familiar with them and, therefore, the aspiration needs to be built. Unless we have a period of certainty, it is very difficult to reassure people that this is a business they want to be in.

Chris Hopson: We should also be honest with you. You took an NHS perspective. There is no doubt—again, you know this because you have been very involved with an NHS provider—that there is excessive, unwarranted variation between individual trusts and foundation trusts. The Carter review has absolutely shown that in the number of different variables in clinical outcomes and procurement efficiency. When I say to our members, “This variation clearly exists. Do you accept the argument?” everybody accepts that variation exists. I hope you will not think this too feeble, but the conversation goes on in which managers and leadership teams say to us that to get that variation you need quality of data, a really difficult and challenging debate, often with senior clinicians, change management and project management, and sufficient management bandwidth, capacity and capability to drive a very far-reaching and difficult change process.

As a classic example, I was speaking to a very good chief executive of a district general hospital on the phone last week who said, “I know it’s there. I am having difficulty persuading my senior clinicians about what we should do about it but, to be honest, I simply do not have enough data analytical people, change managers, project managers and people to bring that senior clinical workforce with me. This entire leadership team has spent the last year trying to prop up the day-to-day operation. If I could find £2 million to employ a group of people to drive that change and take the senior clinical workforce with me, over a two or three-year period I could probably get to that variation, but you are asking me whether I can get there now with my existing resource and given the pressures I have, keeping this increasingly fragile system upright.

She said, “We have been counting detocs—delayed transfers of care—and there have been double the number of delayed transfer of care from last year”. They therefore had to use elective beds and they were now having financial problems because they could not have elective surgery going through. She said, “It is just a nightmare trying to keep this up and going. If I am going to get to this complex, difficult-to-winkle-out variation, I just do not have the bandwidth and I do not have the middle management capacity because, if I am honest, I stripped it out when I

was doing the first set of cost improvement programmes between 2010 and 2015.”

I know it sounds feeble, in some senses, but the reality is that is what our chief executives are telling us. They can see the variation there, they know they should be getting to it but it is a very complex, difficult task, particularly the relationship with the senior clinicians, and they do not have the bandwidth or the people to be able to do it. If we want to get to the variation with the speed and consistency we would all like and which Lord Carter would like, we have to recognise that we need to support our trusts and not beat them up and spend the whole time saying, “Why have you missed today’s target?” That is the reality of what it is like trying to lead in the NHS today.

Lord Warner: A quick question: are we whistling in the dark about the social care sector? Are we not at a point where, if we get to 2020 and not much changes, there will not be a publicly funded social care sector to provide the services anyway? That seems to be the message coming out of the *State of Care* report by the CQC. Is it now at a tipping point where, even if later this decade we start pumping money into this sector, there will not be any providers who trust the public sector to go on funding them to run this sector?

Chris Hopson: There is a real risk of that.

Rt Hon Stephen Dorrell: I do not agree with that. Economic sectors are more flexible than that. Pressures build, spending is reduced in care homes and quality suffers. At the margin, capacity is falling—that is not a prediction; it is falling—and pressure, and the pace of pressure, continue to build. Chris and I were at my former committee in another place last week and the question was asked: where should money go in the system? Where is it most unstable? Chris and I were of the view, reflecting the view of NHS England—it cannot be too often that NHS England or its predecessor organisations have argued for extra resource for a different spending head from the NHS—that to protect the NHS it is necessary to stabilise social care. It is not right to say the sector would not be there by 2020 but it is being damaged and the pace of damage is quickening.

Lord Warner: Can we hear from the local authorities?

Margaret Willcox: It differs geographically in different parts of the country but it is about having the capacity to build up an alternative, much broader domiciliary care market. If we take the example of personal assistance, generally speaking we have had quite a lot of success in getting that model to support people with physical disabilities and learning disabilities, less success with mental illness and very little success, generally speaking, with some exceptions, for older people because it is not something they are familiar with. We have started the personal assistance model for younger people and that has worked well.

As I said, the attraction of being a domiciliary carer in the current market is not good and we need to build career structures. Many of us are talking to our universities already about linking it to the associate nurse programme and the apprentice nurses, and having an apprenticeship for the voluntary sector. Again, it is about building up that esteem and building a career for people who want to look after other people. We know

those people are out there but we cannot attract them at the moment because of the instability of the market.

The Chairman: If there is no funding available now, the system, no matter what you try to do, will not be there by 2020?

Margaret Willcox: I would not say it will not be there but it will be under even more pressure.

Q96 **Lord Kakkar:** I should declare my interest as chairman of University College London Partners. To be absolutely clear, then, a sustainable health service will not be possible without a firm and established social care system beyond 2020. I want to focus on the importance of the two being properly integrated. Would you agree that for there to be longer-term sustainability, healthcare and social care have to be fully integrated in a way that they are not at the moment? Do we have any evidence that the Better Care Fund is providing that type of integration in a way that will be sustainable in the long term? Do we have some early examples now to show that it is achieving what needs to be achieved in the period between 2020 and 2030 for us to have confidence that that route forward is feasible? Can we be clear that local authorities are being funded, at this stage, beyond the funding that is going into the health service, to drive that kind of thinking in integration and allow them to be courageous enough to bring the two services together?

Chris Hopson: My argument would be, absolutely, that to get a sustainable NHS and a sustainable health and social care system the two systems need to be integrated, and they need to be integrated effectively and consistently right across the piece. If I am honest, the Better Care Fund is a complete red herring and was right from the beginning. The reality is, if we are being kind, that it was an attempt to cover up the fact that the Government were pulling money out of the health and care sectors. Finally, we are at a point where, at the end of this Parliament, the Government will be putting money into the Better Care Fund, but as a means of driving better health and care integration, for me, it is mostly a red herring.

What is happening, though, is that through social sustainability and transformation planning processes and other processes, as I was describing earlier, local health and social care systems are coming together. For us it is a very differential process. I can point to four or five places where it feels pretty well advanced. Often they are places which are NHS England vanguard sites deliberately designed to speed up this health and care integration, but in other places, to be frank, it is lagging a long way behind. What is clear, and the international evidence absolutely suggests this right the way, consistently, across the piece, is that when we do this integration, first, it takes a long time—it is not three to five years, it is more like five to 15 years—and, secondly, it does not produce significant amounts of extra savings. What it does relatively quickly, it seems, is produce a better quality of patient and service-user experience.

When we talk about health and social care integration we need to understand that it is something that needs to happen on multiple different levels. It needs to happen at a national structural level, at a local leadership level, at a local workforce level and in the way we treat funding

streams. It is a very complex, multi-layered process in which a whole load of different things need to change. Culture is a very good example of where we need to get past this idea of separate silos. This is a complex process that will not take a short time; it will take a long period and it will not fundamentally solve what appears to us to be a growing gap.

One thing we have not talked about is forthcoming demand. Demand patterns in the NHS are not going to be stable. As the post-war baby boom comes up to its 70, 80, 90 year-old natural life, we are about to have a huge spike in NHS demand where we are struggling to make the system work workforce-wise and money-wise. We are wholly unprepared to cope with this bulge we know is coming.

Lord Kakkar: What would you say is the single most important impediment to ensuring that that integration takes place effectively over the medium term?

Chris Hopson: Without doubt, the way that the system currently operates. Our chief executives will tell you the regulatory system is based on silos, the culture is based on silos, the way they are measured is based on silos and the way the money works is based on silos. I am sure my colleagues will want to talk about this as well, but the acute sector is currently funded by payment by results. Effectively, there is an incentive on them to pull activity into the hospital as a means of maximising income. Most people who want to create an integrated health and social care system know you need to move to a whole-population capitated budget. The joke we have in our office is that almost everything about the existing system is locking people into the existing silos—the culture, leadership training, performance management, regulation and existing governance structures. The people making most progress towards integrating health and social care at a local level are doing so despite the existing system.

The Chairman: The message has come across quite clearly that you are seriously taxed by the current system.

Chris Hopson: Yes.

Bishop of Carlisle: You have given an answer to the question I asked and I am interested to know if the others agree. We have heard at various times in this Committee that the integration of health and social care will not produce monetary savings but will improve the quality of the service and care. I just wanted to clarify that.

Rt Hon Stephen Dorrell: That was a point I wanted to pick up out of what Chris said because everything else he said in his last answer I broadly agree with. There are two points to be made about the impact of more integrated services. The first is that there are better outcomes for citizens. The second is to be careful about this argument that there are no savings. The reason is there is a saving in an acute hospital only if you remove the capacity. What happens when you have more joined up services that sustain people for more fulfilling lives outside hospital is that they have a better life and we do not close the capacity but use the capacity for somebody else. That is not the same thing as saying “no savings”.

Margaret Willcox: I agree. There is no international evidence because that has never happened. People do not close the door behind them, they just develop something else as an alternative. We would say that the key to it is through commissioning collaboratively and jointly in an integrated way. We are not just matching provision in one culture in the local authority with one culture in the acute hospital or the CCG. In health there are 25 or 30 different cultures. Every department, as you know, has its own way and its own thoughts and behaviour. It is a completely new culture you need to develop and not try to mix the existing ones, otherwise you will have one predominant feature. It is very trite to say it, but the bottom line is trust. When people trust each other and are allowed to test that trust, you can pull off good integration.

The Chairman: In that context, Baroness Blackstone has a very important question.

Q97 **Baroness Blackstone:** Could you each say in just a couple of sentences what your key suggestion for change might be on which the Committee can make a recommendation to support the long-term sustainability of the health service?

Chris Hopson: My view would be that we need to keep a taxpayer-funded system but increase the funding coming in, in which case we need to think much more carefully about how we build a national consensus around that increase in funding. That requires a much better quality of public debate about what the funding levels for the NHS should be and what the consequences of not increasing funding might be.

Rt Hon Stephen Dorrell: There are two elements to a sustainable health and care sector. The first, to go back to the argument with which I began, is that there is public support for and interest in, and a long history of those things, a growing health and care sector. We have to convince ourselves and the public that our policy structure can deliver that. It is a growing sector. The reason I emphasise it is that we are constantly told that if you draw a straight line through the graph for umpteen years it takes 100% of GDP. If you think about it, that is true of any growing sector in the economy. We should be seeking to facilitate the growth of this sector as part of a growing economy. Of course we should want to deliver it efficiently in a way that reflects the needs of citizens, which is why I focus on the need for empowered local government as a key partner in that process.

Margaret Willcox: In support of both, we would say that there is a recognition that health and social care are inextricably linked and they are also inextricably linked to our economy. Therefore, the conversation we need to have with the public is: what do you want us to do when we are working and paying our taxes? How do you want that to work? What do you want us to do when we provide that service for our families, and what do you want us to do when we need it for ourselves?

The Chairman: Thank you all for coming today. We have had a most exciting session. I have allowed it to way, way overrun and I hope that is not going to restrict our next important session. Thank you very much.

NHS Providers, ADASS and NHS Confederation – Oral evidence (QQ 87-97)

Rt Hon Stephen Dorrell: Thank you for your tolerance of our long-windedness.

Dame Kate Barker, Professor Julian Forder and Sir Andrew Dilnot – Oral evidence (QQ 98-104)

Evidence Session No. 9 Heard in Public Questions 98 - 104

Tuesday 18 October 2016

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; and Lord Warner.

Examination of witnesses

Dame Kate Barker, Chair, Commission on the Future of Health and Social Care in England, Professor Julien Forder, Professor of Economics of Social Policy and Director, Personal Social Services Research Unit, University of Kent and Sir Andrew Dilnot, Chair of The Commission on Funding of Care and Support.

Q98 **The Chairman:** Welcome, and thank you for coming. My apologies for keeping you waiting; we, unfortunately, got too excited with our previous witnesses. I have no doubt that will happen equally in this session because you are very distinguished witnesses and we want to explore key issues with you. First, we are being broadcast, so any conversation you have will be recorded. Secondly, at the end of the session, during the week, you will be sent the record of our session to make any pertinent corrections. You cannot add to or subtract from it but you can edit it. Please feel free to send any additional material you think may be useful as a result of the session today.

Would you introduce yourselves and say who you represent, if you do? Also, if you wish to make any opening statement, please feel free to do so. Can I start with you, Dame Barker?

Dame Kate Barker: I am Kate Barker. I think here I am mostly representing myself but I am here because I chaired a commission for the King's Fund a couple of years ago. In that regard I should say that since I completed that work I have not really stayed in touch with this issue.

The Chairman: It was a very important report.

Dame Kate Barker: It is very kind of you to say so. I still think it is a very important issue, but I wanted to say I have not really followed the ins and outs of the debate. We face very difficult issues here: how far, as a nation, we want to share the financial burden of illness and ageing is the first one, and the second one is how on earth do we deal with a huge bureaucracy such as the NHS and make it efficient without losing what is

so important to it? I assume that those are two questions you will want to address today.

Professor Julien Forder: Hello. I am Julien Forder. I direct a research unit at the University of Kent called the Personal Social Services Research Unit and I have worked for over 20 years now on social care and social care issues, more recently looking at health and health outcomes.

Sir Andrew Dilnot: I am Andrew Dilnot. I am warden of Nuffield College, Oxford, and I was the chair of the committee on the funding of care and support back in 2010 and 2011. I have been thinking about these things for many, many decades. It seems to me the big challenge we face and that your Committee needs to address is that in this country, as in almost all parts of the world, the demand for healthcare, broadly construed, including social care, rises more quickly than the economy grows. In this country for the last 60 years the average rate of increase in health service spending has been 1.6% a year—more rapid than the growth of the economy. That is the challenge we face. I do not think it is in any sense an insuperable challenge. We spend less as a share of national income in this country on healthcare than many other comparable countries: indeed, probably less than half of what is spent in the United States. So I am not at all tolerant of those who say we cannot afford anything very particular, but we have some choices to make and getting the public debate to engage with those choices has been a struggle.

The Chairman: Thank you very much.

Q99 **Lord Lipsey:** An easy, a medium-easy and a hard question. The easy: do we need to spend more on social care? Harder: how much more? Hardest of all: how do we divide any extra we spend between helping people—perhaps better-off people—to pay for the care they receive and the alternative, which is spending more on services themselves?

Sir Andrew Dilnot: I am happy to have a go. The answer to the easy question, “Do we need to spend more?”, is yes—and nothing more needs to be said on that. We face what looks like a critical situation in social care across the country at the moment. Of course, that has been said before but it does look critical at the moment. We see things such as the closure of large numbers of care homes and we have challenges such as the living wage coming down the track at us, so the answer is yes. How much more? I do not think that is at all an easy question to answer. My own view is the answer to that depends very much on the answer to the third question: how do we split the responsibility between individuals and the community? It will come as no surprise to this Committee that my view is that it is perfectly reasonable to split this between individuals and the community, and certainly the work that we did on the care commission, of which Lord Warner was a noble and distinguished member, showed that most people think it is entirely legitimate that they should pay something towards their care costs.

The principal argument we put forward was that in the split between the individual and the community it was the catastrophic costs that should be borne by the community; that is why we argued for a cap. There are all kinds of arguments that can be brought forward for that. Precisely where that cap should be placed is, in the end, a political judgment: the further

towards the left and to the universalist position you are, the lower you would tend to argue the cap should be; the further towards a more self-responsibility, libertarian position, the higher the cap should be—but it seems absolutely that there should be a cap. Until there is a cap, so that we take away the gross fear of disaster from individuals, we will not get a better care structure where individuals are willing to spend more of their own money and where the private sector can provide something that is not always ground down towards the lowest possible level of quality.

Dame Kate Barker: I certainly agree on the first point. It is clear to me that we need to spend more on social care, and I echo what Andrew said about the fact that the system looks as though it is closer to crisis now than it has ever been. We have this tremendous fall in the number of people who receive public support and we see real pressure on care homes. We know that, even when you take the new 2% precept and the Better Care Fund, it is still hardly going to help the care system out with meeting the costs of the national living wage, which in other respects is a worthwhile proposition. It will lead to much greater pressure on care homes, and we have just had the Care Quality Commission report pointing out that care homes have not improved very much since the last time they went around—which is a rather sad conclusion.

So we need to spend more and the question is whether the “more” is going to come largely from the public or the private sector. Part of one’s response to this is one’s sense of morality and what is right, and seeing poorer, frail elderly people getting very poor-quality care is something we should be ashamed of. The other thing which should give us pause for thought is that we are asking people who are paying for their care, people who pay privately, to effectively cross-subsidise other people because we do not fund those other people adequately. It means that those individuals are doubly hit: first, they are not well or they would not be in care in the first place; and, second, they are having to pay for themselves and a little bit for somebody else. I feel that that is a very profound injustice in the system.

I agree with Andrew that a cap is absolutely vital, and I agree with him that people who can afford it are going to have to find some money towards their care. Although we talk about the NHS being free at the point of use, there are a lot of things impacting health you have to pay for: teeth, prescriptions and other things. If you break your leg, the health service will mend your leg but they will not move you from A to B when you need it to go to work; you have to work out how to do that yourself. So we have to recognise that not every need can possibly be met, and should not be met, by the public sector.

One of the points that came out of my work when I was at the King’s Fund was that this is not just about funding but about how people work their way through the system and the difficulties people have in working their way through the system and the oddities that arise within it. A big point of the work was not about what people are entitled to and how that might be funded but about a system that would work better for people, suggesting that when people had fairly low-level needs they should have a small, non-means-targeted benefit that, as their needs grew and the help became more extensive, would have to be means tested—but, at a

rather lower level than today, people should be able to have more free care from the state, and, in particular, trying to move away from the cliff edge that exists with regard to continuing healthcare. It is truly heart-breaking to think of families who are suddenly told their relative is a little bit better—and that is great—and now they have to pay a large bill because they have come off continuing healthcare, but obviously their care is still very expensive. To have that difficulty in the system, so that in some ways you would quite like your relative to be a bit more ill again, also seems to me profoundly morally difficult.

The Chairman: Is that what you meant in your report when you suggested that the various forms of wealth taxation should be explored further?

Dame Kate Barker: Talking about wealth taxation here I am thinking about inheritance tax, which I am aware is a deeply unpopular subject. I remain a bit baffled by a world in which we do not want to tax people's family homes when they die because, quite rightly, we know that people want to pass on the value of their home to their children—I want to pass on the value of my home to my children and I recognise that that is a very natural human desire—but that if they need social care the whole thing gets wiped away. That, again, feels uncomfortable. I do not quite see why we would not want to tax inheritance a bit more to enable there to be some money so that individuals who do have social care may still enable their children to inherit. People will then say that that is what the cap is about; it is enabling rich people to pass things down. Of course, family housing is not just among the rich, it is pretty widely spread throughout the population.

The Chairman: Professor Forder—on the original question from Lord Lipsey.

Professor Julien Forder: Yes, certainly. The two questions are intertwined. One way of looking at them is to consider some of the problems. The two main ones are underconsumption in the current system and underinsurance. Underconsumption stems from two things: the way in which the needs threshold for eligibility has been set and has recently been increased, so that we have seen considerably fewer people being eligible for support in the social care system, particularly older people. The other is around the charges that people face and the disincentive effect that charges have. Those people who are below the threshold for eligibility are likely to be in a poor situation. I say "likely" because we do not know a great deal about their situation. Those people who are still eligible have a reasonable level of support, and more work should be done to determine whether that is an appropriate level. But for those people who are not eligible we really need to consider their situation.

On the underinsurance issue, Andrew tackled the issue around trying to provide insurance for people at the tail end of risk. Those people who fall outside the means test are in a situation where they could well face catastrophic costs. It has always struck me as something you would want to insure against. There is very little provision for insurance. The private market for insurance clearly does not work. Voluntary insurance has not worked in any country. It does not work in the US. In fact, the few

providers of voluntary insurance in the US are now departing the market—and if it does not work in the US it seems very unlikely that it will work anywhere else. With that market failure in mind, there seems to be an important solution for the state and some role for statutory insurance.

Q100 **Lord Warner:** I ought to declare my interest as a member of Sir Andrew's distinguished commission. I have a question mainly for Kate Barker but perhaps for both groups. Have you changed your views in any way since the publication of your report? Are those still the recommendations you would like to make? Could you also say something about a situation which has occurred both since the Barker report and particularly since the Dilnot report, which is that the synchronisation between the uprating of NHS health and social care has got worse—it has got more out of sync—in the sense that the real-terms supplement each year for both those services is now very much out of sync? How do you think the Committee should address that issue as well, given its impact on the sustainability of the NHS?

Dame Kate Barker: I explained right at the beginning that since I wrote the report I have not stayed closely in touch with the debate, which means that I have not spent a huge amount of time reflecting on whether I would reach the same conclusions again. When I look back, my sense is that I would reach broadly the same conclusions again. I think—Professor Forder made this point—that there should be better entitlement to state support for people at a lower assessed level of needs than today; it seems that you have to have quite a high needs test to get over to be entitled to state support.

If there is anything I have changed my mind on, again, as Professor Forder said, it is probably insurance. We did not suggest insurance. The proposals we made were largely about raising a little bit more tax today from the whole of the pensioner population and their wealth; after all, we have old people needing social care today and insurance is potentially more a solution for tomorrow. If I were rewriting it today I might think harder about whether, in the long run, we needed to have some form of insurance for social care. We commented in the report that the lack of understanding in the population of how the social care system works is still very significant, and we ought to do something to address that.

On the variants in the public budget, yes, I absolutely agree, and have already made the point, that the extra money that has gone to social care will not be sufficient to do more than offset the impact of the national living wage, so we are facing a situation in which care beds, which we badly need, are not likely to be supplied in the right number. That will add to the pressure on the health service. At the same time, and since I think it should be part of the same budget, local authorities' ability to invest in health prevention has been affected by the cutbacks. All that, as you rightly say, is adding to pressure on the National Health Service.

The failure to think of this as a system means that we then continue to have what I found the most extraordinary and saddest feature—I know in some parts of the country people are progressing with integration—which was people who had been stuck in hospital or in some other way because

while the health and social care system felt they were entitled to something, they could not decide who they were entitled to it from. That is a terrible thing to happen and we have to work out a way of making that work better, not because it saves money—that is not my primary reason—but because it is fundamentally wrong that people should be left in that situation.

Professor Julien Forder: Dame Barker's report was very good and covered many of the issues. I, too, think that perhaps we should be moving more toward a statutory insurance model and this question of hypothecation, which I know was looked at in detail. In preparation for this meeting I was thinking: why argue for hypothecation in social care but not in healthcare? That remains a knotty issue for me, but I would say that it is partly to do with two things. One is the age relationship in social care. If you were to move to a hypothecated system having some age-related elements to that would be important. You can see examples of that in the Japanese system, for example. Their long-term care insurance has a 40-plus contribution; people over 40 make contributions. In the German system, although there is no specific age threshold it is certainly true that pensioners make contributions all the way through, and families without children make differential contributions as well. So there is some distinction between that and the health service.

There is also a role for informal care and where we are on social care and long-term care, coming very much from a tradition of it being a family responsibility, which also changes the equation somewhat. So I would argue for some form of partial hypothecation and some form of insurance system for long-term care as a way of more closely linking the idea of people making contributions with the care they receive.

The Chairman: In the German and the Japanese systems of insurance, what is the level of contribution?

Professor Julien Forder: The German system, I think, is around 1.9% of income. The Japanese system is quite complicated because some of it comes from income tax and some of it comes from a specific, earmarked contribution—but it is quite a generous system so it would be slightly more expensive than the German system. So you are probably looking in the order of around 2% of income, but that would cover, certainly in the Japanese system, quite a generous system; in the German system, not quite so much.

The Chairman: Sir Andrew, on the question that Lord Warner posed.

Sir Andrew Dilnot: Most of that question was really a question for Kate and not for me to trespass into. It is perhaps worth saying that in the five years now since we finished our review, I certainly have not changed my view about what the ideal system would be. I have changed my view about how bad the position that we are in now is. The position we are in now is much, much worse. It was bad then; it is much, much worse now. I think it is pressing and urgent. It is pressing and urgent for government, because if government does not act there is a risk of a very bad crisis. But I am much more interested in why it is pressing and urgent for people. It is pressing and urgent for the population because we live in a country that is now, by historical and international standards, extremely

well-off, yet we live in a country where it is an issue that is likely to face most of us. I used to say repeatedly that the probability of needing social care was higher than the probability of falling pregnant, because half of us are never going to fall pregnant and about three-quarters of us will need social care, and need it badly. So this is a widespread issue facing most of us and the system is inefficient, ineffective and at risk of becoming defunct. We really need to get on with it and we would need to get on with it even if it was not causing problems for the rest of the healthcare system. It is causing problems for the rest of the healthcare system because of bed blocking and associated matters. So I am still honestly puzzled as to why we have not managed to take a bit more action.

The Chairman: Why do you think that is so?

Sir Andrew Dilnot: I do not know, because I am not part of the decision-making group. It is worth noting that I do not think that this is a simply a matter for the current Government; I do not see it being very high on the priority lists of any of the major political parties. It may be because the group affected is not a very noisy group, and that when the crisis comes, as it comes in many families, it is not a time when people have a great deal of time and energy available for campaigning. I am puzzled because I think it is a major problem. It is a major problem in itself and it is a major problem for the wider health service, and it would be great if as a result of the travails of your Committee more were to be done.

The Chairman: We will come back to that. Lady Redfern, you have a supplementary.

Baroness Redfern: Just very quickly, Sir Andrew. We mentioned about funding and extra funding, possibly before 2020. Do you think it should be targeted to social care? You alluded earlier to the closure of residential homes. I like to think that local authorities have played their part in helping people live in their own homes much longer with extra support, and therefore that they benefit by that, particularly with the introduction of the well-being helpers as well, where people can go and not feel isolated, et cetera, and looked after in the community. If there is any extra targeting of funding, do you think that it should go to social care?

Sir Andrew Dilnot: By "social care", do you mean domiciliary care as opposed to residential care?

Baroness Redfern: Yes.

Sir Andrew Dilnot: Honestly, I would not claim to be in a position to assert what the proportion should be. Certainly there are huge merits in both domiciliary and residential care, and it would be very surprising to me if, in the case that there were extra funding, all of it should go to one or the other. The appropriate settings are different for different people.

Baroness Redfern: Some of the closure in residential settings is because people are looked after in their own homes—so it is just not the funding issue.

Sir Andrew Dilnot: That is certainly true. To the extent that residential care homes are shutting because demand is falling because people prefer

to be looked after in their own homes, that should be entirely supported—but I do not think that that is the whole story, by any means. Some of the closures are being driven by some of the processes that Kate and Julien described, where the funding available simply is not enough to keep homes going.

Baroness Redfern: Thank you.

Q101 **Lord Bradley:** Can we turn to the integration issue, which Dame Kate Barker mentioned? By that I mean the integration of health and social care but in the context of the wide integration of physical and mental health and wider public sector services reform being integrated into that programme. Do you think that is achievable? Have you done any assessment of where integration is working successfully, or where there are barriers to successful integration? Do you think savings can be made out of such integration? What key drivers should be put in place, if you think it is an appropriate direction of travel, to achieve it more quickly?

Dame Kate Barker: The fundamental difficulty with integration, which is apparent, is that the NHS has a ring-fenced budget, and, of course, social care comes from local authorities and is not ring-fenced. It is also means tested and the National Health Service is not. However, I do not think that that should necessarily prevent integration if the relevant local authority and local health service can be persuaded to put their pots of money together so that they are able to take more rational decisions across it. Of course, that requires both of them to give up some degree of autonomy, which they are often very reluctant to do. That is one of the problems that arises in the system.

Another problem with full integration is that they have grown up with two different workforces, and you might need a rather different workforce if you are going to use people to try to combine some of the social care and health functions. Of course that happens today, but you would be doing it much more explicitly, and it is not easy to get there.

Do I think this would save money? I am sure it would save some money. However, if it were to save money, I would wish to see it staying in that system. But the primary reason that I believe it to be desirable is not because it would save money, but, as I said earlier, because it would be better for the people involved if they did not have a system where they had to battle with two different organisations at a very painful time. Andrew rightly raised the point that the reason people do not shout about this so much is they are too busy getting on with it. It would be much better for individuals and their families if the system was more easily understood, was delivered to them more effectively and was not so bureaucratic. That must be the real reason for integration, alongside the points that have already been made about reducing bed blocking and maybe getting a bit more money back into prevention. People are a bundle of needs and we know that, and we are responding to that bundle of needs ineffectually.

Professor Julien Forder: I would certainly say it was possible; however, I do not know of any country that has a truly fully integrated health and social care system. Some of the Scandinavian countries come pretty close. Finland in particular is one example that springs to mind. I think

there are still some differences between healthcare and long-term care that are important to be clear about. Informal care is the key part of that equation. Informal care and family play an important role. There is also the range of skills that Kate alluded to, and the potential for the substitution for some of the lower-skilled tasks involved with caring that informal carers do. So there are some differences but there are clearly some benefits as well.

In some of the work that I have been involved with, we have seen benefits that I have loosely placed into two categories. The first is prevention effects. For example, if you do a bit more social care, it helps people with nutrition, with mobility, with prevention of falls, which has a preventive effect on their need for healthcare. If you supply the right configuration of social care, that allows a more timely transfer of care, of people out of hospital, for example. Those preventative co-ordination activities are there.

There is also a lot of duplication. Needs overlap to a certain extent and you get two sets of professionals doing very similar tasks in trying to assess those needs and plan around an individual.

I think that there is some scope for cost savings and/or improvements in outcomes; in fact, probably more of the latter. It is very difficult to put a figure on this. If pushed, I would say that there are certainly cost savings to be had, but I think that they would be relatively modest. Again, I think that if there was a greater level of co-ordination and integration it would improve the way that people experience the system and the outcomes that they achieve. Of course, how you do that is another question.

Sir Andrew Dilnot: I think integration is probably a good thing. Of course, it has been in existence in Northern Ireland for a very long time and I do not think it has been shown to be any kind of silver bullet. It is a good thing, for the reasons that Kate and Julien have described, and we should do it—but it is absolutely not a way of addressing the fundamental pressures on either the healthcare or the social care system.

The number of people aged 85 and over should double over the 20 years from 2011. It is absolutely fantastic that people are living longer, but if there are twice as many people aged over 85, the pressures are simply going to continue to grow. Instrumental reform such as integration might help us at the margins address the pressures, but it will not address the key question in social care, which is that there are many, many more of us living much longer—and that is wonderful—and, by and large, living slightly longer healthy lives. But we need to look after ourselves as we get older and we have a system that fails to do that. Nor does it help us address the fundamental question for the wider healthcare system, which is that demand grows more quickly than the economy, so we are going to have to work out who is going to pay and how. Integration is an important issue and something of which I am fully supportive—but, in the context of the questions you are facing, it is a distraction.

Baroness Blackstone: Do we have to think more radically about this, given that the barriers to integration are partly caused by two completely separate systems: a nationally organised top-down NHS and a local government system which provides social care? Would it not be better to

try to devolve some of the NHS spending and some of its services—or, indeed, maybe a great deal of them—to local government, so that you could create a more integrated system of social policy more generally and get the kind of integration that one needs and a more sensible allocation of funding than we have at the moment, where basically we have a silo system?

Sir Andrew Dilnot: You have to give the money to either the health service or local authorities. One or other has to take responsibility. The question as to who it should be, if you are to get a fully integrated system, is one over which we could spend a great deal of time. In some parts of the country I suspect you would like it to be the local NHS and in some parts of the country you would like it to be the local authority. I am not sure whether there is an answer that would work across the whole country. Certainly it needs to be radical and there are some signs of experimentation in some parts of the country at the moment where either the local authority or the local NHS is willing to give greater delegated authority to its counterpart. I am not deeply pessimistic about it, but I do not think that it is going to answer the core question that this Committee is trying to answer, which is how we can move to a more sustainable system in the long run.

Professor Julien Forder: When you talked about devolution, one thing that struck me was taking it all the way down to the individual in some form of personal budget. A few years ago we did a large evaluation of personal health budgets and my colleagues have worked on personal budgets in social care. At that level, you saw two things: people engaging with their personal budgets and a shift in what they used their personal budgets for. You saw more social care, if you want to use that term. You saw more well-being services and perhaps less of the traditional mainstream services. Where this seems to have had some traction is where it has been pushed all the way down to individuals. I agree completely with your point. At the moment their organisation, funding and culture are different. So it is not surprising that we have not seen as much integration over the years as I think people had expected to see when first looking at this issue.

The Chairman: Dame Kate, do you have any comments?

Dame Kate Barker: No, it has been very eloquently covered. I would like to support the comment about personal budgets because I suspect that means that money gets spent better in terms of the outcomes for individuals. But administering personal budgets puts some cost back into the system and on to the individual and their family—but it seems a desirable thing to do.

I want to go back and pick up some points other people have made. One of the things that perhaps we have not talked about so far in this session is how we think about carers in the voluntary sector. None of us wants to feel that we do not wish to be responsible for our elderly relatives, but the fact is that many of us live a very long way away from them—which, frankly, makes it much more difficult. Julien referred to this obliquely when he talked about family circumstances changing. If you look back at the post-war settlement, first, people did not live so long with needs such as dementia, and I imagine that the assumption was that they would be

cared for within families where there were fewer working women. That is no longer the case.

So we need also to make sure that we try to make a better offer to carers. My understanding is that, following the Care Act, that has not really happened as much as people had hoped. Carers do not feel any better supported. Supporting carers better so they were clearer about how much they could expect to have the burden lifted from them in a physical sense might make people more willing to undertake it in the first place. Caring must feel terribly lonely for a lot of people. We must not lose sight of that, because we all know that lots and lots of informal and voluntary care goes on. Ensuring we are able to get the best out of that seems to me very important.

Q102 **Lord Warner:** This is a question particularly for Julien Forder. Have we made a mess of the boundary between health and social care? Are we out of step with international opinion in similar countries in having nursing homes not part of the healthcare system? How much out of step are we with that? If we then turn that on its head, are we fighting a losing battle in keeping continuing care in the NHS? Should we not transfer it clearly to social care and cap individual liability? At the moment we have neither fish nor fowl; it seems a bit of a muddle. What are your views on trying to straighten out that muddle?

Professor Julien Forder: My first response is there will always be a boundary issue wherever you draw the boundary. It has been helpful to break the type of care down into its various components. Broadly speaking, you have acute healthcare intervention, nursing care, personal care and then practical or long-term and well-being type services. It seems to me that if you can get your fault line at the junction of those components of care, it would work better. Certainly if you try to draw the fault line in the middle of what constitutes personal care, it is going to be incredibly difficult to sort out.

I agree that the way in which NHS continuing care works is difficult and has proven there are some significant boundary issues. On the other hand, I am not sure that those would improve necessarily if you pushed the boundary one way or the other. It might even be more difficult if you pushed it to a greater degree into what people consider to be personal care. Currently there are some issues around the way those services are funded. I think both Kate and Andrew have picked up in their reports, as I did previously when I worked with Derek Wanless, the accommodation issues with NHS continuing care. I think that is an issue that could and should be addressed.

Lord Warner: Are we out of line with international opinion on nursing homes?

Professor Julien Forder: In some respects we are. Baroness Redfern made the point earlier that it is not necessarily a bad thing to be moving away from residential care. If people want to live in their own home and can be supported to do so, that is a good outcome. Taking one form of care with a residential component—nursing homes or care homes—and putting it into one system and leaving home care in another system could create perverse incentives in that regard.

Baroness Blackstone: What happens in Scandinavia? You said that there was a more integrated system there.

Professor Julien Forder: It is closer.

Baroness Blackstone: Can you tell us a bit about how it works? Surely it is relevant to Norman's question, too.

Professor Julien Forder: Yes. If you take Finland, at the moment most of health and social care is organised at the municipality/local authority level. More specialist hospital care is distinct. There is closer integration in that respect. Getting this balance right between residential and home care is important. It would concern me if that was where the boundary line was drawn, because, although a person is in an institutional setting if they are in a nursing home, their combination of needs is not necessarily different from those of a person who is supported intensively at home. So it strikes me that if you take a needs focus or an outcomes focus, that is an artificial distinction to make. I do not think anywhere has got this absolutely sorted out. I would certainly look at the experience of the Scandinavian countries, but, there again, lots of the other countries I mentioned earlier—France, Germany and other places—maintain a distinction between their health and social care systems.

Lord Warner: The health service is now taking the law into its own hands. It is buying and is even being encouraged by Lord Carter to build nursing homes to get people out of hospital. Are we fighting a losing battle here? If you have a collapse of publicly funded social care, do you end up, force majeure, with a nursing home being a better option in the NHS than keeping people in the medical wards of acute hospitals?

Professor Julien Forder: Certainly you would want to see greater co-ordination. People began to talk about different models for that and the accountable care organisation is one where you see responsibility for a greater part of the spectrum of care needs being afforded to one organisation. It seems likely that there are some gains to be had by improving co-ordination between the systems. Delayed transfers of care is a very topical issue at the moment and an improved level of co-ordination seems to have produced benefits. That would seem to be a good solution. How you achieve that, though—whether it is health assuming some social care or personal care responsibilities, or whether it is vice versa—is a complex question which many people would struggle with.

Q103 **The Chairman:** Does the whole discussion that we have been having for the last half an hour or more come down to one thing: appropriate funding of the social care sector? Would you agree that if we do not do that now, it will have an impact on the long-term sustainability of the NHS, including the acute sector? What do we need to do now?

Sir Andrew Dilnot: I think the answer to your question is yes. It is already having an effect on the sustainability of the wider NHS. We need to act, and the need to act is growing more pressing month by month. At the moment there is inadequate funding to deliver acceptable levels of social care provision in England, and that is having an effect on the NHS itself. Some of the developments that Lord Warner talked about are a

reflection of that. We are now seeing some major acute hospitals trying to organise the funding of care homes because that is the only way they can imagine getting people out of acute beds into more appropriate care.

The Chairman: So is it your view that the NHS is currently suffering because of lack of social care?

Sir Andrew Dilnot: Yes.

The Chairman: And that the lack of long-term sustainability in social care is more important to make the NHS more sustainable in the long term?

Sir Andrew Dilnot: Yes.

The Chairman: Will your recommendations, if adopted, achieve the long-term sustainability of social care?

Sir Andrew Dilnot: I think putting a cap in place would certainly help, but one of the things we were extremely clear about is you also have to have adequate funding of the means testing system. There are two separate questions. The first is how we can make a social care system that will function and take away the fear and anxiety that affects the whole of the population. The second question is how we can make sure that those who have no or very few resources of their own are adequately looked after. To deal with that second question, you have to have a means-test system that is adequately funded.

To deal with the first question, which I think is crucial for long-term sustainability, we have to take away from people the fear that they will face catastrophic costs over which they have absolutely no control. Social care is the last big risk that we all face over which we can do nothing but shut our eyes, put our fingers in our ears and whistle bravely—and that does not seem a very sensible place to be in 2016.

The Chairman: Are you saying that the key thing about the long-term sustainability of the NHS is a proper level of funding for social care?

Sir Andrew Dilnot: No, I am certainly not saying it is sufficient. It is nothing like sufficient. I am saying it is necessary: if we do not sort out the social care system, the NHS will continue to face this constant problem. For the long-term sustainability of the NHS, the issue is how we balance the way in which demand grows much more quickly than the economy. It is a separate question, but we will not be able to answer it adequately unless we tackle the social care problem.

Lord Warner: Can we take the logic of that through, Andrew, and possibly with the other members of the panel? As a country, if we do not fund adequately means-tested social care and we do not cap catastrophic costs for people, do we end up with a situation in which the demands on the NHS become so large that you have to tackle the issue of whether it can continue as a tax-funded, free at the point of need system? Is that where this logic takes you?

Sir Andrew Dilnot: In extremis, yes, but there are other pressures facing the NHS that are hitting it even more quickly on the grand scale than this. But, yes, if we do not have an adequately funded means-test system, we will continue to have bed blocking, which is getting to be

increasingly serious. If we do not have some system that allows all of us to help take control of our own social care needs, we will have many more people ending up in the NHS with falls that could have been prevented, for example, than we otherwise would need.

The wider problem for the NHS is that in 1955 we spent 2.9% of GDP on the NHS; 10 years later it was 3.4%; 10 years later it was 4.6%; 10 years later it was 4.5%; 10 years later it was 5.2%; and 10 years later it was 6.7%; and 10 years later it was 7.4%. It goes up and up. It is rising at 1.6% a year more quickly than the economy. There have been two occasions in the past 30 years when Governments have tried to stop that increase. One was in the middle years of the 1980s and after that in the late years of the 1980s, when Mrs Thatcher's Government substantially decreased spending on the health service because they felt it was unsustainable. The second was in the middle years of the 1990s, after which we saw the very substantial Blair/Brown increases. These pressures are seen throughout the developed world. I do not see any reason to think they will go away. Of course we can have better integration; we can try to make the system more efficient. There will always be ways of making it more efficient, but there is a long-run, upward trend in the amount we want to spend on health services, including social care.

We change the allocation of our spending very readily in the private sector. We have gone from spending 4% to 12% of consumption on transport as private individuals. We want to do the same with health. We have not yet found a way of doing that. Essentially, there are two options: either we can go on with a tax-funded, free at the point of use healthcare system covering it all, in which case taxes will have to go on rising, or we can try to find some other way. It seems to me that the central challenge facing your Committee is: if you do not believe that taxes will continue to rise, how are you going to square the circle?

Dame Kate Barker: That is right. I think the way you put the question was a bit odd. I completely agree with Andrew that in some sense you are asking a question about both systems together to ask: if we do not fund the social care system better, will we find that the NHS funding falls over? Implicit in that is that we have to fund both social care and the NHS better to meet a decent standard. The money has to come from somewhere. In a way, in social care I find it more compelling in some sense than in the NHS. In the NHS we could always choose not to take fancy new technologies or more expensive drugs and let people die. In the social care system people with dementia will carry on living pretty much regardless of what we do to them and ought to be dealt with decently. That sounds terribly hard—I know it does—but these are the kinds of choices that you have to think about.

I am never quite sure what is meant by "sustainability". If you are asking whether I think the NHS, as people would like to have it—free at the point of use with the present level of GDP going to it—is sustainable for the next 20 years, I agree absolutely with Andrew: it is not. We will be able to have an NHS free at the point of use that meets what people would really want out of it only if more money goes in, which means either that we have to introduce charges in some way or that we raise taxation. This seems to me a very profound political choice.

This is made more difficult for the NHS if we do not fund social care adequately. But the reason we should fund social care adequately is because it is not decent and humane not to. The side effects on the NHS are, of course, undesirable. It is very inefficient to have people in acute hospitals when they could be looked after probably better—and they would probably prefer it—in a less expensive way. The tragedy of having people stuck in acute hospitals is that it is neither good for them nor the hospital—it is doubly awful, and clearly we should get rid of that. But the problems of funding will persist even when we have removed that issue.

Lord Warner: The oddity of my question, just to be clear, is that I was trying to provoke you to say what you have said, because I am a sceptic about politicians' willingness to actually increase taxes, with the demand increasing from the NHS.

Dame Kate Barker: I recognise that.

Lord Warner: I successfully provoked you.

Dame Kate Barker: Yes, that was a result for both of us.

Baroness Redfern: To pick up on Andrew's point about the funding and its increase year on year, nevertheless, the ageing population is growing and we want to see people living well without any major concerns, which there are at the moment. Targeting funding on social care is really important because it helps the acute trusts get people out of those beds as quickly as possible. The local authority, with its intermediate care, is a step to help them get out very quickly and then on to their own home. So there is a three-stage process and it is vitally important that we treat people as individuals.

I am very pleased that we have personal budgets. Last night we debated disability and helping people with a disability have real choice with their personal budgets so they are helped to integrate into the system as much as able-bodied people. Going back from there, with funding to social care, it would be interesting to see what happens when we get people out of acute as soon as possible, because we all know people who are in acute beds for longer lose their confidence to go home eventually. Intermediate care is the real help that we want to focus on and improve.

Sir Andrew Dilnot: When we are looking at that particular set of issues, yes—but, of course, social care is not just about taking people out of hospitals and getting them back into their homes. A lot of social care, at its best, will be about helping people take control of their own lives so that they do not end up in hospital. The optimal mix is a delicate term or question of art and I would certainly defer to Julien who these days is much more expert on that than I am.

Professor Julien Forder: I think that was a very important point to make. Recently we have been doing research on trying to measure the impact of social care in its own right. I think that is a crucially important part of the debate. A lot of the focus of the discussion recently has been on the interface between health and social care, but I think it is very important to think about social care in its own right, as well as the fact that these additional benefits come from greater co-ordination. A lot of people rely on that. It improves people's quality of life. We have a body of

research now showing that social care does that, so it is important to keep that in mind. It is also important to link it with informal care, as we have mentioned before. If we are talking about integration and about social care in its broadest definition, we are talking about housing, criminal justice and the benefits system. All these things need to be considered, not just the interface between the health and social care systems.

The Chairman: Thank you very much. Baroness Blackstone, you have a question.

Q104 **Baroness Blackstone:** Do you have a key suggestion for change that the Committee could recommend that would support a sustainable NHS?

Sir Andrew Dilnot: I have two—I am cheating. The first is to try to create a serious debate about this. I have been working in this area for 35 years. I first gave evidence to a parliamentary Committee—the Treasury and Civil Service Select Committee—about this sort of issue in 1983. I think we are lacking a serious debate about the kinds of choices that the three of us have tried to describe, and that is going to be crucial. The second thing we ought to do is make sure that the Government introduce a cap on social care while at the same time properly funding the means-testing system. Those things were agreed, legislated for and in the Government’s manifesto, so I am very much looking forward to seeing them done in 2020.

Dame Kate Barker: It is pretty difficult to say anything after that, so I will not. I completely agree with that. I think Andrew is correct: it is not just about the cap, it is also about entitlements. We argued very strongly in the report that the entitlements between social care and healthcare are, bizarrely, different, and that is a problem. We have to accept, as I say, that we probably cannot fund everything out of general taxation. People are going to have to cope with some of the ups and downs in their lives with social care, as they do with other things, but they should not have to cope with catastrophic costs, and people who do not have the resources to cope should not be left without any, as I think is happening too much today. Julien referred to this earlier and the fact we do not really know what has happened to all these people who are no longer getting local authority care. We do not quite know how they are coping. I think that is terrible. I completely agree with Andrew that the main thing we have to do is have a bigger and honest debate to develop a sensible longer-term plan for this and stop producing little bits of sticking plaster that paper over the cracks. We cannot just keep doing that.

Professor Julian Forder: Can I indulge in two? The first is certainly about the funding of social care. As I think I said at the beginning, it is time to look more seriously at statutory insurance and some form of hypothecation. Since the royal commission in 1999, there have been many attempts to reform social care. I think now is the time to look at statutory insurance very closely.

The other point is co-ordination. Obviously, they are linked as we have been discussing, but I think there is a lot of co-ordination activity that could be done, not least much better information sharing between the health service and long-term care, which has become very difficult

Dame Kate Barker, Professor Julian Forder and Sir Andrew Dilnot – Oral evidence (QQ 98-104)

recently, along with joint care planning and assessment. There are lots of organisational and delivery-type things that can still be done that will improve that, even if we operate within the same envelope of funding.

The Chairman: Thank you, Dame Kate, Professor Forder and Sir Andrew, for coming today and giving us your time in a very important session. If you think of any further information, please send it in and we will include it as evidence.

Ipsos MORI, Institute for Government and The Rt Hon Frank Field MP – Oral evidence (QQ 105-117)

Evidence Session No 10 Heard in Public Questions 105 - 117

Tuesday 25 October 2016

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Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Warner; Lord Willis of Knaresborough

Examination of witnesses

Ben Page, Chief Executive, Ipsos MORI; Emma Norris, Programme Director, Institute for Government; and The Rt Hon Frank Field MP, Chair, Work and Pensions Select Committee.

Q105 **The Chairman:** Good morning to our witnesses, and thank you very much for coming today to give evidence. We are very keen to hear from you about issues related to public attitudes to healthcare and other issues. We are recording and broadcasting, so I say to Committee members and to you, any private conversation may get picked up, so be careful about that. I will tell you when we stop broadcasting. I would be grateful if you could please introduce yourself, starting from my left, and if you want to make any opening statement, please feel free to do so.

Frank Field: My name is Frank Field. I am the Member of Parliament for Birkenhead. I very much welcome your inquiry and am grateful to be asked to be a witness.

Ben Page: I am Ben Page, Chief Executive of Ipsos MORI, the research company.

Emma Norris: I am Emma Norris, a programme director of the Institute for Government, a not-for-profit organisation working to support more effective government.

The Chairman: Do you want to make any opening statement? No. Okay, we will kick off. The first question may appear targeted particularly to you, Ben Page, but I would like to hear from the others. Are you able to outline the main trends in public attitudes to health services and how are they shifting over time? What issues in public health services are the public most concerned about, particularly currently, and in the future of the health service? Is there any aspect of health policy that has seen a bigger shift in public attitude?

Ben Page: If you look at the last 20 years, the pattern of public attitudes has, in some ways, mirrored funding of the NHS. Back in 1997, nearly 20 years ago, the NHS was top of the list of things that people said, spontaneously, worried them in Britain. As expenditure on the NHS doubled—and we can talk about how effectively that money was spent, and there are many members of this Committee who will have opinions on that—concern about the NHS declined.

It is now back up there again as an issue of public concern. Overall ratings of service standards remain much better than they were in the 1990s, but they have started declining slowly. The key challenge, in a sense, is that the public are completely wedded to the idea of a free, universal NHS. When we ask people which public services should be protected from cuts, which we have done repeatedly since 2010, it is always at the top of the list of the priorities. Aid for the developing world is always at the bottom of the list of priorities.

When you ask people what the biggest problems are in the NHS—and, to be honest, this has been the same ever since we started asking the question at the beginning of the century—it has always been a lack of funding and investment. This was the case even as funding was pouring in and real-terms rises were occurring. At the moment, though, there has been a real swing in the last few years to an anxiety about the future. People have always believed there will be a funding problem, but we now have 55% of people, the highest figure we have ever recorded, saying that the NHS will deteriorate in the future.

On current ratings of individual aspects, such as GP services, people are starting to notice that access is a bit more difficult, but things are still much better than they were 20 years ago. It is certainly under pressure, and the challenge is that people talk about paying a bit more in tax for it, but it will take some brave politicians to do that. Hypothecation, as with the rise in national insurance rates at the beginning of this century, may be a way of packaging it up, but in the fiscal environment we are in, with rising consumer inflation possibly challenging real wages, it will be very difficult.

Finally, as waiting times fall in the NHS, there tends to be a non-linear relationship between public opinion and delivery on the ground, if you like—particularly access, which is often how the public judge it, rather than clinical standards. As waiting times fell, there was not a linear recognition, in line with those falls in waiting times, that things were getting better.

If you read the STPs, you have bed spaces being reduced and things closing. As the service comes under more pressure, with deficits all over the place, and if waiting times do start to rise, it will not be a gradual switch in public opinion. There is likely to be a tipping point. When that will be, I do not know, but it will presumably be in the next few years if it is to occur, and at that point the public will be willing to see perhaps more radical measures.

As we put in the slides that I think were circulated to the Committee, there are some measures that the public tend to favour, but they tend to prefer the idea of other people doing things—other people paying fines if

they are late, rather than them paying £10 or so to see a GP. They prefer other people perhaps losing weight before they have an operation, but probably not them and their families. That, I think, is the challenge, but it is certainly the most loved public service in Britain. I will stop there, but I am happy to take questions.

Frank Field: Thank you, Chair. The paradox is that there is no question that the data Ben gives is true about the importance the public attaches to this one great institution that has survived the Attlee era as somehow giving the country a sort of social coherence. Yet, I have a massive postbag, and the question “What are you doing about protecting this service?” almost never occurs in the postbag. I think the main reason for that is that there has been no crystallisation of the debate about what we can be debating for or against. That is why I am so pleased that you are undertaking this inquiry and that there will be a parliamentary report around which that debate may take place.

Emma Norris: As Ben has said, the public place huge importance on the NHS. They are wedded to the idea of a free NHS, but we know that funding pressures are likely to result at some point in radical changes, whether that is continued and expanded reconfiguration of services, changes in the breadth of service provision or rises in income tax. Given how passionately the public feels about the NHS, I think that the only way to pursue change, whether increased taxes, reconfiguration or whatever it might be, is to involve citizens in that conversation. Otherwise, we are likely to see that conversation and any policy change being derailed. I can talk a little more about what a national conversation on the NHS might look like.

The Chairman: Ben Page, what effect are the problems in social care having on public attitudes?

Ben Page: The point about social care is, of course, that it is very complicated. I speak as somebody who has just nursed my mother and stepfather to death at home, on the other side of the river, in Lambeth. Trying to navigate the system is incredibly difficult. The issue of the problems in social care is clearly there in that, if you look across the public sector, there are two areas where people have noticed the impact of cuts. One is road maintenance, which we will quickly put to one side. The other is adult social care, which people have noticed.

It is still not a majority of users who say that they think it has deteriorated, but it is the largest proportion, pretty much, of any public service. The point is that such a small proportion of people directly receive it and the accountability for it is so confused, as opposed to the straight line in theory to NHS England and the Department of Health, that the public has not clocked. In a way, to be honest, I am quite surprised, given the demographics. Back at the beginning of the century I was expecting that by now there would be a very active pensioners’ party. There would be people saying, “I cannot cope with my mother any more”, and dropping her off somewhere.

Instead, people like me have ended up doing domiciliary care at the weekends; it is our parents. Society has proved, in some ways, more flexible, but the pressures are undoubtedly there. In a way, what we are

doing—the way the system is set up at the moment without integration—of course, hides that. If I were a politician, quite frankly, I would probably want that to continue, rather than ending up being made to take responsibility for it. What it would do, of course, is highlight the massive shortfall in supply.

Q106 **Lord Warner:** Ben, I am quite influenced by a bit of work that you did for us when I was on the Dilnot commission, the interest I declare. Sticking with social care for the moment, what data is there around whether people think social care is part of the NHS, and whether they think they and families should be paying more, or saving more, or paying for this service? They separate out in their minds social care from the “free at the point of use”. That is a paradox, because there are two views. One is that it is all in the NHS anyway, and the other is that it is not the state’s responsibility; it is much more mine. What is the data showing on that now?

Ben Page: From memory, it is still showing confusion. People are not aware; some people think local government delivers social care, which, of course, in theory in part it does. There is much more confusion about that than there is for, say, acute services. In terms of taking responsibility, about four in 10 people say, “Yes, I recognise that I will need to save up money for my care when I am older”, but a large proportion will take the view, “I pay taxes”. In particular, older people who are coming closer to the event are saying, “I have paid taxes and national insurance all my life; why on earth should I pay?”.

When we ran large-scale consultations to look at paying for social care, we found that everything was fine, even with the idea of the Japanese system of introducing extra national insurance payments at the age of 40. We found that broadly the public might go along with that. With the idea of the state getting a bit of your house when you died, however, at this point there were rebellions. People are not rational about it, and they are also divided. If it were simple and easy, any Government of any colour would have done something about it a long time ago.

Lord Warner: Is that all static? Is it changing?

Ben Page: It is fairly flat, to be honest, apart from people noticing a deterioration. There is a bit more recognition in the data that people know that austerity is here, that prioritisation needs to happen, but it is not moving anywhere near as quickly as we would need it to.

Frank Field: Can I just add to Ben’s comments, in a sense, a note of dissent? On his idea about his weekends being given to look after his parents, we downplay the strength of families still, and families still expect and want to carry out that role if they can. If they have additional support, they are grateful for that, and they come to their MP only when they are almost worn out, at the end of their tether, when they do not know, and they ache with pain wondering what the next move is. If you are in that state, you are not in a very good state to form a new political party; you want a rest.

Q107 **Lord Mawhinney:** Frank, nice to see you again. I would be interested in your views about people saving for social care, which is being tossed

around here already. Specifically, how would you react, as a former Minister, to the idea of attaching some function to national insurance payments that were designated specifically for social care as a first step in starting to address this?

Frank Field: Brian, I much welcome that, and maybe I could develop the ideas now, or a bit later. If one were starting again, one would not come up with an NHS. Naturally, then, they did not care as much about social care, because it was not a big issue. If we were designing a system now, the two would be combined. How do we make the transition from where we were to where we might be?

I hope the Committee, if it is considering any financial reform proposals, makes the point that we need to be using that transition of raising additional funds to change the nature of the service, so it is an NHS social care service. That means, of course, that group that at the moment does not pay national insurance, which is pensioners, would come into the scheme and start to pay for it.

You could have a transition by saying, "If you want to play around, you may have to lose your house. You may have to get this terrible lottery by your local authority about whether there is any help available to you. That is fine; but if you take a model that you will be in, you get the whole package". That would be part of the transition. At some stage in this Parliament there will be a God almighty eruption over the funding of the NHS. The exercise on trying to get savings is a good thing to do; we all should be conscious about worrying not just about how much we put in but what we are getting for the outcomes. We should be looking at that as well.

This offers the Committee a real opportunity to try to bring the debate together and suggest which way forward we might go. Might I, Chairman, suggest what I would like to see here, or should I do that later on? May I? We should follow Gordon Brown's model, possibly in two stages. One is that he was terrified introducing the increase in national insurance; he thought it was almost going to be the end, and was then surprised by the cheering he got in the streets. He could not have been more popular as a Minister after he did this.

What we did not realise then, but do realise now, is that while that one penny was a very useful way of bringing us up to the European average, Gordon, clever as ever, diverted half of that money to his other pet schemes. Certainly, there will be enough in the campaign leading up to that to make sure the public realise that, and they would want a separate scheme. Therefore, it would allow you to begin to develop a different form of governance.

Stage one could be to accept the system as we have it now, and follow the Gordon line of a penny on national insurance on employers and employees, without a ceiling. That would fill the gap that will develop, if the efficiency savings are achieved. However, there is a longer-term objective here, in that as now, increasingly, people cease to believe in God, our public religion, as Nigel Lawson said, is the NHS. It gives us a real chance of rethinking that position, particularly as we are bringing social care in. I hope the Committee will seriously consider looking at a

national insurance base. I say that because Ben and others have done surveys that show that the public see a difference between a tax and what they regard as a contribution.

Lord Mawhinney: Can I just be clear: I asked you about national insurance as a fund for social care; do I detect that you are broadening it to be NHS and social care?

Frank Field: Brian, I am, in the sense that the Government are already trying to get local authorities with their funding to work with local trusts so that the bed blocking, as it is rather cruelly called, is lessened. There is an attempt to come together locally, and anything you propose, I hope, would reinforce that trend rather than ignore it.

The Chairman: We will have an opportunity to expand on this when we come to it in the questioning, but Baroness Redfern will carry on with the original line.

Q108 **Baroness Redfern:** From a local authority's perspective, obviously we have raised an increased 2% that is targeted towards health and social care. Ben made a broad statement that 55% said the service was deteriorating. Can I just tease a little out of that? Is that regional? Is it well people or ill people? You can make a broad statement—

Ben Page: Sure. That is the population as a whole, just expecting it to get worse. If you look at the very detailed data that NHS England collects on patient experience, it is not the case that 55% currently are dissatisfied.

Baroness Redfern: That is what I wanted to tease out.

Ben Page: We need to be very clear about it. This is the point. The NHS, partly by raising its deficits, is holding the line. Waiting times are increasing, but they have not hit a tipping point where they are on the front page of the *Sun* every day. However, and this is the point of what I was trying to say, there is a non-linear relationship. If the trend continues, at some point the pressures will feed through.

At the moment, patients are not rioting in the streets about standards and it is generally, as I say, about access. It is a slow deterioration, but the point is that it will not go on. The evidence suggests that there will be a tipping point when suddenly people notice, but at the moment it is holding together. It is fascinating that the press coverage of junior doctors' troubles et cetera has not led to a more marked fall.

Baroness Redfern: Is it focused mainly on the acute sector?

Ben Page: Yes, and GP access. The acute data is still reasonably good. There has been a rise in mortality in the last year, which nobody quite understands, and if that trend continues, that will be interesting. I started to think that was the canary in the mine and possibly was partly related to social care, but no. Satisfaction is holding up; it is drifting down slowly, but there is anxiety about the future.

Q109 **Lord McColl of Dulwich:** Ben, from your surveys do you get any sense of whether the public understand that half the illnesses are self-induced and that the obesity epidemic is the worst epidemic for 100 years? Do

they have any sense that they could do something themselves about this? You see old people constantly being blamed for getting older, but they have always been getting older. It is the young people who are getting fatter and fatter.

Ben Page: People estimate that 45% of the population is obese. Obviously, they do not think they are, but the actual figure is about 62%. There is some recognition of the public health dimension of the problem. People recognise that obesity, drinking too much, lack of exercise et cetera are a problem. The challenge is changing behaviour. The NHS has talked about moving from being an illness service to a wellness service, certainly since the 1990s, when I first became involved in measuring it, and obviously probably for longer. However, the cultural shift that we need to achieve is enormous, and we are nowhere near it yet.

Baroness Blackstone: I wanted to ask Ben whether, in any of your surveys, you have asked the question: "Should more money be spent on the NHS or on social care?" If you have, what do you get as a result? Can I just follow up on Frank's suggestion that pensioners should pay national insurance? Have you also asked the public whether it would be a good idea to introduce national insurance for pensioners, since they are by far the heaviest users of the health service, and if you could in some way link that with improving the services that they will get?

Ben Page: The short answer is that I do not think that we have asked—I have not seen it, but it may exist out there somewhere—about basically charging pensioners more somehow. Obviously, people massively underestimate the rise in DWP's expenditure on pensioners over the last 10 years.

On social care versus the NHS, the only thing I can give you is that when you ask people to prioritise the NHS versus care of the elderly, or however you want to define it, the NHS massively outstrips it. Of course, that is in a sense the culture we have inside the NHS, which is always blue flashing lights and surgeons, rather than some of these slow and creeping problems that we face.

Q110 **Bishop of Carlisle:** You have made it clear that everybody wants additional funding for the NHS; they are clear that there needs to be additional funding. You have made a couple of very interesting comments. You said, Ben, that everybody basically wants somebody else to pay for it. Frank, you said that there is likely to be an eruption fairly soon about the public funding.

Could I ask a question that is very much about what you think the public would find most acceptable? This is not for your views but what you think the public would go for best. I note that one of your slides says that six in 10 say they are prepared to pay more taxes to help the NHS. That is quite a high proportion, but if you are taking into account things such as direct taxation, statutory insurance, national insurance and so on, which of those do you think the public would favour most—that is likely to be the thing that politicians will go for—and does it matter?

Ben Page: It probably matters, in the sense that you want to get elected, although the nature of politics at the moment is somewhat

lopsided. To be honest—and Frank and I might agree on this, although we do not agree on everything—some sort of hypothecated national insurance rise that is very clearly badged as for, in positioning terms, the NHS as much as social care. Because social care is so complicated and people become so confused about the range of providers and responsibilities, the NHS brand is much stronger than social care.

Anyway, some type of hypothecated taxation is probably the easiest way out. Of course, the NHS is already trying demand management; it is doing it, trying to charge for extras. We charge massively for car parks; it is very expensive. There are some options, and you will have other people who are better on the detailed economics of the NHS than I am, but it would appear that only something like that will get us out of the hole we are in. It is probably easier to do that than a rise in VAT or in taxation generally. That would be my take on it.

The Chairman: In terms of what this inquiry is about, which is the long-term sustainability of the NHS beyond 2025 or 2030, so that we do not have yearly or five-yearly cycles, what kind of funding will the public find acceptable for long-term sustainability? It will have to grow year-on-year.

Ben Page: I will pass the buck on this one, Chairman. John Appleby of the King's Fund has done some interesting work on this. I do not know if he also presenting to this Committee. If you ask him about it, he says, "If you look at Germany, the Germans spend a lot more on their health services than Britain. It is just a matter of choice". I will give it to other people to consider that. I would also urge us to look at investment in public health. This, of course, is part of the NHS's current troubles, as I understand it.

The difficulty is the need to re-engineer the service with a surge in demand that is in some ways even beyond what would have been anticipated with the change in the profile of the population. It is a bit like changing the engine in a ship while the ship is moving along. However, we need to make that investment in public health. Probably, that is part of it, but we do not operate on those sorts of cycles as politicians in this country.

Bishop of Carlisle: Thank you, that is very helpful. I know there are other questions that people want to ask on this.

Q111 **Lord Bradley:** Could I just pick up, Ben, on your point about the integration of health and social care having political consequences? I have to declare an interest as a non-exec on a trust board in Greater Manchester. The direction of travel is to push those budgets down, to integrate those budgets—Frank mentioned joint commissioning between local authorities and public health as part of that, and the trust et cetera.

You are suggesting that the political consequences, when the pressure comes even further on, from those decisions could be found at the local level as opposed to the national level, where you are trying to get a national system in place to mitigate that. What are your further views on that issue?

Ben Page: It is clearly sensible to integrate things at a local level. There is massive duplication, inefficiency and confusion. Will the Secretary of State suddenly become responsible for my mum's bedpan in her house in Clapham? To be honest, that is the direction we are going in. I am not clear what the new Government's view is on devolution, however, because we seem to have such a patchwork quilt of different deals and options.

To a certain extent we will need to go to that model, and there will be differences between different parts of the country, but this is where we run into the central problem that 81% of people want the NHS to be the same everywhere. It may be a fantasy, but that is what they want. They do not want, for example, Herceptin to be available in one part of the country and not in another. The fantasy of the NHS, which is an enduring fantasy for the British public, is that basically clinical care is the same everywhere, and you are guaranteed, as a taxpayer in Britain, to get a certain thing.

Devolution is probably necessary, and it is more efficient. The Scandinavians have great examples of it working, as far as I can see. However, there will potentially be some fallout, yes, because suddenly it will be, "Why are we not getting this here? Who made these decisions not to give us this in Greater Manchester, when over in—"

Frank Field: Birkenhead.

Ben Page: "—Birkenhead, on the other side of the river, they get it?"

Lord Bradley: It is heading your way.

Ben Page: That is the challenge.

Lord Bradley: Just a quick supplementary: within the question of the integration of physical and mental health, is there a growing recognition among the public of the need to develop services around that?

Ben Page: Yes. Obviously, mental health still has a massive stigma and massive misunderstanding. If you ask people the question, they do not sit in the pub talking about this, and we saw that again. When given the choice, they will say, "Make those investments".

The Chairman: Frank, you wanted to come in.

Frank Field: I did. Could I just pick up a couple of points, Chairman? On Baroness Redfern's issue, we have seen this Parliament part of the NHS bowing to public pressure. It was not by politicians, but it was by opinion polls. The junior doctors were not beaten by the rhetoric of politicians, but the polls were showing it swinging against them. Although, in a sense, it was not an immediate, "I am looking after my mum and I should not", there was a real anxiety growing that the standard of service would suffer and waiting lists would grow even further if this strike went ahead. This was reflected in the polls, and very sensibly the junior doctors withdrew.

On Keith's point, when we are talking about reform it is important that we are talking about both kinds of reform. We need to start to educate the public that maybe, particularly in this age of devolution, the role of government is the Webbian one of laying national minimum standards,

but there will be other bodies that will improve on that. The Webbs always saw that, because some authorities would do better than others, that would be one of the stimuli for driving up what the national level should be.

On the Bishop's point, speaking as a politician who likes getting elected and wants to get elected again, it would be a more choppy campaign if we were vaguely talking, although we had not even done it, about there being some increase somehow in the next Parliament, but we could not tell you what it was. It would be a real opportunity lost if we tried to make the hospital sector raise more money by these charges, because it is quite arbitrary if you compare what you can charge for parking in London hospitals with that in Birkenhead hospitals.

Also, there is something terribly important about the NHS as the last great institution binding us together as citizens. Rather than start dividing us over, "Oh God, is it not unfair? Look at those hospital charges", we should say, "We bit the bullet, and we have done it together. It has been done in a progressive way. We support this move. We feel it belongs even more to us as a community than before". The latter offers not just a way out of the funding for the NHS, but plays a crucial part in adding to social cohesion. It is a strange phrase, but we are all aware when social cohesion begins to collapse, and we are then at a loss about what we do about it.

Q112 Lord Warner: Can I just pursue this issue of efficiency and productivity and where the public are? This Government has put quite a lot of pressure, through the media, on improving productivity and efficiency in the NHS and the wider public services. The present Prime Minister had a pretty good go at another sacred cow, which was the police. Where are the public on this? Where are the public on the NHS in the context of greater efficiency in the public services?

Ben Page: Every year we have asked people what the biggest problems facing the NHS are. Obviously, some of the booking procedures are nowhere near where they should be. People can see inefficiency. Three-quarters of people agree that there is a lot of waste and inefficiency in the NHS, but simultaneously believe it should have more money. Spontaneous anxiety about bureaucracy and inefficient management has declined since 10 years ago, so I do not know whether they have noticed that it has become a bit more productive.

The main shift in public opinion over the past six years has been an acceptance of austerity, which is interesting. One of the things we have seen is the proportion of people who believe that the amount of cuts that have been done has fallen from 40% in 2012 to 28% in 2015. There is a recognition—you can argue about whether it is right or wrong—that austerity is necessary, and that there is more of it to come. We believe that in many public services there are people rowing back their expectations.

In the past I have had chief executives of councils saying, "If I offered a free nose-blowing service down at the town hall, there would be a queue of people waiting for it". Now people have bought the rhetoric that money has to be saved.

Frank Field: In Birkenhead, Chair, they have been working out what the code is for nose-blowing.

Q113 **Baroness Blackstone:** A lot has been said by you and by previous people from whom we have taken evidence on the need for a big public debate about the NHS and the future of our health services. We have been told that people need to have better understanding, and they need to be able to express their views about what they want. Emma, in particular, can you start on the question of how this should be done? This is a big ask; it is not an easy thing to do and it has to be got right if it is to be reliable and valid.

Emma Norris: On how, it is worth pointing out that there is a lot of nervousness at the moment about talking to citizens about the challenges and the future sustainability of the NHS. The STPs are perhaps a case in point, where citizens were not engaged as early as they might have been. If citizens are not involved in a big national conversation, however, it will make change even harder, whether that is financial reform or something else.

We have seen examples many times in the past of citizens derailing, sometimes for good reason, policies when they have not been involved in big conversations to begin with. It could be opposing hospital reconfigurations, opposing long-term storage solutions for nuclear waste, or scrapping plans for nationwide road pricing. If citizens are not involved in these big conversations up-front, it is very hard to make policy progress.

In terms of how, there are many international and domestic examples that we could learn from. For instance, in Canada, about five years ago, a national dialogue was held on the future of their healthcare system, what a good-value healthcare system looked like, and, crucially, what the responsibilities of citizens were in helping to achieve that good-value system. Just a few months ago Canada launched another dialogue, this time on electoral reform. Even in the UK, back in 2006, the "Our Health, Our Care, Our Say" listening exercise was run to look at out-of-hospital care and how it could be improved. There are international and domestic examples of how to hold big national dialogues.

This was also something that we looked at on a slightly smaller scale at the institute quite recently. We were very interested in how you involve citizens in difficult policy decisions that we know people feel strongly about but have very divided views. Our research told us a couple of things. We looked at examples of citizens' juries that were run by PwC and BritainThinks, on how to create the right criteria for a spending review. We looked at examples from abroad of when the public have been asked to deliberate on how to expand airports. We looked at local councils that were implementing budget cuts and were trying to involve citizens in the choices they needed to make.

A couple of things came out about how to run those conversations effectively. The first was about being transparent about what is and is not up for grabs: taking Redbridge Council as an example, where it was talking to citizens about cuts, it was very clear about what citizens could decide on and what they could not. There was no room to reject the

requirement to make £25 million of savings; budget deliberations could only occur within that envelope. Similarly, any conversation on the future sustainability of the NHS would need to be clear about what was up for discussion and what was not.

There is also a point about timing, and not leaving it too late to involve the public in these conversations. The examples we have looked at have been most effective when people have been involved from day one on deliberating about future options. For NHS England, the timing of engagement on sustainability and transformation plans has not perhaps worked as effectively as it might have. One of the first times that citizens heard about the plans was, I think, through media coverage. In a bigger national conversation about the future funding of the NHS, getting that timing right and making sure citizens are involved as early as possible is crucial.

Ben Page: I am a huge fan of consultations, because that is how my company makes its living. The challenge is the scale: to make a nation of 60-plus million people feel that they have all had a say is a huge communications challenge. However, there are some interesting examples in our recent history of difficult policy choices that Britain has done without too much trouble, and we could maybe look at those. One is pensions: basically, the parties, and these Houses here, have agreed that everybody will pay in more and work longer, and there is no big debate about that. We are doing it with social care, and it does not seem to work there.

My worry about a consultation, or an engagement exercise, is that you would need to be very transparent about the choices. The difficulty will come when experts start arguing with the choices, or saying they are fake choices, or something like that. Somehow, in the pensions debate, that did not become as incendiary. I am all for doing it, because it is the right thing to do, but in getting people to feel that they have definitely had a say, I wish everybody a huge amount of luck.

Lord Lipsey: Were you all for doing it the day after the Brexit referendum, where we had a great national debate?

Frank Field: Chairman, on this point, if, in working on your proposal, you are working with the grain of human nature, you get support very quickly. I have given one example of Gordon being surprised. There was another where Healey challenged the trade unions to maintain the pay freeze, and he said, "If you do not maintain it there will be tax increases. If you do, you will get tax allowance increases".

From the second poll onwards, it showed that the public understood what the choice was and which they wanted to choose. If you were having a national conversation about trying to persuade people to dismantle the health service, it is a different conversation from one about how we strengthen it.

Baroness Redfern: Following on from Lord Bradley on mental health issues, Frank, would you advocate a closer working relationship with local authorities and GPs? We have talked about mental health issues; we can talk about isolation, depression et cetera. Would you see a closer working relationships with GPs?

Frank Field: They are pivotal, as are the support services they are building up. In the area that I represent, they are losing those under pressure as the hospital budgets try to suck money out of primary care. When we are making these changes, we ought to be thinking about the regional aspect of this, which has been referred to, but there is also very much the local aspect of this—having services to which people can walk, particularly if they are poor. It does not mean that all doctors would be good on mental health services, and again their budgets might be structured in a way that would encourage them to be so.

However, to be able to refer patients in my constituency by all doctors, not just the best ones, as quickly as those who, for example, got secondary services in their GP surgeries would be a tremendous breakthrough. One does not want to underestimate the difficulties of somebody going to another person outside the family and saying that they have real mental health problems.

Lord Warner: We have not had much luck with representative democracy in recent times. Is there any evidence that getting the elected representatives, local and national, engaged in the conversation has worked? That is probably for Emma as much as anybody.

Emma Norris: Yes, absolutely. We looked quite a lot at infrastructure, another area where obviously there are incredibly difficult policy decisions being made, and citizens have a big interest in them. It is something that some of our European neighbours have perhaps been slightly more successful in having conversations about than us. The expansion of Schiphol Airport in the Netherlands is a good example. They created a deliberative forum to have conversations about how to expand that airport after there had been a lot of public backlash against the initial proposals.

It involved citizens, but one of the most effective things that was used in that deliberative forum was bringing together local and national representatives to try to deliberate on their respective evidence bases about what was and was not going to work. It was important for citizens to see that local and national representatives had been given an opportunity to come together to hash out some of those details.

I think you are right that sometimes just showing, definitively, to the public that there is space to look at national versus local interests, and to have conversations about the evidence base, is enough to take some of those conversations forward. That is just one example of how.

Q114 **Lord Willis of Knaresborough:** Mr Chairman, I am always slightly amused when I am talking about public consultations, being a member of the National Environment Research Council. We have just recovered from Boaty McBoatface as a result of that, so I would hate for us to get into that space. I wonder if we could come back to Frank Field. I always enjoyed, Frank, your commitment to finding a long-term funding solution when I was in the Commons. You have often been a lone voice in suggesting hypothecated taxes for that.

There were three things you mentioned in the earlier discourse. I do not think we need to go back over that, but there are issues with your

proposal, first of all about hypothecation and ring-fencing it. I would be very interested if you could add to your idea of an NHS mutual as to how you keep it retained. You are quite right that Gordon Brown's one penny quickly became half a penny in that sense. How do you stop that? There is a sense that at the moment the contributions simply go into the pot and are spent by the Treasury.

Secondly, if income is attached to a source that cannot remain constant and economic disactivity results in a significant downturn in tax revenues, you would then get a shortfall. What would you do with that?

The third point, which is crucial, is that if you do not have a mechanism that ties your spending to productivity and efficiency, which Lord Warner was talking about earlier, we end up with a situation where you pour a lot of money in, having won that argument, but you are no better off. I wonder if you could start perhaps with the NHS mutual, and give us the solutions to tackling those problems—including, of course, taxing the elderly, because in this room we are cash-rich. The Chair is, anyhow.

Frank Field: I have three points, one about hypothecation. I genuinely think the Government could get away with quite a major restructuring without hypothecation, given that the wish of the electorate will be to see the NHS through to its next stage of life. However, if it did that, it would be a real lost opportunity. It may have to do an interim increase, and then spell out what that longer-term reform is about. I would be very happy to submit a paper, if I may, through you, Chair, to that.

I would link it to a mutual so that the Government was the post office, collecting the money from the reformed national insurance base to go to that mutual for that mutual to spend. It would be transparent, it would be very clear and it would stop any of this sleight of hand that somehow says "There is a large sum of money here, and I would like half of it, or even more of it, to go to some of my other pet projects". It would strengthen the NHS's place in the affection of the country, and it would strengthen democracy in that it would be another great bulwark both in helping lead the debate that you have been talking about, and protecting revenues and making sure they go where they should.

Secondly, you raise the question about a downturn. You would not want to make this change without giving the mutual power to build up balances so that over the cycle—whatever we regard now as the cycle—there would be enough in the bank to offset. Certainly, one would not want, when there is a downturn, for the contributions to go up and therefore, in a sense, restrict individual spending. We would want that as a period where you could reflate. Even Beveridge proposed that in his schemes, but that was one aspect that was ignored. The mutual would have the powers to build up balances to deal with the very point that you raise.

Thirdly, if we had lots of new money slushing around, it raises the whole debate about efficiency and how we look at outcomes rather than just inputs. How do we put patients at the centre, and staff—whom we should not forget about—second but still crucially important? Undermining staff morale, whether teachers or NHS workers, is very good for politicians

short-term to gain headlines, but long-term it starts to make the culture even more inward-looking and even more difficult to change.

One of the aspects noted by people who use the NHS, and we all do and we see the inefficiencies, is that there needs to be a massive cultural change in how they approach their individual functions—the cog within the wheels. I, again, think it is the role of the mutual to lead the national debate on the change in culture, what we are expecting and what we want from increased productivity. We also, however, need to start debating publicly whether there are limits at all to what you are prepared to pay for, and the conditions for which you are prepared to pay in the future, given our projections. They would be like those that the Office for Budget Responsibility produces; they would produce the same: “If, in fact, we are going to quickly incorporate, thank goodness, all the latest drugs and all the latest equipment, this is where we will land up”. Going back to the previous question, is there not a duty on you to perform in a certain way so that you are not “abusing” the health service? Here, from the word go, are courses that you could be on or become part of, which would reduce obesity, understanding the difficulties there are if you are poor in engaging in those.

Thirdly, this would be a great body whose responsibility would be to guarantee transparency, but to have a constant duty to seek out at every opportunity to lead a public debate. The debate would consist of defending what we have, why it is being reformed, why it continues to be reformed and why your contribution, which we are now debating with you, is clearly linked to the sort of service that you wish to continue. That service, I think, will increasingly be one that demands an end to this mess-up between hospitals and social care.

Lord Willis of Knaresborough: Could I just follow up, very quickly? The one flaw, when I read your earlier work, seemed to me that you were advocating a hypothecated national insurance contribution over and above existing national insurance contributions. Somehow you have to interrelate both of those, which means you have to recognise where the current money from the contribution is being spent. If you do not do that, you end up then with a set of services that are hypothecated for this money to be spent on, without a relationship to the whole.

I could not work out how, in fact, you unpack the current contribution to say how much of that is the NHS spending, unless you link the whole thing together, in which case you cannot fund the lot.

Frank Field: No, there are two stages. One is that we must have an emergency package, and that we would have a Gordon Brown approach stage one, linked to the establishment of a new body that guaranteed they got the money. Secondly, we would need to convince the public that almost none of their National Insurance contribution goes to the health service, although I think Ben’s surveys show that everybody thinks all their National Insurance contribution goes there. It actually goes to pay pensions. We need to think about that.

I would like, as the third stage of the reform, over time to transfer the whole cost of the NHS and social care budget to the new mutual, and the new mutual’s job would be to say, “That therefore allows the Government

to make tax cuts". It would not use this transfer of a budget that people are already paying for generally through taxation, to pay for it again in the reform and by sleight of hand get away with huge increases in revenue, but without saying, "We will not charge you twice". I hope nobody would even try the double taxation trick, and be very popular for sloshing money all over the place.

Lord Willis of Knaresborough: The increase in the NI contribution would be quite significant. We are not talking about a penny; we are talking about a significant amount, if you were going to remove the NHS spending from the tax base to reduce taxes, and therefore make that a sweetener. For those who are not earning, and particularly for elderly people who have incomes that are coming in where they are not working, that shift is monumental.

Frank Field: The shift would be, but they would get a guarantee that they would keep their house. We may not understand it, but move one is: maybe we just do the increase in national insurance. We then think about the longer term, as you are suggesting—and I agree—and we take the whole of the health and social care budget to this new funding basis, which becomes progressive rather than regressive, as it is at the moment. There is then a clear commitment that, for each billion that is moved over from the existing health budget and general taxation to the new progressive base for the mutual, that money would come up and be earmarked for tax cuts. It would not be used by sleight of hand to get tax increases on people, because the whole thing would blow up in the face of whoever was trying such a foolish move.

Q115 **Lord Lipsey:** Frank, I just want to home in on your proposal on national insurance, which you earlier described as a progressive way of funding it. Is it a progressive way when national insurance falls entirely on working people, who, as the Resolution Foundation and others have shown, have done very badly in recent years, and the benefits of improved healthcare disproportionately accumulate to people like me? We older people who do not pay national insurance will now get, as well as the triple lock and the cornucopia of goodies that have been heaped on us, even more money spent on their health.

Frank Field: I have tried to stress a couple of times, David, that this package would be accompanied by bringing pensioners into the scheme, and they would be paying national insurance along with the rest of us. There may be a case for asking pensioners to pay national insurance contributions now on their income. Certainly there is no case for a reform package that would generally most benefit older people, and for those who could not pay most—pensioners who are exempted from national insurance contributions—not to be included within the scheme.

The Chairman: Ben, you mentioned the Japanese system of paying national insurance specifically for social care. Do you want to comment on that?

Ben Page: I am not an expert on it, but it was certainly one of the things we looked at in a consultation on paying for social care, a while back. It was certainly pre-2010. It was interesting; we did not go into the mechanics with the public, but the idea is that you have reached the age

of 40 and it is therefore quite likely now that you will live on et cetera, and now you will pay a bit more. Of course, by the time you are 40 you are earning a lot more than you would have done in your 20s anyway, so it is more affordable. Of many of the things that we looked at, that idea was broadly accepted as a principle.

Baroness Redfern: For pensioners paying towards that care, would that have to be means tested and therefore would that be very complicated?

Frank Field: It would be means tested only in the sense that if you were below the threshold, wherever you set it, you would not be paying through the national insurance scheme. However, it is not a special means test.

Baroness Redfern: It would be interesting to know where you would set the threshold.

Frank Field: Again, that is a matter for debate. In the Japanese system, Chairman, it comes in at 40. There has been a big change in my lifetime. One left university expecting to get a job, a house, a pension, and to save. Now at 40 you would be lucky if you have maintained a job, and you may well be thinking about a family and trying to acquire a house. There will not be a good point in the life cycle to introduce these contributions. Again, as with all great reforms, the bullet has to be bitten.

Baroness Blackstone: Maybe 40 is a bit too young. Maybe it would be better if you said 50.

Frank Field: I agree. When we left university, we were invited to pay our back national insurance contributions, which most of us did, thinking that was likely to affect our pensions, and that we would not be working all that long. It is easier to bring in contributions when you start paying contributions, rather than hiking it up later.

Q116 **Lord Warner:** Can I carry on from this a bit with my question? It has been very difficult over time to get political commitment to addressing the question of longer-term sustainability of public services, including the NHS. The Chairman has said that we are set up here to look at the longer term, not the immediate problems, although the immediate problems can, of course, affect that longer term. You, Frank, have identified an external force, which you called the national mutual fund. Is there a more fundamental case, without getting into how you raise the money, for trying to get some better assessment over time, independently of government, about what these systems need?

We have done that a bit with the OBR. Is there a fundamental problem or flaw in the present system, whereby politicians wait until the crisis occurs and we then have a dose of catch-up money? Is there a danger, Frank, that your proposal will be just another catch-up proposal, and we will never get to stage two? Is there a case for at least trying to see where the direction of travel should be for these services, outside direct political control?

Frank Field: I think there is. As I said, the model of the Office for Budget Responsibility is one that one might follow—although initially, given its standing, one might commission the King's Fund to undertake

that function for it. You seemed to suggest earlier, Lord Warner, how poor our representative Government is. In the Labour Party, most MPs now represent constituents who overwhelmingly wish to leave Europe. I almost got crushed in the rush of Labour MPs adopting a new position once they realised where their constituents were.

We are sensitive in that: representation and representativeness do not just come from general elections. MPs do try to pick it up in other ways. The sort of debate that you are initiating might well be one of those factors that helps clarify their minds, so that they are cheerleaders for it in their local communities and beyond.

Ben Page: Could I just add that depoliticisation is obviously desirable, but the people doing it will not necessarily be popular. One of the things we might need to confront the public with is, I think—somebody will correct me—the current amount we spend on maintaining somebody for a year is about £35,000, and if your treatment will cost a lot more than that, it is not available. People do not want to be faced with this. They sort of know it, but one of the things about Britain is that so many things are left unsaid.

We like fairness, but we do not like to confront the fact that people in certain parts of the country live 20 to 30 years longer than those in other parts of the country. If we are told that, it is outrageous, but then we do not want to do what is necessary to stop that happening. If we try to depoliticise it, we want to have that very honest conversation with the public—“How much are you prepared to pay for? What treatments are not available?”—rather than having it obfuscated through our various processes at the moment. Somebody will have to be pretty brave to have that conversation, but it is worth doing.

Lord Warner: Exciting to do, as well.

Ben Page: Yes.

The Chairman: Lady Blackstone, with her golden question.

Q117 **Baroness Blackstone:** What key change would you each recommend, which we in turn can recommend, to make a more sustainable NHS?

Frank Field: I merely summarise, Tessa, what I have been saying: there is going to come a point at which the public will be even more open to radical reform. I would like to see that focusing on both a new progressive funding basis and a real strengthening of people’s sense of ownership of the NHS. Some of us might—others might not—be surprised by just how popular that was. One would need to do it in stages, and one would need something like a report that you are going to produce, which is not “the Tories” or “the Labour Party, up to their tricks with something we love, which we want strengthened”. Then they, in a sense, are coming behind you to lead the debate, rather than them, in desperation, kicking off the debate themselves.

The Chairman: You have suggested previously establishing some sort of commission.

Frank Field: You are the commission, are you not?

The Chairman: We thought we were, but we are not.

Frank Field: You are doing that work, and therefore if it is possible for you to report unanimously, the report will be even stronger. You will be sowing on fertile and not on stony ground, when your report is ready.

Ben Page: My shopping list would be some form of hypothecated charge, probably through national insurance, but at the same time a new Government closing all the hospitals that are uneconomic, which we do not close because it is difficult, and a massive investment in public health.

Emma Norris: Mine would be the instigation of a national conversation on the future of the NHS, and critically that should include establishing an independent evidence base about options to support that conversation.

The Chairman: Thank you, all three of you, for coming today. If you have any further information—Frank, you mentioned something—please feel free to provide it, and we will include your slides as part of the evidence.

Frank Field: I will, indeed. Chairman, might I also make a suggestion that for you to commission polling on this would be helpful? There is one person not very far to my left who—

Ben Page: Last time he got me to do it for nothing.

Frank Field: I do not know whether you have a research budget, but you might like to ask him to pose certain questions for you, for your research.

Ben Page: Happy to consider it.

The Chairman: Thank you very much. Thank you, indeed.

The Rt Hon Lord Willetts, The Rt Hon Steve Webb, Strategic Society Centre and Institute for Public Policy Research – Oral evidence (QQ 118-128)

Evidence Session No 11

Heard in Public

Questions 118 - 128

Tuesday 25 October 2016

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Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Warner; Lord Willis of Knaresborough

Examination of witnesses

The Rt Hon Lord Willetts, Chair, Resolution Foundation; The Rt Hon Steve Webb, Director of Policy, Royal London Group; James Lloyd, Associate Fellow, Strategic Society Centre; and Tom Kibasi, Director, Institute for Public Policy Research.

Q118 **The Chairman:** Good morning, gentlemen. Thank you all for coming to assist us with this inquiry today. We are most grateful. First of all, we are broadcasting, so any conversation you have privately might be picked up. Secondly, at the end of the session and subsequently you will be sent the transcript of today's session, and, please, if there are any crucial corrections to be made, let us know. If there is any evidence that you may not have been able to send, or that you feel after the session you would like us to have, please feel free to send it to us later on. If you do not mind, introduce yourselves, and if you want to make an opening statement, please feel free to do so. Can I start with you, Lord Willetts?

Lord Willetts: Thank you very much. It is obviously a great honour to be invited before this Committee. My name is David Willetts; I was a Member of the House of Commons between 1992 and 2015. Now I am a Member of this House and executive chair of the Resolution Foundation.

Steve Webb: I am Steve Webb, director of policy at the mutual insurer Royal London and, as I think of myself, the last but one Pensions Minister.

James Lloyd: I am James Lloyd, associate fellow of a public policy think tank called the Strategic Society Centre, and I have done thinking and writing on the topic of how we pay for an ageing population, social care and interaction with pensions for a number of years.

Tom Kibasi: I am Tom Kibasi; I am the director of the Institute for Public Policy Research. For today's discussion, it might also be worth mentioning that I led on the financial sustainability of health systems for

McKinsey for many years, working with the World Economic Forum, the OECD and a number of different national Governments.

The Chairman: Thank you very much. I will kick off with the first questions, which relate to funding. Do you think there is a case for reforming the current funding system for both health and social care? Furthermore, what acceptable and viable alternative models might there be? Is a “free at the point of use” national healthcare system sustainable in the long term? Who would like to start?

Lord Willetts: Shall I set the ball rolling very briefly? On the funding of the NHS I am very cautious, perhaps because of my experience in the past of having been a policy adviser in Margaret Thatcher’s policy unit, where health was one of my responsibilities. We did then look at co-payment, private insurance—all those conventional options. We did conclude that a nationwide risk pool to fund healthcare was a perfectly reasonable arrangement, and that the costs of moving from what we had to some other system were very high.

You also asked about social care, however. It is on social care where I would be much more radical. Interested as I am in a fair deal between the generations, it is social care where we have a real muddle on our hands. I was on the Cabinet Committee that considered Andrew Dilnot’s proposals, which of course have now been so watered down as to be barely happening. On social care, there is some scope for a combination of proper and distinctive public financing—perhaps doing as they did in Germany, with some national insurance element dedicated to covering the cost of social care—plus being explicit about private payment on top of that.

That would then open up a wider question as to what we offer pensioners. I would like to see a revised triple lock, which did not cover solely the pension and had some revised promise on the uprating of the pension, but included some commitment on the costs of social care. It would be a combination of a national insurance element plus private payment if you had significant assets on top. In summary, I would be cautious on NHS funding, and radical on social care funding.

Steve Webb: In terms of how we pay for social care, you hear two main arguments. One is that we should all be encouraged to save more; people have talked about a long-term care ISA, or something like that. I think that is ridiculous. I work for an insurance company, but I have always thought that social care is an insurance issue, because most of us will not face catastrophic care costs. The idea that somehow we should all try to put tens of thousands of pounds aside for the minority who end up spending tens of thousands seems ridiculous, and will not happen.

If you want it to be insurance, lots of countries do it through social insurance. I do not sense there is any appetite in the Treasury to go down that road; one could call for it, but it will not happen. The question then is: how do you encourage people to insure, when insurance companies are not willing to offer insurance products? That is partly what the Dilnot report was trying to do. It was trying to say, “We will cap liabilities here”, and then the insurance industry says, “Right, we know what we are on the hook for. It is up to this amount. The state will take the tail, and the

state is quite good at that kind of thing, because it is still there in a generation”, and then you would have had products.

We can argue about the detail, but I talked to Andrew Dilnot recently about this, and he said, “Catastrophic long-term care cost is the last unpooled risk”. We pool our car insurance, our home insurance, the risk of unemployment and growing old. This is the one risk that falls catastrophically on a minority of individuals. One of the problems with insuring is that people do not know. They have this slight sense of, “If I need care, the council will provide”. They have this vague sense that they will not be on the street, so what is it you are insuring? You are insuring quality and choice, I think. The council will provide something, but it will be in the worst place in the borough, probably, and barely cover the cost of that. We need to facilitate insurance; we need to be clear what we are insuring; and, critically—this is the answer to all your questions—we need to deal with prevention and early intervention.

I will make one further point, and then I will shut up. The beauty of the Dilnot scheme was not what happens at the end, when you have racked up £70,000-odd worth of care costs. It is what happens on day one, when you open your Dilnot account. The day you open your Dilnot account, you send a signal to the local authority, which hitherto does not know you exist, to say, “I have started to incur significant care costs. I am a person on a journey”.

If local authorities were able to intervene at the start of that journey to help you stay in your own home, and all the things that we know help to reduce the catastrophic costs at the end, society would save a huge amount and families would benefit. However, we do not have that trigger. We should start the Dilnot process and get that clock running today, even if the Government do not want to pay at the end, so we get much better information about the people coming into the system, and we can act early to help prevent costs later.

James Lloyd: We have moved very quickly, have we not, into the detail of what is a fair partnership to pay for social care in England? I presume this Committee is covering the whole of the UK, but I will focus on England nevertheless. Obviously, in broad terms, social care is a special case, because there is now total recognition, politically and in terms of local authorities, care providers and so forth, that we are absolutely at the cliff edge. We simply cannot go on as we are. There is also widespread recognition that the underfunding of the local authority social care system is now resulting in clear and explicit, and indeed higher, costs for the NHS.

If you look across the social care system, what is also clear is that in a way there are no efficiencies left. There is not much scope to do things better, so to speak. The demand, or the expenditure required of local authorities for social care, is reduced. The care fees that providers charge to local authorities have been pushed down as far as they will go, and are now reaching points that naturally incur implications for people receiving care. There has been a confluence of other factors, which are putting pressures on the care system, not least the national living wage, and the implications for a very low-paid care workforce.

On the first question of how we fund care and fund a sustainable system—the question of whether we can do things better within the current system—I would say all the low-hanging fruit, and indeed the fruit above those fruit, have been picked. We are left with some very difficult choices. Typically, you might then think, “Where else within public spending can we find this money? Can we reallocate funding from the NHS or from other areas of, for example, benefit spending? Is there a case for targeting public expenditure on the state pension in a different way, so that that would release money to transfer into the social care system?”.

Obviously, we have already had mentioned the possibility of looking again at the triple lock and perhaps the uprating process that is attached to that. In addition, we can get into discussions of fiscal measures associated not with reallocating public spending but with increasing the tax take, and what might be appropriate new specific taxes for social care. For years, we were told that tax rises for social care were not possible, but of course last year the Government announced the social care precept, which gives local authorities the option to raise council tax specifically for the purposes of social care.

There are also other options that could be considered in the context of tax rises and fiscal discussion. Inevitably, having participated in this discussion for about 10 years now, at some point we will get to talking about the fact that the cohort that is coming through, which is putting such pressure on the social care system, displays a very high rate of home ownership, and unprecedentedly high levels of housing wealth. For the large part, this is completely untaxed. That might be a question the Committee wants to explore.

All that is completely separate from a different policy question, which is: what is the fair partnership between the individual and the state in paying for care? What should people expect from the state—from local authorities or from whatever arm of the state is going to support them in their care costs—and what should people have to pay for privately? This, again, is a question that has been explored over a number of years, and I can see people around this table who have participated in multiple commissions on this question.

The most recent attempt was, of course, the Dilnot Commission on Funding of Care and Support. The Government in 2014 adopted its recommendations, but then chose to delay implementation from 2016 in an announcement made in July 2015, despite having previously, in their manifesto, committed to implementing it in 2016. The Government said that the principal reasons for that were associated with the fiscal outlook, which obviously has become worse and more uncertain in light of the referendum vote this year. On top of that, there was no evidence of the insurance market coming forward with products that would sit alongside the Dilnot cap.

Where I would disagree slightly with the previous comments is that, having looked at the Dilnot proposals throughout their process of development, publication and adoption by the Government, I have never been convinced that they would lead to any kind of pre-funded insurance market. Indeed, I know of no insurance company that thinks they will

lead to a pre-funded insurance market. The reasons for that are complicated, and maybe something that the Committee would like to think about in another session. In very simple terms, the liability with which individuals are left under the Dilnot cap is uninsurable for a private sector insurance company.

Why is that? People's liability, when their meter starts and when they reach the cap are determined by individual local authorities' positions at some point in the future. Insurance companies cannot incorporate that uncertainty into the actuarial projections that they undertake. To put it another way, the insurance company cannot be sure when your meter, under the capped cost model, will start, and when it will finish. That is just one reason why the Dilnot proposals, specifically, would never unlock a pre-funded insurance market.

It is worth observing, around that issue, that there is no country in the world that has a functioning pre-funded insurance market in the way that we might expect to see one. The barriers to the development of an insurance market are many, and they exist on the demand side and the supply side. If you wanted to go through them we can, but they are long and detailed. I will stop there.

Q119 The Chairman: That has been put to us through other evidence and, Lord Willetts, you might wish to comment on that—although I hear you clearly say that in terms of funding for healthcare, after all the discussion and investigation, you came to the conclusion that the current tax-funded model for healthcare is the right model. The problem is that currently how much money healthcare gets varies, depending on what is affordable and how the Department of Health and the Treasury feel about it. How could that model work in a sustainable way, year on year, looking ahead to 2025, 2030 and beyond?

It has also been put to us that not an insurance model that is run by insurance companies, but a national insurance that pays towards social care, might be one way of going. That would include those who are claiming pensions paying towards it. Do any of you have a comment on that?

Lord Willetts: Ironically, that is historically how the system began, in the first part of the 20th century. It was national insurance for healthcare, and it was Beveridge who shifted it all around and shifted it to national insurance for pensions, with the NHS taken out of the social insurance model. We looked at all these options, and of course it is right to look at them again; maybe the arguments have changed. However, is a contributions requirement intended? Is it a contributory principle in that sense—you are entitled to healthcare if you or other members of your family have paid contributions for X year or in X circumstances?

I can see in the current mood of anxiety about migration that that has some advantages. On the other hand, you may find there are people who then are not entitled to care for whom you need to provide care. We have sometimes looked at trying to define rigorously whether you can have a more limited list of available publicly funded treatments, and say that you have to pay for treatments on top of that. By the time you have got to

tattoo removal and perhaps vasectomy reversal, you rapidly run out of these things that you are not willing to pay for. It becomes trivial. We were never able to crack it.

The short answer is, therefore, as part of the political process, people are choosing Governments who will decide how much they spend on healthcare. It is fascinating how we have all so rapidly moved to social care—both because that is so clearly in a much greater state of flux, and, as Steve said, it is the area where the pressures on healthcare look as if they could be relieved. I am sorry to be so cautious, but I never found a private health insurance model, a contributory model or a limited list model that seemed so manifestly superior to what we have. Governments have to decide how much they spend.

Tom Kibasi: I wonder if I could come in on that question of structure and how you look at different countries. An extraordinary thing has been achieved, which is that ministries of finance around the world have been utterly persuaded that you invest in education and you get a return, and that is a worthwhile investment, and the more you spend, the better it is for society. However, healthcare—you are doing this with the way you have asked the question from this Committee—is framed as a burden, something that is imposed on us and something that we should be seeking to minimise.

The short answer to your question, “Is the NHS sustainable?” is: it is as sustainable as you choose it to be. There is a conflation between financing on the one hand, which is whether you are putting in enough money compared with your expectations of what you want. That is one set of questions. A different question is whether you are doing it in as productive and efficient a way as you possibly could. Those two questions get conflated, and get a different answer. On sustainability alone, the answer is surely that it is as sustainable as you choose it to be.

This issue is not a uniquely British one. We look at this and say that it is somehow something to do with the NHS. The reality is that in all advanced countries, healthcare expenditure growth is growing, typically, at GDP growth plus two percentage points. This is an issue across different health systems.

I have always found it striking in these kinds of conversations that there are people who argue, “Does that mean we need to move away from our tax-funded system?”. If we are concerned about the level of expenditure that we have at the moment, and we are in the cheapest possible way of financing healthcare, it surely makes no logical sense to ask whether we should be moving away from that to private insurance, co-payments, any sort of health savings accounts, or any of those systems that are more expensive. In terms of how you start to think about the question, the first bit is to take away the question of whether we should be moving from the most efficient way of financing a system, and into a discussion about how you finance it at the correct level, which is a more important and difficult issue to debate.

There is also a unique thing that we have in Britain, compared with other countries, and there are two aspects to the debate that are quite interesting here and very different from elsewhere. One is that the debate

is utterly dominated by the supply side. It is all about how you fix the hospitals and how you fix primary care, and everyone has a point of view on clinical commissioning groups, or whatever it is. The reality is, however, that the 90% of the economy that is everything else drives the 10%. You need a discussion about that.

The second bit is that we do not talk about capital in the NHS, and the accumulated capital stock that we have, and take expenditure over a 30-year period, when if you look over a 30-year period, we are well behind other comparable countries. Let me leave it there, but that is a bit of framing that is quite important in this whole debate on the sustainability of the NHS.

Q120 Lord Willis of Knaresborough: What I found interesting about all your responses, particularly those from the two former politicians, is that despite the fact that all major political parties are committed to having an integrated health and social care system, you do not see that. You see the way forward as perpetuating a separately funded NHS, and separately funded, by some method, social care. I would like you perhaps to turn your brainpower to that question. If we had an integrated model, would they have to change?

Steve Webb: I certainly think integrating budgets is essential. I well recall visiting my local acute hospital and going on the elderly care ward, and all the patients had red, amber and green stickers against their name. Most had green stickers, and I said, "What does that mean?" and they said, "Ready to be discharged, but there is nowhere for them to go".

In my view, it is essential that we have joined-up budgets, which gets you part of the way there. My point about setting the Dilnot clock running is precisely that. If you have combined health and social care budgets, spending some money early on someone who is showing the first signs of needing care saves you bucketloads on health and social care later. I absolutely would say that.

Just coming back to this question about whether we just put national insurance up or hypothecate, social care funding is an area that, as we all know, is littered with commissions and reviews that got nowhere. The sine qua non for what you come up with seems to be, "Fine, if you want to write a report that says 'Put national insurance up', it will go on the shelf with all the others". I would suggest that you find something that the Treasury will buy into.

What will the Treasury buy into? It would be keen on more people self-funding, to take the pressure off local authorities. If you can find a mechanism that will encourage the people who can afford to do so to self-fund, the Treasury will be in listening mode. The one thing we miss in these discussions is that we always talk about care, and I think we should talk about inheritance. That is what a lot of people care about.

I am in my 50s, along with my brother. My parents are in their 80s. My brother came to me recently and said, "We need to think about the family home. If my dad goes into care, it doesn't matter, because my mum is still in the house; it does not count. If my mum goes into care as the last

person, the family home is on the hook. What can we do to protect the value of the family home?"

If we talk to people about insuring their inheritance, rather than talking to them about being old and infirm, which no one wants to think about, then you would have a product people could sell, and people would be motivated to buy it. That would take the pressure of local authorities, who could then concentrate on the people who really need it.

Q121 Baroness Redfern: To James, first, who mentioned prevention: I find prevention sometimes very difficult to measure. To put him on the spot a little, does he think that budgets from the acute sector should be transferred to health and social care, getting people out of those expensive beds? Would local authorities working with intermediate care be better for the patient and save money at the same time?

James Lloyd: Where it could happen, it should, clearly. The Better Care Fund that the Government have set up has been put in place to make that happen and provide the upfront funding for the health system and local authorities to be able to do that. In a way, this relates back to Lord Willis's question on integration. Integrated care, as we all know, has been around as a concept for 50 years. It means different things to different people, but I generally take it to mean the integration of health and care funding streams, assessments and/or delivery.

What has been interesting to observe over the last five years is that the interest in integrated care models, and real money coming through the system to achieve integrated care, is now happening in a way that it was not, despite decades of talk, previously. This poses a challenge for related debates on how we finance health and social care, particularly social care. For years, I have participated in discussions of how we finance and fund social care as a society.

However, if we genuinely think that the future is to bring the two much closer together, we clearly, in a way, have to pause and think, "How will the decision that we make around funding what we think of as social care affect our ability to integrate health and social care, and the different models of integrated care?" To put this in practical terms, if you were to implement the capped cost model proposed by the Dilnot commission or some other similar model such as the Wanless model, which rely on local authority assessments of your social care needs—personal care needs in the home for example—

Baroness Redfern: Do you agree that there is more money going into the acute sector that should be diverted to—

James Lloyd: Yes, but just to make this point, it does—

Baroness Redfern: Tom is shaking his head.

James Lloyd: Okay, I will let him answer.

Tom Kibasi: We have to be very careful with this, because a mythology is emerging that we somehow have far too many hospital beds and that we should just be pushing money over to other parts of the health and care system. That is not quite true. If you look at the number of beds that we have, we have a very low number of beds compared with many other

comparable countries. With growing demand, the reality is it is a question of how we keep our bed base stable, rather than having to grow it with growing demand.

Regarding this idea that we can just rip all this money out of the acute sector, I have not been to any hospitals where there is dust gathering and there is not enough to do.

Baroness Redfern: They were not my words.

Tom Kibasi: I think it is worth just being clear about that. The principal problem with integrated care, and the real reason why it does not happen, is that it is not as simple as trying to integrate the NHS with social care. As a one-to-one interface, that ought to be relatively straightforward. The problem is the byzantine complexity of the NHS system makes it next to impossible to integrate health and social care, because the health side is far too complicated and completely disjointed.

To answer that question of integration between health and social care, the first step has to be a dramatic simplification on the NHS side. One of the big problems with the Health and Social Care Act 2012—one of the many problems—was the explosion in bureaucracy and complexity within the NHS, which makes actual integration next to impossible. For the local authorities, the first question is, “Who am I integrating with about what?”. In a world that is incredibly complicated and messy, at the moment it is simply not possible to give a serious answer to that question.

The other bit that I would add to this is that there is a little misdirection going on here. If you look at the breakdown in what needs to happen to meet the productivity requirements within the health service, the vast majority is people getting more efficient in their existing models, in their existing organisations, and reducing the variation between them. It is a classic response to say, “I will point at the boundary and this issue that no one is really accountable for; I will apply 100% of the blame on to that specific area”. Integration is really important—I am not saying it is not—but it is also a bit of misdirection by everyone pointing at the thing for which no one is really responsible.

The Chairman: Some of the answers have gone on to your questions. Do you want to pursue it further?

Baroness Redfern: They have, yes. No, it was just about the challenges facing the implementation of health and social care.

Q122 **Baroness Blackstone:** Can I pursue this just a little further? I just wonder if you are going to get the genuine integration that you are talking about, in funding, delivery and the provision of services. Do we not have to devolve and have a proper system of devolution, so that we get away from a top-down NHS and create regional and local systems of NHS, where you can much more easily integrate those systems properly?

Tom Kibasi: Except in theory, that is what we have done. We have had a fragmentation of commissioning: it has gone from 152 commissioners in 2010 to over 200 commissioners now. If anything, we have over-devolved, in the sense that it has been more fragmented down to a local level. The other thing I would just say is that, if you take a step back

and think about what activities are involved in health and social care, and where there is a crossover, we are talking about a relatively small number of people who are receiving multiple services in their own home that could be consolidated.

It is where the social worker is coming in one day, and the COPD or cardiac nurse is coming in the next. Could those activities be consolidated? In terms of the core expenditure on health—doing hip and knee replacements, cancer therapies, out-patient appointments, in-patient surgery, day-case surgery and GP appointments—the vast majority of what is going on in the health service has nothing to do with social care. Yes, at the boundaries there are some ways that you could create additional value, by keeping people in their homes better and for longer.

I would argue, however, that financial integration makes a very small difference, and the big difference that you get from integration is an improvement in quality of care and experience. That is valuable and we should do it, but it is a red herring to focus too much of the sustainability conversation on the integration between health and social care. The economics just do not stack up on that.

Baroness Blackstone: Can I just question that? I think you slightly misunderstood what I was asking. I was not suggesting that within the NHS there should be more devolution to yet more commissioners and yet more bureaucracy. I was suggesting something much more radical, along the Scandinavian lines, where there should be local health provision, done through local or regional authorities, whichever is the best. Can I just also comment on the other thing you said—that there are all these different forms of treatment in the NHS that have nothing to do with social care? You have to set that against the fact that a very high proportion of people being treated by the NHS are elderly, and they need a mixture of social care and health provision.

Tom Kibasi: I absolutely agree, which is why I say it is about quality. On the Scandinavian point, however, because it is a really important example, I worked with the Government of Denmark for many years. They made me a Danish healthcare ambassador as a result of my association with them for many years. I am not sure what that consisted of, but they did that because I worked with their Ministry of Finance, their Health Minister and Health Ministry.

The reality was that when they pushed the financing of the hospital over to the local municipalities, they found that instead of prompting the municipality to solve the social care issue, all it did was push taxes up at a local level. If anything, they would argue that their experience was that it reduced hospital efficiency, because the local hospital could make a direct emotional appeal to local people, saying, “Put the taxes up because otherwise services will be compromised”. In fact, it did not have the improvement on integration that it was expected to deliver, and they were largely quite disappointed by the impact of that act of devolution.

In Denmark, though, they consolidated from 21 health regions down to five, while we went from 152 up to 211. Norway went from 14 down to one; Alberta in Canada went from 13 down to one. Every other country in

the world has gone in the opposite direction from us by consolidating, and we have gone to fragmenting and making it much more complicated.

Q123 Lord Warner: Can we come back to this issue of integrating the funding, which Steve Webb raised? I should declare my interest as a member of the Dilnot commission. The Dilnot commission was a real live test case: we tried to persuade the insurance industry to produce products for insuring social care, if we capped the risk. It was a total failure; they showed no interest whatsoever in that, so we know about that bit. We tried to persuade the Government to do the right and proper thing about publicly funded social care, and failed again. We have some real historical evidence about trying to do those things.

You were saying, Steve, that you could envisage integration of budgets. I am struggling with how you do this. How are you going to integrate budgets that are largely budgets for publicly funded social care, on a means-tested basis, with the NHS budgets? Let us take Manchester. How is this going to happen in Manchester? How will you integrate those budgets in real terms?

Steve Webb: If you take the analogy with the pension system that we have now, you have a role for the state and a role for the individual. The state is providing a baseline level of provision, but most people would not be satisfied with the baseline level of provision, so we have auto-enrolment to workplace pensions, which enables most people to do more and get something better in retirement. We all expect acute healthcare to be there and not be means tested, et cetera. We expect a basic level of social care to be there for the destitute and so forth.

However, we might also want individuals who want something better, who want choice of provision, and maybe want to access it earlier than the state will allow them to, to self-provide. The state is providing the safety net, which is pretty comprehensive for acute healthcare, but the private market is buying you quality and choice. That is analogous to what we have in pensions. We can bring in another pot of money here, which is one that we have not mentioned so far, which is attendance allowance. Were I still trying to get elected, I would not say this, but attendance allowance is a complete nonsense, as you know.

The Chairman: Is that honesty on the part of a politician?

Steve Webb: It is the honesty of an ex-politician. I think of an elderly member of my family who got a few thousand quid a year of attendance allowance and did not spend anything on care. He qualified because he was not very well, but he was not spending anything on care. That was pure transfer. It is ridiculous that the DWP has that funding stream when local authorities and health could do a lot more with it. That might be a useful place to find some money that the Treasury might be interested in.

On your point about the insurance sector not being willing to come up with products, it is because they did not believe you, and they were right. You said, "We will do this thing, cap this thing, come up with some products", and they said, without moving their lips, "We do not believe you". You got the law through Parliament, and it still has not happened,

so they were right. Do it, implement it, and the products will follow, but they do not trust you.

Lord Warner: They do not trust George Osborne, rather than—

Steve Webb: Sorry. Yes, “you” corporately, my Lord.

Q124 **Bishop of Carlisle:** Could I put a question to you, Lord Willetts about generational equity? You mentioned that earlier, and it is obviously something you feel strongly about and it is important. How do we begin to ensure that in paying for health and social care?

Lord Willetts: The health service is disproportionately used by older people, and so be it: that is understandable and natural. It is social care where the issues are most explicit, and where we will either have to have higher taxes to pay for it, or draw on money that would otherwise pass on to children as inheritance. People want to discharge their obligation to the younger generation individually, by their own inheritance pot being passed on, but that is not the only way we should do it.

I personally think that the accumulated wealth of the baby boomers is now so substantial, in housing equity and other forms, that it is reasonable to use that to help fund social care. I, like Lord Warner, have observed over decades attempts at creating insurance products in this area. There were glimmerings: I think Norwich Union had one for a time, and then it pulled out of the market. It has proved very difficult.

I would look instead at easier ways in which housing equity can be used as a financing model for social care. It might even be that this is a role for Government in providing some kind of wider scheme, because that seems a way in which you would harness the wealth that this generation has built up.

Bishop of Carlisle: Thank you. Is that something you feel that we as a Committee ought to be pursuing in what we are suggesting here?

Lord Willetts: It is for the Committee to decide, but it would be a very useful line of inquiry, because this stock of housing wealth is very considerable, and so far different schemes for housing equity withdrawal and mortgage schemes have had relatively modest effect. Whereas I am a pessimist about ever getting an insurance model going for social care, I am more of an optimist about accessing housing wealth if the right kind of model can be constructed.

There is a role for government in helping to promote that. There is a big issue of trust, and people not knowing what terms they will get from mortgage providers or other equity providers.

Q125 **Lord Willis of Knaresborough:** One of the biggest issues this Committee is facing is not simply how can you get sufficient resources to meet sustainability over the next 10-15 years, but, given the variations that there may well be in economic activity, how do we ensure that that is consistent and that you can get funding certainty? Providers want more than anything else to know that there will be funding certainty, particularly for manpower, over a significant period.

On pensions, Steve, you were able to deal with a very tricky issue and, by

creating the triple lock in terms of pension policy, were able to get some certainty, which then encouraged, for instance, the new comprehensive pension policy. I wondered if you could transfer your mind to the NHS and say whether that same approach is possible with the NHS and with social care funding. Irrespective of where the money comes from, could you put those mechanisms in to create certainty over a period of time?

Steve Webb: You certainly hear the plea for policy certainty in the pensions world all the time, particularly with regard to tax relief, where every six months we get speculation about change. Pensions and health are long-term businesses: how can you have policy certainty? It is funny that in pensions, commissions seem to have worked, and in long-term care they seem to have failed, for various reasons. I have asked myself repeatedly why. The Turner commission, which led to auto-enrolment and so on, was a triumph, in my view. What was it that it did that the royal commission did not do—that Andrew, Lord Lipsey, Lord Warner and their colleagues did not? Why did that not fly?

The thing about getting long-term stability of policy in pensions was that there was something in it for everyone. If I think about automatic enrolment, the trade unions were happy because they were getting mass membership of lower-paid workers. The CBI liked it because most of its members were already paying in and were competing with smaller firms who were not. The Treasury did not like paying tax relief, but was potentially saving itself long-term costs, because if we all retire poor, the state picks it up.

You saw all the different players, and there was something for everybody. Auto-enrolment was a dirty great compromise: everyone had to give something, but everyone got something. Whatever you come up with on your Committee, if it is just going to the Treasury for money, you are wasting your time. However, if the Treasury can see something in this, you have a chance of buy-in from the Treasury and of something happening. You need something that would encourage more self-provision: quality provision for those who cannot, but enabling and encouraging people who could provide for themselves to do so.

Once it has happened, the momentum keeps it going and gives you a chance of policy stability, but until you can get something where there is something for all the parties, you will just have another initiative, another report and not get anywhere. Give each party something to gain out of this, and build people to advocate for your package: "Local government likes it because of this; the NHS likes it because of this; the Treasury likes it because of that". There has to be something for everyone in it.

Lord Willis of Knaresborough: David Willetts, you seemed to indicate in your introductory remarks that there was a way of linking the triple lock on pensions, with this issue of long-term care, at least, and to be able to do something in a combined way. Could you just perhaps expand on that?

Lord Willetts: My thinking there was that the triple lock is extraordinarily generous to pensioners. When I look at what is happening to the value of the benefits for working families, compared with what is happening to pension income through the triple lock, it is a conspicuous

example of unfairness between the generations. However, politics is politics, and you cannot expect our successors, as democratically elected politicians, to be kamikaze pilots.

Lord Willis of Knaresborough: I thought that was the rule now.

Lord Willetts: How do we make it rational for a politician to go into the next election without repeating the triple lock in its current form? We are looking into this at the intergenerational commission at Resolution that I am chairing: can you have some other kind of triple lock, where you reduce the extreme generosity on the pension income, and offer some other feature instead? I think the biggest anxiety is around social care, so you would offer something around social care, which would be Dilnot-type. We got quite close to implementing Dilnot. The problem with Dilnot was that there were some political anxieties that the cap would be exploited by opposition parties and would be thought to be very tough on older people.

We got quite close then. I was trying to think of a way in which a politician would say, "We may not quite be able to afford the full-blown three-part triple lock for the value of your pension. We will still give you something there—earnings or prices—but in addition this is our promise on social care". The promise on social care is that if your income is below a certain amount, you will get help. Who knows what the alignment of political forces is? But if you were trying to avoid making that pledge in the next manifesto in its current form, this might be an alternative pledge that was sellable. I am trying to think of a political model that would work.

Q126 **Lord Lipsey:** The trouble with that is most people think social care is free anyway, so the offer is not a very good one. In a similar vein, on the idea that you get quality if you pay for it yourself and not quality if you get local authority: these are usually the same homes. You might get a slightly smaller room if you are paid for by the council than if you are a private payer, but you get the same people looking after you. What you are paying for is a whacking great subsidy from the self-funders to the council, not improved quality. These are not as clearly attractive, politically and to individuals, as you perhaps think.

Lord Willetts: May I make a quick comment on that? I would be open to seeing the opinion survey evidence. However, one of the advantages, and one of the reasons why it should be possible to make progress on social care, is that people, I thought, contrary to Lord Lipsey, do understand that it is a mixed market. That is why there is a fair amount of private payment for it already. It is one of the reasons why I do not want to integrate it into the classic NHS model. There is already a fair amount of private spending, and people are very aware that they may have to use up resources to pay for it. We are halfway there.

Steve Webb: Can I just chip in very briefly? Something that astonishes me about this issue is that we are always told the over-85s are the fastest growing section of the population. You might imagine, pro rata, there would be a surge in the number of people in long-term care, but it is static. It has not gone up at all. Clearly access is being rationed more and more toughly. Another thing that self-funding buys you is earlier access.

The council is now setting the barrier right up here; it must be, because there are far more people potentially accessing the system, and yet no extra people getting into it.

The bar is being set higher, so, again, self-funding gets you in sooner. While it is clearly true that there are homes where there are those who are council-funded and self-funders, I think that is breaking down. We have people who had council contracts handing them back, and care homes now not taking local authority. That division is growing.

James Lloyd: I certainly like David's overall political strategy of saying, "Is there flexibility in future around the triple lock, if we take off the 2.5% guarantee but replace it with some other guarantee?" Having worked on social care policy, I suppose I can see many limitations to linking that guarantee to the social care system. There is no one social care system in England; there are 152. There is massive variation across local authority areas. People do not understand the social care system or the concept of needs assessments.

It is also very tricky, because, as Lord Lipsey has alluded to, if you are going to try to insert in there some improved partnership offer, such as a Dilnot model, around the balance between the state and the individual in paying for care, you are up against people's ignorance of the current system. As alluded to, most people think it is free. Any other model that we might come to will still be quite tricky for people to understand. The Government announced the cost-cap reforms, but it was never clear to me how many members of the public understood them.

If you wanted to think about what else might be the third component, or the new third component, of some sort of triple lock, you need to look across the full gamut of public spending on health and disability in the older population, and think, "What reaches far more people than the social care system? What is consistent, understandable, popular and navigable?" That is the attendance allowance system. I know that the attendance allowance system has its critics; we had some comments from Steve earlier.

However, it is far and away the most popular bit of public spending on social care and disability. It reaches significantly more people, and people understand it; it is consistent. Many people do not spend it on social care, because it is not for social care. It is to assist with the cost of living with a disability, and to take your quality of life up, in theory, to the level that somebody else would have if they did not have your level of disability. It strikes me that that, in some rebranded form, perhaps, could form the basis of a new triple lock.

That does, in a way, take you into another discussion that might be worth exploring, which is around the state pension and whether or not we have, if you like, a disability-linked component of the state pension, which effectively is what attendance allowance is, by another name.

Lord Bradley: With the new triple lock, would that be regardless of other income from other sources?

Lord Willetts: The short answer is that for the social care element, if that were the third part of the triple lock, I do not think it could be. You

would have to have some element of a Dilnot-style means test. You would be saying that if your income had fallen below a certain amount, at that point you would be helped. It could not be universal.

Lord Bradley: With pension freedom, would there be an incentive to reduce your pot to get into the new triple lock at an appropriate point to get access to better social care?

Steve Webb: That was an argument with the pension freedoms themselves under the current system. The trouble is, if you are 55 or 58 or 63 and you are not going to incur catastrophic care costs until you are 80-odd, are you going to blow your average?

Lord Bradley: That is the unknown factor.

Steve Webb: It is peripheral.

Tom Kibasi: The issue that we are getting into here with the discussion on the triple lock is that the true driver of the intergenerational inequity is wealth inequality rather than income inequality. That is the bigger element in all this: the extraordinary rise in house prices and the inability of young people to get on to the housing ladder. As we have the discussion, our pensions, from an international perspective, are not excessively generous. There are a lot of people for whom getting old meant growing poor. We should be a little more focused on where the real inequity is, and it feels to me that that is in wealth rather than in income.

We should be coming up with models that are more around releasing some of the accumulated wealth of that generation, rather than trying to unpick a triple lock that politically, with the differential voting rates between my generation and perhaps the generation of many of the people on this Committee, would be rather tricky. On the NHS side of funding, I am broadly supportive of what Frank Field has talked about regarding using the national insurance system. I would quibble with some of the details, but broadly that direction of travel, so that the NHS has a more guaranteed income, would be important.

On the stability point, it is not the total aggregate spending of the NHS that providers are worried about in terms of the settlement. What makes it very difficult for providers is not whether the NHS budget as a whole goes up year on year. It is the arbitrary nature of commissioning decisions. The more disaggregated the commissioning is, and the more you have a completely amateurish approach to commissioning, which is the system that was created by the gentleman amateur of GPs doing this, the more you have completely arbitrary decision-making. I am on the board of a mental health trust. Every year there is a huge fight about the total amount of expenditure, because of the arbitrary imposition of saying, "You have a block contract, so we thought we would cut it 5%". It is much more about how you have a rules-based system within NHS funding streams, and a bit less about the predictability of the aggregate spending figure. The big issue, as you heard evidence on earlier, is how, in total, the NHS funding evolves in a pattern that is less moving forward in jerks, where you artificially suppress it and then the case becomes overwhelming to address the suppression of expenditure. It lurches back up, and moving in those lurching cycles is something that Frank's proposal might go some way to addressing.

The Chairman: Lord Warner, your question might have been partly answered, but do you want to ask it?

Q127 **Lord Warner:** I do. I want to pursue this a bit more. I have been writing down bright ideas for cracking social care funding. We have on the list: attendance allowance, housing assets of the baby boomers, and I have written down whether auto-enrolment can be made to work for social care, and the Japanese Government's levy from a given age for social care. We are fishing around for sources, in a market where there is already a degree of public acceptance of meeting some of the costs if you can afford it. They all seem to require some kind of cap on catastrophic costs to go in that direction. That seems a given.

What about auto-enrolment? People have got used to it; can it deliver some social care money? What about the Government taking money off people from a given point in the age cycle to fund future social care?

Baroness Blackstone: Can I just add a question that relates to what Norman has just asked? We have been told by some other witnesses that introducing national insurance payments for pensioners, which is a form of government levy, to contribute towards social care costs and indeed health costs for the elderly might be a way through some of this.

Lord Willetts: It is a very peculiar feature of the current system that working pensioners are not paying employee national insurance. It is not a massive sum, but it would be an obvious way of tackling several problems and inequity in the current arrangements. It would be a source of some public funding that you could use. Lord Warner mentioned Japan; I was not aware of the Japan model, but something along these lines was done in Germany. You need an input of public funding; you need an explicit recognition that you will expect people to use some of their housing wealth.

You could imagine some rewards of larger amounts being passed on tax-free to heirs if the rest is made available for housing. You have a Dilnot-type structure, and you put all this within the framework of an updated triple lock, and you begin to see something. It is not neat but it incorporates several different factors, and you could have a deliverable proposition there.

Steve Webb: On levying national insurance, on the pension levy, one can see the anomaly, but the other bit of my brain is telling me we want people to work longer—we want to encourage not discourage. Just at the point when the Government are saying, "Voluntarily work beyond the state pension age", and all that, to then say, "But if you do, we'll take another 12% out of your pay", for me sends the wrong message.

You do not get a huge amount of money; you get some money, but just at the point where pension ages will be rising and rising. If you do put pension ages up to the late 60s, which is where we are heading, you will not get much money from NI on pensioners in their 70s anyway. On the politics relative to the revenue, that score seems completely wrong to me. I am not convinced by that. Auto-enrolment is a fantastic mechanism, and there are probably about seven things you might want to have in the queue to graft on to it.

Probably, if I did not work for my present employers, I would put life insurance first, because you can do it for 10 million people just like that, and it costs threepence-halfpenny. That would probably be the first thing I would do. Long-term care: you could, but you would have to be an awful lot clearer what on earth you were insuring. Okay, I now have cover, but what is this thing? I am 51; I might not need this thing until I am 87, so you are telling me that you will just take some more money out of my pay packet, and in 36 years' time I will get something.

I am absolutely convinced that what you have to do is play to my selfishness. I am a very selfish individual. I care about not losing my parents' home. I do not care about my care costs in 36 years' time; I want my share of my parents' home. If you ensure that, I will vote for you, if I could.

Lord Warner: What about starting taking the money at 60, not 40?

Tom Kibasi: I rather like this idea of an age-related levy that kicks in at a certain point in life, so long as it is a levy that applies to wealth rather than income. If it were just an additional tax, people would see it as an additional form of income tax if it were applied to income. However, you could say, "From 40 or 50"—I am not sure what the right point would be—"your assets over a certain sum will be taxed at 0.5% or 1%, and that will go into a fund to pay for social care".

I am not saying it would be easy, but compared with a vision of people saying, "Will I lose my whole home?", having to contribute a bit of the assets every year would be, in equity terms, far preferable, and it might just open up for the first time that discussion that we need to have as a country, which is about inequality not just being about income but about wealth, and it ties it to a very particular issue. It is one that is definitely worthy of being explored further.

On the anomaly of national insurance, I have to say I rather agree with David rather than with Steve. I would correct it, because it is a pot that you could access. The way that things are currently done seems pretty unfair. I do not think it would be vastly controversial, because the inequity of it is pretty blindingly obvious. I do not think there is a real disincentive. My dad has worked until he is 75, and he keeps promising my mum that he will retire this year. He has said that every other year for the last 10 years.

I do not think it will be a real disincentive for people to continue working. I do not think at the moment it factors very much into the conversation as to whether people continue to work or not. It feels like a modest and reasonable thing to do, which I do not think would be politically impossible. It might cause a bit of noise, but it would be very marginal. It would raise a very modest amount of money, but that is the way it goes—not a huge amount of money, not a huge amount of noise but probably something that you should do.

Steve Webb: If your Lordships remember the omnishambles budget of 2012, there was the granny tax. Do you remember what the granny tax was? It was simply not putting pensioner tax-free allowances up in line with very low inflation. There was an outrage: "The Granny Tax!" I remember being harangued in the streets about it. You are suggesting

that we can just dib 12% of the income of the working pensioners and get away with it.

Tom Kibasi: Were we to decide that we cannot do anything and that this is a portion of the population that do not need to contribute, and meanwhile there is a whole generation of people who are saying, "I do not have any job security, I cannot buy my own home and I cannot start a family because politicians do not have the guts to take simple, small measures", why not just give up and go home? I cannot comprehend how a small, modest change is something that we decide is politically impossible. In which case, why did we decide that we are in this discussion on public policy, full stop?

Lord Willetts: I would rather do that than get rid of the attendance allowance.

James Lloyd: When the issue of older people's housing wealth has come up in the debate over the last decade, inevitably we have discussed it generally in terms of taking the tax, hypothecated for social care or otherwise, at the point of a transaction. It is not saying to people that because they are retired and own their own home, which is worth more than £200,000, we will add a social care levy to their income. It would effectively put up income tax. I do not think that would be politically tenable, but when people die and pass it on they could pay an additional form of inheritance tax for social care.

That is why it has featured in debates so much. Of course, when homes are sold and people downsize and so forth, there may be scope for some sort of capital gains levy for social care there, for people in retirement.

The Chairman: Baroness Blackstone, we had better get to your golden question, because I know some people have to leave.

Q128 **Baroness Blackstone:** Can you each suggest a single change that the Committee could recommend that would help the sustainability of the National Health Service?

Lord Willetts: One thing we have not talked about, and which I care about, partly from my background as the Science Minister, is the difficulty of getting innovation into the NHS. It was deeply frustrating that people with smart ideas, when they wanted to get into a healthcare system, moved to Boston or to the west coast. The NHS is a slow, late adopter of innovation. It seems to be a management challenge: shifting to a new way of doing things is hard to organise.

Even with social care, I look at some of the extraordinary advances in technology, where they can literally track your pattern of electrical use. They can work out when you are turning on a particular device, and register that this person is turning on a kettle between 9.30am and 10am and she has not turned it on and it is 11am, just by monitoring the electricity supply. We need to use technology and embrace the capacity of innovation. We experimented, and one way of making it happen is a list of required innovations that healthcare providers are expected to introduce.

The Chairman: That was a good way of fudging the issue about funding.

Lord Willetts: It is not a bad answer. I am standing by it.

Steve Webb: I would start the Dilnot clock running now, not because we are worried about people spending £70,000-odd on care in 10 years' time, but because we need to know when people start having care needs. We need to intervene early. Prevention, prevention, prevention is the answer to all this stuff. We are obsessed with the glossy acute stuff, and it is on the telly all the time, but getting in early—early intervention and prevention—is the only way to have a sustainable health and social care system.

James Lloyd: I will not speak to the NHS but to the social care system. Where can savings be made? I will give you one idea. I would digitise the attendance allowance records for the entire country, and I would share that information with local authorities. Why would I do that? At present we have a couple of hundred thousand people in the social care system in England. There are well over 1 million who receive attendance allowance. At the moment, we take their information; we require them to complete a form and provide details of what conditions and what support they have.

Having obtained that useful really information that could be used particularly for preventive interventions, we apparently—the last time I checked—take those forms, put them on a shelf in Blackburn and leave them there. A very simple thing to do to make better use of the attendance allowance system, to significantly extract more value for it, would be to digitise those records. You would have to put in the relevant necessary data protection safeguards and so forth, but I think most people would be happy for their data to be shared in return for some money that they will get each week when they apply for attendance allowance.

You could hand that information to local authorities, so that we can stop finding out who receives AA only when they turn up at A&E, which tends to be the case for local authorities at the moment.

Tom Kibasi: On the financing question, I would move to a hypothecated NHS tax, by moving national insurance on the overall financing. In terms of the sustainability side of your question, which effectively is how you can slow the growth in demand, and how you can ensure you have the most efficient supply, I would pay for innovation, and use big data to change the equation in care.

The way you do that is to pay for best practice. That means you also have to stop paying for poor practice. We need a fundamental reinvention of the delivery model. We have had 1,000 years of hospitals and doctors' offices, and it is about time we changed that. We need to spend a huge amount to rebuild the infrastructure, particularly in primary and community care. Thirdly, we ought to invest in healthy cities and, as you do your report, I would encourage you to have a look at the *Better Health for London* report of the London Health Commission in 2014, which starts to look at how you can use cities to drive better health in the population.

You have to disentangle these two things: how you provide financing for the NHS, which I would say is moving to a more automatic basis by using NI on a hypothecated basis; and how you make it sustainable, which is lower rates of demand and more efficient supply. You should look at those things quite separately.

The Rt Hon Lord Willetts, The Rt Hon Steve Webb, Strategic Society Centre and Institute for Public Policy Research – Oral evidence (QQ 118-128)

The Chairman: Thank you very much for coming today to give evidence. You have been most helpful, and if you have any further material you would like us to have, please feel free to send it. Thank you.

Migration Advisory Committee, Health Education England and NHS Employers – Oral evidence (QQ 129-134)

Evidence Session No. 12

Heard in Public

Questions 129 - 134

Tuesday 1 November 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Turnberg; Lord Warner; and Lord Willis of Knaresborough.

Examination of witnesses

I: Professor Alan Manning, Member, Migration Advisory Committee; Professor Ian Cumming, Chief Executive, Health Education England; Professor Wendy Reid, Director of Education and Quality, Health Education England; and Danny Mortimer, Chief Executive, NHS Employers

Q129 The Chairman: Good morning. Thank you for coming today to give us evidence. We have a rather long morning today, with several evidence sessions, so we will try to keep the questions and answers brief and to the point, because there are a lot of issues we want to explore with you.

This session is being broadcast. Committee members will declare any particular interest that has not been declared before in a written statement. If you have a statement you want to make or say anything before we start the session, please do so. Otherwise, can you introduce yourselves?

Professor Alan Manning: I am Alan Manning. I am a member of the Migration Advisory Committee and a professor of economics at the LSE.

Professor Ian Cumming: Good morning. I am Ian Cumming. I am the chief executive of Health Education England, the body responsible for education, training and development of the current and future workforce of the NHS.

The Chairman: I do not know you at all, Wendy.

Professor Wendy Reid: Lord Patel, I am Wendy Reid. I am the medical director and director of education quality at Health Education England. By background, I am a gynaecologist.

The Chairman: Yes, I know Professor Reid because she is an obstetrician.

Danny Mortimer: Good morning. My name is Danny Mortimer. I am the chief executive of NHS Employers. We are the organisation that represents the NHS in England on workforce matters.

Q130 **The Chairman:** Thank you very much. Do any of you have any statements you want to make? No, so I will kick off. Obviously, you know that the workforce has become a major issue. This Committee is looking at the future sustainability of health and social care in England, where workforce planning for the future is the key issue. It is right, I think, to say that, hitherto, we have never got workforce planning right, so we are relying on you to tell us what part you have been playing to get this right.

What work is being undertaken on the long-term planning over the next 15 to 20 years for the health and social care workforce, and how far ahead is the current planning looking? How much planning have you done in the headcount which will be required, particularly with all the rhetoric about the seven-day NHS, and what that would mean for future workforce planning? What other organisations, apart from you, are responsible for thinking about long-term planning for the health and social care workforce? We have heard evidence about not only the problems in healthcare workforce but serious problems in the social workforce. Who would like to start?

Professor Ian Cumming: If I may, I will disagree slightly with your statement that we have never got workforce planning right. The bit that we have never got right is the correlation between workforce planning and service planning. The workforce that our predecessors in strategic health authorities planned for is what has been produced. The challenge has been that the NHS has changed very quickly. As a result of Mid Staffordshire, for example, the NHS suddenly needed an extra 25,000 nurses in the space of two years. That is why we have a shortage of nurses at the moment. It is not because the numbers that were being planned for at the time were wrong but because there was recognised to be a serious issue with the quality of care being delivered, which required a large increase in nurses. If you require an extra nurse, I can produce one for you in four years.

The Chairman: So you mean that there is no joined-up thinking between the service providers and you?

Professor Ian Cumming: No. The joined-up thinking is there, but things happen which take the service in a direction that is perhaps unexpected, which could be the impact of new technology or a different way of providing healthcare. The plans many years ago assumed a much greater shift of delivery of healthcare from hospitals into the community than has actually happened. The workforce plans that our colleagues and predecessors in strategic health authorities put together were based on that higher level of care delivery in the community, and that pace has been much slower. Therefore, the workforce plans matched the service plans, but the way in which care is delivered has not run in line with the service strategy.

Danny Mortimer: I would echo the point that Ian has made, and would actually go slightly further on the planning problem that we have had. The

mismatch has been between the financial assumptions that the NHS has been forced to make and the service assumptions that it makes as a result, and then the workforce plans to support that.

My last job was as a director of strategy in an acute hospital in the Midlands and, within two years, we had closed 100 beds because that is what our commissioners had told us we would need to do—that they would manage demand and reduce demand for our services. Two years later, we had opened 150 of those beds, because actually the service plans had not been delivered. The financial assumptions that sat behind them totalled up, and workforce and service planning became a product of a figure at the bottom right-hand corner of the spreadsheet, but actually it was not realistic. I know that one thing that you are wrestling with is that longer-term financial settlement for the NHS as well as for our colleagues in social care. That uncertainty around that financial planning drives some perverse decisions around services which, in turn, has meant that we have made some mistakes in workforce planning as well.

Lord Kakkar: I declare my interest as chairman of University College London Partners. To be clear, to ensure appropriate long-term workforce planning, what needs to happen to the rest of the planning in the NHS?

Professor Ian Cumming: As Lord Patel has said, you need to make sure the service and workforce planning are properly joined up, so we need commissioners' intentions aligned with those who will be delivering the service, aligned with workforce planning. We also need to recognise that workforce planning has to be a very long-term strategy. The question that Lord Patel asked was about the next 15 to 20 years. Of course, medical students entering university this year will become consultants in about 13 to 15 years, so the plans we are making at the moment on the numbers entering medical school will not have an impact on the workforce until 2030-31.

We have produced a document called *Framework 15*, which takes a 15-year forward look, specifically designed around the medical workforce, to ask what we believe patients' needs will be in 15 years' time, and how we make sure that we are training doctors and other healthcare professionals to work in that timescale and not training people to work in the health service that we have today—because it will look very different.

Lord Kakkar: If you have that document, where does it go now and how does it influence what the medical schools are going to do with their intake from next year?

Professor Ian Cumming: It is available and is being shared with all our partners. It was produced last year. We have not produced paper copies of it, because it will be wrong, because nobody can accurately predict 15 years ahead. So we are updating it on an annual basis, reflecting changes that happen, and we share that with medical schools. As part of our responsibility, we fund the clinical placements for undergraduate medical students and, through doing that, we make sure that we have those clinical placements in the right areas where we need them to get the geographical spread. With the recent announcement by the Secretary of State of up to an extra 1,500 medical students, we are now working with colleagues in the Higher Education Funding Council, the DfE and the

Department of Health over how we place those to make sure that we produce the medical workforce we need for the future.

Lord Willis of Knaresborough: I declare an interest as a consultant working for Health Education England. It seems to me that we build in automatic inflexibility in that we commission on the basis of what we see now and we expect those people, in seven years in the case of a doctor or four years for a nurse, to deliver a care pattern which is going to change radically over that period of time. The one area that you have not spoken about, particularly with medics, is the fact that the royal colleges trump virtually everything you say, because they have responsibility for saying what these medical students actually do. Where are we going to get the flexibility into the system to deliver a much more proactive workforce, both of medics and nurses?

Professor Wendy Reid: We have tried to influence it through the young people leaving medical school, so we have radically changed the foundation programmes. For the first two years that doctors spend after graduating, 45% of them now are doing a psychiatry job, which was not happening before. In the old days, it was six months' medicine and six months' surgery and then you were out. Everyone does a general practice attachment and everyone has to do an emergency or acute medicine attachment, so we have already changed the mind-set of those young people leaving medical school. The questions we ask are about preparedness to work, and they are expecting to work for two years in a very different environment.

We work very closely with the colleges. For example, one of our biggest investments, and a sea change in surgery, will be the work that we will pilot from 2017-18 onwards on the new acute emergency general surgeon. It is a six-year, coherent programme. So the colleges are prepared to look at the needs of patients, and we can facilitate that.

The Chairman: Do you think that our model of five years at university, followed by two years of foundation, followed by a decade of training is an old model that requires thinking out of the box a little?

Professor Wendy Reid: Yes.

The Chairman: So why do we not do it?

Professor Wendy Reid: I think we are doing it. The Shape of Training, under David Greenaway, proposed a generalist approach. The way to do that is to engage the medical profession and deliver it collaboratively. If we try and force the medical profession—

The Chairman: Why do we need to engage with them? Why do we not just do it?

Professor Wendy Reid: Lord Patel, of all people, you know that collaboration is better. You are talking about sustainability. We want people to feel that this is real. Many of us have done pieces of work that sit around, over or on top of the medical profession—for example, the Hospital at Night project, which I led. What we want is coherent leadership from all branches of the medical profession. Therefore, things such as the Search project and the work we are doing with the Royal College of Physicians to create the chief resident model are the ways in

which you change it. It is not particularly glamorous, but it is good, thought-through work that is grounded on what patients need, and we sit in the middle of those conversations.

Baroness Redfern: First, I declare that I am a leader of a local authority. I think that you mentioned a shortage of 25,000 nurses, or the full-time equivalent of that.

Professor Ian Cumming: No, the increase in demand for the NHS in a two-year period was 25,000 over and above the normal demand. We train about 22,000 nurses a year. That big surge in demand for nurses is what we are now trying to catch up on, with the commissions coming through the system.

Baroness Redfern: Of those, how many fully trained nurses do you lose when they go on to be bank nurses?

Professor Ian Cumming: I do not have that figure. We know that there are approximately 550,000 nurses on the nursing register in England, of whom about 100,000 are not actively working in healthcare. Those are the figures of registered nurses in this country.

Baroness Redfern: I am just trying to look beneath those figures.

Baroness Blackstone: I want to talk about medical education and the issue of flexibility. Why has there been so little pressure on medical schools to provide more places for graduates? There are a huge number of graduates with science degrees wanting to study medicine, and their opportunities for getting on to a four-year course are very small because there are at least five to one applicants to places. What are you are doing in your discussions with universities to get more of them to introduce four-year courses? You would then get people out into the medical workforce a bit faster and save good graduates from the frustration of going back and starting right at the beginning.

Professor Ian Cumming: There are a number of issues here. Undoubtedly, some of the four-year courses for people with a first degree have been very popular and have produced very high-quality doctors at the end of them, because they are people who have a different perspective when starting the course. Certainly, as we get into allocating the additional 1,500 places, we will want to look at a range of models and not simply at how we increase the number of 18 year-olds entering medicine. As we move through that consultation, we expect to have a significant debate about that and potentially other areas, possibly including part-time medical degrees for people who are already working in a different profession in the healthcare system.

There are a number of challenges in making sure that the course can be completed in four years and that people get the necessary levels of exposure, but a number of the courses at the moment have demonstrated just how well that can be done.

The Chairman: But in the United States they do it in three years, and there is no evidence that their doctors are any worse.

Professor Ian Cumming: But we also have some challenges around accessing student loan funding. If you have accessed student loan funding

for a first undergraduate degree, you cannot then access it for a second undergraduate degree, so it makes the funding route somewhat trickier as well.

Q131 **Bishop of Carlisle:** You have already mentioned some of the factors that are driving the need for change in the workforce, such as the quality of care and the emphasis on care in the community, and a brief mention was made of technology. I wonder if we could develop this a bit and think about some of the other factors that are driving this need for change and some of the things that are making it very difficult to take those on board.

Professor Ian Cumming: In answering that question, perhaps I could deal with the point that Lord Patel asked about—workforce planning over the next 20 years. I have certainly started talking about producing the future workforce. The first thing that we have to remember is that the majority of people who will be working for the NHS in 20 years' time are in employment at the moment, so more than 50% of the people who we will have delivering care are actually our current employees. One mistake that we must not make is just to focus on the future workforce, and people coming through the education and training system. If we are to deliver transformation, we must focus on the people whom we currently employ, and I do not think we have given that enough attention. That is why perhaps the pace of change has not been as quick as we would like it to be. In looking at how we do that, we need to properly pick up issues around multi-disciplinary and multi-professional learning. The global drivers of change affecting how healthcare is delivered are the economic situation; the impact of the genomic revolution on the delivery of healthcare; the impact of informatics, which is going to be absolutely enormous on how healthcare is delivered over the next 15 to 20 years; and the demographic changes, both in the population and the workforce, as people are having to work potentially through into their 70s. I would argue that those are the four biggest drivers of change that we are going to see in that 20-year period. We need to make sure that we do not allow those to happen and then seek to respond and that we are actually proactive in preparing the workforce for each of those challenges.

The Chairman: Wait a minute. That is the completely wrong thinking, is it not? How a doctor whom you have trained, who comes out of a medical school, or a specialist whom you have trained, who comes out six years later, practises then bears no relation to how they might practise 20 years later; they pick up developments, as they occur.

Professor Ian Cumming: They do.

The Chairman: How can you plan for future developments, when you do not even know what they will be, for the workforce?

Professor Ian Cumming: We know what some of the changes are going to be. On the impact of genomics, for example, we have been ensuring that all undergraduate curricula for all healthcare professionals have a genomics component within them, and that is something that would not have happened otherwise. Yes, it is there in medicine, but it will not impact only on medicine—it will impact on all allied health professionals.

The other issue is how we prepare people to be more responsive to change. There is plenty of published evidence that shows that new technology and new ways of doing things take about 15 years to be in widespread use and adopted across the NHS. I would argue that we do not have 15 years, and that we need to increase the pace of that, which is where more of a focused emphasis on education and training for the current workforce will help to speed it up.

Bishop of Carlisle: Do you think people are taking this seriously enough at the moment?

Professor Ian Cumming: Yes, I do. However, when money is tight, sometimes, in some organisations, the education and training budget is seen as an area that can be easily diverted into spending on direct patient care. I completely understand that, but part of our responsibility in our organisation is to make sure that we keep that focus on education and training so that we can speed up the pace of delivering change and on doing things more efficiently.

Lord Warner: You are bound to be blown off course from time to time, in that timescale. Whose job is it to ensure that there are some contingency plans, if you do get blown off course, and whose job is it to ensure that the existing workforce do retrain, rather than it just being wishful from HEE?

Professor Ian Cumming: To answer the second part first, it is a joint responsibility. Continual professional development and lifelong learning are an individual's responsibility, an employer's responsibility, and our responsibility with others in producing the sort of NHS that we want and the people with the skills that we need. So it is a three-way responsibility.

To break that down into a specific example, we have been doing some work on dementia awareness and work on genomics awareness across the whole of the NHS and the current workforce. An individual maintaining their professional registration and the CPD that they require to do that is an individual's and an employer's responsibility, but they come together in those specific areas.

We are supposed to be more strategic when it comes to the current workforce, but we respond by providing educational material and programmes, if needed, on a big scale. Through our organisation, working with colleagues such as NHS Employers, NHS Improvement and NHS England, we have local workforce action boards that sit at a more local footprint level. They would help to determine the needs of the workforce in specific local geographies, and we fund them to be able to deliver some of those activities on a more local footprint.

Overall, the responsibility for setting our mandate sits with the Department of Health, which would hold us to account for delivery against that mandate, which would include regular monitoring against those areas.

Lord Warner: Where are the contingencies? You cannot possibly believe your own plan for 15 years ahead, as you are bound to be blown off course. Whose job is it to deal with that? Is it yours, or is it somebody else's?

Professor Ian Cumming: It is our role to ensure that the NHS has the workforce that it needs for the future. The challenge, of course, that we are dealing with at the moment is the change in the system. The last ever commissions made by Health Education England for nurses and AHPs have now started at universities, with one or small exceptions. From next year, Health Education England will not commission any undergraduate places, because the funding transfers to the Student Loans Company and universities will be marketing their own courses and programmes. Our role will change significantly from being a direct commissioner to an organisation that has responsibility for market management and market intervention when our intelligence suggests that we may be short of podiatrists or nurses or whatever it may be.

Professor Wendy Reid: I will give a very specific example of the sort of just-in-time contingency planning. We are aware of the welcome focus on mental health; there is a real lack of perinatal psychiatrists, so we have agreed the NHS England funding with the college and have found 10 psychiatrists who are willing to be credentialed and skilled up in perinatal mental health. They will be out in the system far earlier than if we had started a learning programme to train them from the beginning. So we can respond, and indeed have responded, to specific service needs with collaboration across all parties.

Lord Mawhinney: I go back to Baroness Blackstone's question about training the 1,500 new students and the possibility of graduates. Given that Professor Reid is here, I should admit to having taught in the Royal Free Hospital School of Medicine a number of years ago.

Professor Wendy Reid: I remember it well, Lord Mawhinney.

Lord Mawhinney: When you went to the Government and said, "You are restraining our ability to produce better doctors because you will not allow medical students access to loan funding a second time around", what did the Government say?

Professor Ian Cumming: We have not specifically had that debate with the Government. The issue of the 1,500 medical students came about as a result of being asked a specific question: if England is to be self-sufficient in the production of medical students, how many do Health Education England believe we need? Currently, we have a gap between medical school output and postgraduate training input of about 500. Predominantly, that falls in general practice, where we have a gap this year of about 250, plus in psychiatry and one or two others. We currently import about 1,000 doctors a year from other countries into postgraduate training. That is where the 1,500 came from.

The Chairman: But the first part of the question was important. If nobody has a conversation with the Student Loans Company about graduates going into medicine and getting a loan for the second degree, it is never going to happen.

Professor Ian Cumming: Certainly, that is something we would be interested in exploring—the ability for people to take out a greater student loan. But we also have to recognise that the level of debt that an individual student would then incur would be very large indeed.

Lord Kakkar: I would add a further interest, as Professor Reid has mentioned it. I was a member of the Greenaway review panel and, until a few weeks ago, a member of the General Medical Council. What relationship does HEE have with the regulators, and how could the regulators develop in future to ensure that the flexibility that Lord Patel mentioned could be achieved in the adaptation of the workforce?

Professor Ian Cumming: We have a very close working relationship with all the regulators, particularly the GMC because we deliver postgraduate medical training that is regulated by the GMC and we undertake a number of joint inspections and joint accreditation of postgraduate medical education training. On undergraduates, three parties are involved in somebody becoming a doctor. There is the medical school itself, which is responsible for delivering the education, academic standards and awarding the degree. There is the GMC, which is responsible for patient safety—that the doctor who is going on to the medical register at the end of their degree is safe to do so. Then there is our role, which can best be described as: are we producing people who are fit to work in our NHS of the future, because we know that 95% of our graduates are going to work predominantly full-time in the NHS? We are responsible for the workforce of the NHS and making sure they have the skills they need, the universities for the academic component and the GMC for patient safety.

Q132 **Lord Kakkar:** I turn to the question of the United Kingdom leaving the European Union, focusing on two things. What kind of planning has taken place with regard to the potential shortfalls that might occur in a very short period of time in the health and social care workforce, with that particular move? What consideration is being taken in recruiting from non-EU countries or, indeed, as you have alluded to, the development of home-grown candidates?

Danny Mortimer: Both the Department of Health and the arm's-length bodies, Health Education England and others, are pulling together processes that take forward the planning that you described. For ourselves, as employers, we have convened a coalition across health and social care, with statutory and non-statutory organisations, charities and others, trade unions included. That coalition is about 31 strong, and working together to understand the implications across health and social care, across the 2 million or so people who work across health and social care.

Our initial analysis suggests three things. First, we accept that there is much more that we can do domestically. The organisations we represent, particularly in the NHS, are probably the largest employers in any single community or part of the country, and there is clearly much more that we can do to provide opportunities, particularly to young people, to work in our services.

Secondly, those 150,000 staff who are EU nationals working in the NHS and in social care need indefinite leave to remain. There is no way that the NHS or our colleagues in social care could provide sustainable services without the input of that 6% or 7% of our workforce. There is geographical variation in that, so it is 10% or 15% of the workforce in

London and it is less in other parts of the country, but that is essential to us.

Thirdly, as employers, along with trade unions and others, we want to see a system for managing migration policy that is flexible and responsive to skills shortages. We have touched in the discussion this morning on the need for contingency, and some contingency will be needed there. What that cannot be, we accept, is the “get out of jail free” card that the Migration Advisory Committee has rightly criticised us for playing in this last few years because we have not planned our services properly or planned our workforce properly. We need sufficient flexibility, as do other sectors of the economy—we accept that entirely. We need to see a more thoughtful process on migration, which does not necessarily just look at salary as a measure of value and contribution to the economy, which present migration policy does at times outside the EU, but looks at social benefit and contribution to the health and wealth of the country.

Professor Alan Manning: I would make a few points. First, the share of EEA workers in health and social care is lower than the national average, so this is not actually a sector which is hugely exposed. Health and social care disproportionately employ non-EEA nationals currently, many of whom become British citizens but were not born here.

It is also important to distinguish between the stock and the flow. A lot of talk is about whether people already here are going to be asked to leave, and there is uncertainty and anxiety around that. The mood music is that restricting future inflow is more where things will happen. Even in that case, as the inflow gets restricted, probably the outflow will go down, so actually you end up with a larger stock. One should not exaggerate the consequences for health and social care of further restrictions on the EEA. It is hard to plan for, because there is uncertainty at the moment.

When we did the nurses review six months ago, we found that quite a lot of NHS employers very much preferred non-EEA nurses over EEA nurses. They had experimented with employing Spanish nurses, but they found that, because they had free movement, they could move from one trust to another, and the salary differentials between here and Spain are much smaller, so they tended to go home. To a non-EEA nurse from India or the Philippines we are offering them a lot more money than they could make at home, and they do not have freedom of movement within the UK, so a trust that has paid the cost to hire them gets to keep them and gets the return from them. That is currently the situation.

The Chairman: So they are bound workers, are they?

Professor Alan Manning: I think that is a slightly emotive phrase. They do not have freedom of movement—

The Chairman: That is bondage, is it not?

Professor Alan Manning: It is a form of it, yes. In all countries, typically, migrant workers have fewer rights to change employers than other workers.

The Chairman: Yet we need them. They fulfil our need, so we have them in bondage. Is that what you are saying?

Professor Alan Manning: No. I think that is a slight exaggeration. We are also offering them, in many cases, a higher standard of living than they could have. Hopefully, there is mutual advantage in this. They are free to move if they can find another employer to sponsor them, so they are free in that sense. But it is a practical matter, and the evidence suggests that they are much more likely to stay with the employer who initially sponsored them.

Professor Ian Cumming: From our perspective, we believe that, as the fifth-largest economy in the world, we have a moral duty to produce the healthcare workforce that we require for our National Health Service, and we should not be reliant on recruiting from other countries. That is absolutely not the same as saying that we do not welcome the opportunity for people from other countries to come and learn here and work with us. In the same way, we strongly encourage, through the Global Health Exchange, which is part of our own organisation, people who have trained in this country to go and spend some time overseas to learn a different skill set and to have experience with different pathologies. We strongly encourage and welcome that flexibility, but it has to be from a starting point that we believe that we are training enough.

There are 15% more nurses entering training this year than three years ago, and we have the 1,500 extra junior doctors starting. But we also have to recognise, as Danny has touched on, that many of the people who are delivering hands-on care are at the less highly qualified level—the healthcare support workforce. So it is about how we make sure that we attract people from our own country into those jobs, in the health and care sector. Some of the initiatives, such as allowing people to train from nurse associate through to registered nurse, which Lord Willis will be familiar with, while working for us—giving people a different training route—will encourage more people to pick up on some of the areas where, in future, the same supply of people into those caring roles may not be available.

Baroness Blackstone: What Alan was saying is all very well, but you have to look also at the specialist end of the NHS. At the hospital that I chair, 25% of its medical staff are EU nationals, and they come because they want to come to an institution that is doing high-end research. They are the brightest and the best, and they are from European countries. If we were to cut off that kind of mobility, we would certainly be losing out in the quality of our medical and indeed our nursing workforce.

Danny Mortimer: We could not agree more. Clearly, there is a very important aspect of healthcare in this country, particularly related to research and academia, which is part of a global market. We want the very best of our people to be able to go and practise and learn abroad and colleagues from across the world to come and practise in this country, so that there is mutual exchange of benefit. There is a real risk that we, unintentionally perhaps, might lose some of that. But you are right that there is a complexity in different areas of our workforce, in its interface with the global market.

Baroness Blackstone: You understand that, but do the Government?

Danny Mortimer: I think they do. Clearly, there is a huge reset of policy following the referendum result, but there is an understanding of that. We are all, clearly, awaiting the outcome of the Brexit discussions and what the new settlement will be in migration policy. As the professor touched on, there is uncertainty in this period, both for the people who are here already and for people who may be thinking about coming and working in our institutions in future. What we all want is a reasonable end to that uncertainty.

Q133 **Lord Willis of Knaresborough:** What we are trying to do here, rightly, is to look ahead to roughly 2030. The fundamental question for all of you is whether you feel that, given the current state of our policies, we will have a sufficient workforce in 2030 to meet the demographic and other needs that you identified earlier. I need just a very quick yes or no.

Professor Ian Cumming: Yes, with caveats.

Lord Willis of Knaresborough: Let us explore a caveat. I will concentrate mostly on nursing and the care workforce. Despite all the conversation that has gone on in the Committee this morning, virtually no mention has been made of this huge workforce. The majority of the people working within the NHS are nurses, allied professionals and care workers. Yet in nursing, we see a move to the DfE commissioning them through the university and the UCAS system and a new move to employers commissioning them through the apprenticeship levy and grants. HEE has no control over those, because employers from now, provided they can get them on to the register, can actually have all their nurses going through an employment route—or, in fact, universities can recruit independently. Given that scenario, how can we make any clear prediction about a workforce in 2030?

Professor Ian Cumming: That was one of my caveats. We need to look at the impact of the Student Loans Company moving into the market, as that starts to play out. Certainly, there are no indications at the moment that we have picked up that any universities intend significantly to reduce the number of nursing places for next year. In fact, a number of universities are talking about significantly increasing them. Overall, we have no evidence for next year that the number of places will be reduced. Of course, what we do not know about is the impact on applications, because those are still working through the process at the moment.

What we have done—as you will be familiar with, Lord Willis—is to build alternate routes to nursing. One of those that we are exploring is, effectively, the apprentice route. We do not want to move away from, or dilute, the degree-level registered nurse qualification, but we believe that there are different ways that people may be able to gain that degree. Entering as a healthcare support worker, completing a care certificate, which we introduced about 18 months ago, as a standard assessment of competencies for a healthcare support worker, progressing on to a nursing associate training programme, which will last about two years—we have just announced the first 2,000 places on those programmes—and then continuing from that to being a nurse, while working and studying at the same time, we believe would open up an alternate route. That could

access the apprentice levy and build a separate pipeline, in addition to the degree-level programme that people will continue to follow.

As to how we deal with any potential market challenges—for example, if somebody does decide to reduce the number of nurses—we are retaining clinical placement funding for nurses and AHPs. We are consulting on how to do this; we intend to work with the NHS to use that clinical placement money to incentivise particular geographical areas, particular professions or particular specialties, if we start seeing that there is a reduction in one geographical area or particular profession.

Lord Willis of Knaresborough: Danny Mortimer, do you have concerns, as employers, about this new fluidity, which is coming into this key area of supply?

Danny Mortimer: Starting with the second question, we believe that the approach is being introduced quite quickly, which is a concern for us; the political decision has been made, and it is being introduced very quickly. However, on balance, I think that employers see opportunities for a better quality of supply. The specific concerns are around the choices that might be made. For example, will we see a massive growth in paediatric nursing and not enough people applying to be mental health nurses because, if they cannot get a place on a paediatric course, they may choose to pursue a different path? In nursing, we have relied on people having second or third careers, particularly in mental health nursing, and we need to make sure that we maintain some of those things. On balance, I think people think that there are some opportunities there.

On your first question, and whether we have confidence in 2030, the honest answer is no, we do not. It comes back to our original discussion. If we continue to have a situation where there is active disinvestment in social care and the health service is having to expand its services to compensate as a result, we will always be developing plans based on false assumptions. We need to have some better settlement of how we fund and plan health and social care services together so that we can properly plan our workforce across health and social care. I do not think we have ever resolved that properly. The STP process that we are currently embarked upon is the best attempt there has been in my 25-year career in the NHS, but we need to see that come to fruition.

Lord Willis of Knaresborough: Where I think you have singularly failed, both as employers, as well as the Department of Health and now Health Education England, is in looking at this issue of the levels of attrition, which would be unacceptable in any business. I cannot get any figures from anyone. Even though it is part of the mandate, I am still not given any figures in attrition from training courses, which HEE is pouring money into, and the universities will not give them to us, other than through HESA which you have to pay for. If we do not have this data about what is happening to the workforce, when they go on to the register—I am talking particularly about nurses—there is no way of knowing how long they stay or why they leave. We cannot have this leaky bucket syndrome whereby we pay £79,000 to recruit somebody and train them and we do not even know what happens to them afterwards.

The Chairman: This is an important question, so do we have the figures?

Professor Ian Cumming: We can certainly give you all the figures for attrition from higher education right the way through. We cannot give you the figures for employment, because we do not keep those in HEE, but we have the figures for attrition from higher education and we can give you those.

The Chairman: So you will be able to give us those figures?

Professor Ian Cumming: Yes.

The Chairman: You said that you cannot give the figures from the employers' point of view. Are the employers able to give those figures?

Danny Mortimer: There are some data available of turnover and attrition, but we do not track where nurses go between employers, whether they move between the NHS and social care, for example, or the NHS and the private sector, or whether they leave caring entirely and pursue other things. We do not necessarily know how many choose to join a bank or an agency or whatever it may be.

Lord Willis of Knaresborough: But it matters.

Danny Mortimer: I accept entirely that it matters. That criticism of how we track and understand the investment that we are making in those people is a very fair one. I also accept entirely that there is much more that we need to do in retaining the workforce that we have, but there are also examples where actually the competition for our people is really fierce. For example, one of the areas that we have had recent problems with is around paramedics. Paramedics are fantastic clinicians with a really good set of skills. Many of them have been recruited to work in programmes set up by the DWP to assess disability because they have such a fantastic set of clinical skills. The NHS never planned for that and the HEE did not know that the DWP would start to recruit our paramedics so actively, so there are other things going on as well that we need to understand.

Lord Warner: I have been sitting here listening to this, and it sounds all very reassuring. In London, on your own figures, the shortfall in sub-medical is enormous. The same story is coming out of social care. This is the hub of economic development in this country. What are your game plans for dealing with London? We know that the attrition rates are appalling, so what is your game plan for 2030 for London?

Professor Ian Cumming: Perhaps it will help reassure the Committee to know that on our current projections against employer demand and the people who are in the system at the moment—just to stick with nurses—we will have a surplus of between 25,000 and 80,000 nurses by 2020. That is on the basis of people currently going through training programmes and the demand that the NHS is currently saying it needs. If that demand changes, those figures will amend, but we are seeing a surplus. That is not evenly distributed geographically, as Lord Warner correctly says, and London is a particular challenge. For example, the figure for all non-medical jobs that are vacant in the NHS across the country is about 5.3%. Last year, that was 7.1%, so we are moving in the right direction. But the figure for north, central and east London, for example, is 15%, so we are seeing a very significant distortion in certain

parts of the country. That is to do with the fact that a lot of people like to train in London and then move elsewhere and with other economic factors, not least of which are the cost of housing and the cost of living, and people wanting to move elsewhere to settle down and bring up families. That will be a consistent challenge.

We are working with NHS Improvement and other organisations to look at issues, and Jim Mackey talked to a committee recently about affordable housing in London for people, but it is a real challenge. It is one of the challenges that the London Ambulance Service repeatedly talks to us about, as it describes somewhere in the region of a 20% vacancy for paramedics, whereas, for example, in the West Midlands the figure is all but zero.

Danny Mortimer: I have two very quick points to make. We have done a piece of work with our trade union colleagues and employers in London, the details of which I can share with the Committee. We have made some very specific asks of the Mayor, which relate to affordable housing and the prioritisation of that for NHS staff, as well as on transport costs in London. We are seeing NHS staff moving further and further out of London, as the average cost of a house now in London is about 15 or 16 times the average salary of a nurse, which is completely unaffordable for them. So those things have to be tackled. We will provide some information to the Committee.

Professor Alan Manning: We need to recognise that London weighting, which has not changed greatly, is simply too low at the moment. Saying you are going to deal with the problem by affordable housing is putting the cost of dealing with it onto the people who provide the housing rather than putting the cost on to the NHS. At the very least, it needs to be considered whether pay levels are sufficient to attract, recruit and retain staff in London. It would seem that they are not.

Baroness Redfern: Following on from Danny about how tracking is really important, particularly when staff leave, can I just focus on workforce development and planning? Do you think that is fully embedded in the STPs, or is there not enough focus on that?

Danny Mortimer: I think the focus is increasing. There is some variation across the 44 different areas, but the structure that Ian has described where the localities are being brought together to look at the workforce implications and plans—

Baroness Redfern: So you think there is more work to be done to enhance that?

Danny Mortimer: There is more work to be done, yes.

The Chairman: Who is responsible for looking at the long-term needs of the workforce in social care?

Professor Ian Cumming: We are not, so it is not a responsibility of Health Education England. The Department of Health has a responsibility and other organisations, such as Skills for Care, which works closely with the very large number of private employers in social care. But there is not an organisation like HEE for social care.

The Chairman: Is that a disadvantage?

Danny Mortimer: Yes, it is absolutely a disadvantage.

The Chairman: So what would you suggest be done?

Danny Mortimer: One thing that we are learning through the coalition that we formed around the post-EU settlement is that we share a lot of common interests with our colleagues in social care. But there needs to be an overseeing organisation with a mandate to intervene, if necessary, as Ian and his colleagues do, in equivalent terms for the social care workforce. It is such a fundamental risk area, frankly, for us as the question we are wrestling with over the next 15 years.

Q134 **Baroness Blackstone:** What is your key single suggestion for change that this Committee could recommend, which would support the sustainability of the NHS?

Professor Alan Manning: If one is focusing on long-term sustainability and the workforce side, I worry that pay gets determined as a residual. There is a bit of temptation to think, “This is the health service we would like to provide, this is the amount of money we have been given and, therefore, this is what we can afford to pay our workforce”. In the long run, you have to pay your workforce what makes these professions attractive to recruit and retain them, given the other choices that people have, and you cannot control how much those other choices pay. I think that is why, over quite a long period, the NHS has gone through cycles of boom and bust in which short-term financial pressures, which I am sure are terrible to deal with, lead to a short-term approach to the workforce issue. That is what I would think about—that you have to pay your workers sufficient to make this an attractive career for them, relative to the alternatives that people have in the long term, and not exploit their ability in the short term.

Professor Ian Cumming: This is a one and a half answer because the answer has to be a continued focus on producing a national health service and not a national sickness service, so what more are we doing about prevention, what more are we doing to get upstream with the inexorable rise in diabetes, et cetera, because that is proving to be the biggest single financial challenge we have in the NHS, so that is the half.

Moving on to the actual, I am very privileged in that I travel a lot around England in this job and I see best practice all over the place. We have to find a way of bottling that best practice and disseminating it, stopping this resistance to somebody else’s idea being adopted and embracing, in particular, the end of paternalism in the delivery of healthcare.

The Chairman: How?

Professor Ian Cumming: By investment in education and training for the current workforce—and it is not necessarily about money; it is about time. We have people so busy doing their day job that we never give them the time to think about how they could do it differently, and how they could step back, redesign and take on board things that somebody is doing elsewhere in the country. That, for me, would be the number one thing to do, along with using technology in a different way.

Professor Wendy Reid: I will not repeat what Ian has said, but, if we do not start valuing and developing primary and community care, the overwhelming push into the acute sector will continue. I would like to see parity of esteem and the focus of professionals being on primary and community care, to stop this divide.

The Chairman: Do you think our current model of primary and community care is ideal for the long-term sustainability?

Professor Wendy Reid: I think it is a good model when it works well, which goes back to Ian's point. When you see it working well, in an integrated fashion, with local authorities, social care and, indeed, the acute sector, it works really well. But that is not what we see everywhere.

The Chairman: Anecdotally, it is all right, is it?

Professor Wendy Reid: I think there is evidence that, when it works well, it works very well, and it is where the majority of patients and public contact exist.

The Chairman: Your answer to Lady Blackstone's question?

Danny Mortimer: If there is to be a long-term plan, there needs to be a single plan for health and social care.

The Chairman: Thank you very much for coming today. If you have any other material, apart from the figures you are going to send us, please feel free to do so and we will gladly receive it as evidence.

Professor Paul Corrigan, Royal Society of Public Health, and Jo Moriarty – Oral evidence (QQ 135-142)

Evidence Session No. 13

Heard in Public

Questions 135 – 142

Tuesday 1 November 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Turnberg; Lord Warner; and Lord Willis of Knaresborough.

Examination of witnesses

Professor Paul Corrigan, Professor of Health Policy, Imperial College London; Shirley Cramer CBE, Chair, People in Public Health, Royal Society of Public Health; and Jo Moriarty, Senior Research Fellow and Deputy Director, Social Care Workforce Research Unit, King's College London.

Q135 **The Chairman:** Welcome and thank you for coming today to give us evidence, which will be very helpful to us. We are broadcasting this session and if the Committee members have any particular interests to declare they will do so, if they have not already done so. If you wish to make any opening statements, please do so, but otherwise will you please introduce yourselves from my left to right?

Professor Corrigan: I am Paul Corrigan. I am down here from Imperial College; I am actually an adjunct professor there and I am an independent management consultant. Would you like me to make an opening statement now?

The Chairman: If you have an opening statement, yes please.

Professor Corrigan: What is very difficult to appreciate in the middle of talking about the NHS is the depth of the change in the nature of the business. We can see it in almost every other industry, but the change in the nature of what sickness and disease are now has left us with a health service facing in the wrong direction. The fundamental change is that 70% of NHS funding is now being spent on long-term conditions. The nature of that experience is a different form of disease. Not just in this country but across the world there are attempts to completely reconstruct an industry to face this new form of disease. Diabetes has been around for a while but the extent of it, as a problem for the health service of these long-term conditions, needs a greater transformation than those of us in the middle of it appreciate.

Shirley Cramer: I am Shirley Cramer. I am the chief executive at the Royal Society for Public Health. I am also chairman of a UK-wide group called People in UK Public Health, which is looking at the future of the public health workforce. It incorporates Health Education England, Public

Health England, the Department of Health and the Governments of Scotland, Wales and Northern Ireland.

Jo Moriarty: I am Jo Moriarty. I am senior research fellow in the Social Care Workforce Research Unit based at King's College, London. I am also somebody who has actually worked in the care sector; I originally started off as a nurse. So as I have grown older my connection with this subject has become more and more entwined.

The Chairman: Thank you very much. Do either of you have any opening statements you would like to make?

Shirley Cramer: Following up on many people you have heard from during your taking of evidence, we would like to see much more of a focus on prevention and improving and protecting the public's health so that we can reduce demand on the NHS. That involves creating a culture of health which we currently do not have where our citizens are able to maintain their own health and well-being and where services are focused and geared towards prevention rather than focused and geared towards ill health.

Q136 **The Chairman:** Today we would like to explore with you some of the workforce issues relating to both the whole spectrum of healthcare and social care. In the current state, is the health and social care workforce equipped to deal with the Government's ambitious plans for the future, both in public health, healthcare and social care? What workforce issues do you think are the greatest threat to long-term sustainability?

Professor Corrigan: Given what I said just now, the answer has to be no. I do not think the current workforce is facing in the right direction with the right skills to deal with the vast majority of the healthcare problems that are coming across the door. Health Education England is spending most of its money on new entrants to the professions. Someone starting this year who will become a diabetologist in the year 2028 will be taught a series of specialisms and hyper-specialisms, when actually what people with diabetes need now is an understanding of a much broader nature of their health rather than their diabetes.

I only have the statistics for Scotland but there are some very interesting statistics. Of the people with diabetes in Scotland, only 16% only have diabetes. If we treat them as if they have only diabetes, we are wrong 84% of the time. Any other industry could not cope with that and yet we are training more and more of those specialists to be more and more interested in only diabetes. The nature of the training system, by the year 2028 when that person starts to practise, will be really out of date. That is my first point.

The second thing is that today there is some press around the nurse associates that the previous witnesses were talking about. One of the immediate things in the *Health Service Journal* is the problem that health associates may be giving out drugs. That is seen as a problem because of skill substitution. Actually, skill substitution is the only solution; it is not a problem. It is the skill substitution and the way in which we work down the trade into less and less professionalised jobs to deal with the degree

of care that we are going to have to deliver. We still have a system which is spending most of the money on probably the wrong people.

Shirley Cramer: I could not agree more with that statement. One of the things that gives us some hope for a turnaround of the “Titanic”, if you like, to prevention is looking at the role of people who might be helpful and supportive in improving the public’s health and indeed public health. We have a 40,000 public health workforce in England, but we have done some work with the Department of Health and Public Health England and there are 15 million people in employment who have the ability or opportunity to improve and protect the public’s health. These are people in a variety of professions. There are about 750,000 of them—we call them “early adopters” or perhaps “low-hanging fruit” who have the ability right now to make a difference in community support. I am talking here about the fire service, leisure services, housing, pharmacy and allied health professionals.

We have a lot of people who are currently in employment and who are keen to be seen as part of the prevention and health and social care workforce right now who are seeing people every day in their jobs. It is a contention of the work that we have been doing on the future of the public’s health that we need to have this huge group of people, almost an army of people, who could be out there with prevention as part of their job and supporting people in communities. There is a huge amount of best practice being looked at. If you look at the West Midlands and Greater Manchester Fire Services, they are doing a huge amount of work, as are housing and Healthy Living Pharmacies. We can upscale and roll out so much more in this area which will really help to sustain and take demand away from the NHS.

Jo Moriarty: I would like to take up the point that Paul made when he spoke about the very small proportion of people who only have diabetes. Sube Banerjee, who was responsible for the first National Dementia Strategy, often quotes a figure that says that only 17% of people with dementia only have dementia and the remainder have another health problem. One of things that is a particular issue for the social care workforce is the fact that they are dealing with people with multimorbidity; they are dealing with people with very complex health conditions. In many ways the expectation, sometimes among people commissioning services and sometimes among the general public, is that anybody can do the job. People think it is about the old days of making somebody a cup of tea and making sure they are settled properly, whereas in fact they are doing very complex issues. Interestingly enough, many of the associate nurses have taken on extended roles in medicine management. We need a workforce that is dealing with people with these very complex conditions.

Lord Turnberg: Coming back to you on the need for diabetologists to deal with the workload that is likely to come at us, I think that misunderstands the nature of what a diabetologist might do. Most patients with diabetes and multiple illnesses have to be dealt with by their GPs and in the community. That is the vast majority. Diabetologists will only touch the tip of the apex of all that activity and are there to deal with extremely complex diabetic problems. This, of course, leaves aside the

question of whether they will all be working on a cure for diabetes in 20 years' time and maybe it will have disappeared. We cannot predict too far on that.

The same is true of dementia. The majority of dementia patients are going to be dealt with in general practice and in the community. We need psychiatrists, of course, and we need experts, but the numbers are quite small. I think your ideas about diabetologists not being necessary is not quite right. Should we not be looking at a much wider spectrum of healthcare workers at a much more basic level to provide the support for the service that we need?

Professor Corrigan: Yes, we should. I would like them to work closely with diabetologists rather than be separated in buildings called hospitals where the diabetologists are. At the moment psychiatrists are not centrally in buildings called psychiatry buildings; they are actually out in the community. The diabetologists could be out in the community.

Lord Turnberg: They are.

Professor Corrigan: Most of their training is spent in a hospital. If they are coming out, that is really good, but most of the training, if you look at the number of hours they spend, is spent inside hospitals. They are learning their trade in one building. That is not a good idea. I agree with you that the vast bulk of care needs to take place and already is taking place with a very different group of people. Most care is administered by patients and their carers: a vast proportion. Most of that is done with very little knowledge and training. Most care is self-care and, if we invested a bit more in that and improved the capacity of people to care for themselves, actually we would transform the outcomes.

Q137 **Lord Willis:** I am particularly interested in this division within the health service between specialisation and generic training. Everywhere we go we seem to see new silos being developed. As one of the architects of the nursing associates I am delighted that you have mentioned them. However, I cannot tell you the battle there is to try to get, for instance, a mental health nurse to treat somebody's physical needs. It is not at this very high level; it is really at quite a basic level. I would like your suggestions on how we move away from a system whereby we prize specialism but we do not prize genericism, to have high-quality, whole-person care at every level, not simply at specialist levels.

Professor Corrigan: I would start by saying that division of labour is a good thing. It works well in every industry and there is no reason why it should not work in health. The difference about the division of labour in most other industries is that it is organised, rather than being organised by people in individual bits. My analogy is always the Shard. About 20,000 firms built the Shard and they were specialists; they were specialists in particular things. Plumbers were good at doing plumbing; they were not generalists. However, somebody organised them rather than actually allowed them to organise themselves. In the health service we do not have the equivalent of a tough supply-chain organiser that would organise for me, as a patient, the various specialisms and would say to the diabetologist, "Paul Corrigan is not your patient. Do not think you can see him on a Tuesday because someone else has to see him on a

Wednesday.” It is the organisation of that that we do not have because we have not put anybody above these very, very high-status specialists.

The Chairman: The old hands round the table might say that that used to be the case but no longer is.

Lord Mawhinney: You are encouraging us—at least I took it as an encouragement—to direct more resources towards helping people to improve their own care. The word you used was, if we did that, the scene would be—your word—“transformed”. What does “transformed” mean?

Professor Corrigan: Transformed would mean that a health service would understand that, for people with long-term conditions, the vast majority of the time they are being cared for they are caring for themselves. At the moment the health service primarily sees that the care for people with long-term conditions only takes place when you come up against somebody who works for the National Health Service. We do not invest in the 5,800 waking hours that someone with diabetes looks after themselves. What I mean by transformation is that if we increased the productivity of those 5,800 hours by 5%, we would transform the health service. If people were better at looking after themselves because we invested in it, the capacity for them to self-manage would mean many fewer emergency admissions—and that is the problem for long-term conditions.

Lord Lipsey: I am agreeing with everything you say instinctively, but I am struck by what happened in our first session today, which was also about workforce planning, where the witnesses were also sympathetic to what you are saying—except that they only talked about increasing the number of nurses by 25,000 and the number of doctors. They did not mention changing any other people’s possibilities. Could you talk about what practical things are necessary? To take a possible example, should we be increasing the pay of those providing social care quite considerably and, if necessary, diminishing the pay of consultant physicians, the number of whom has soared in recent years for reasons that are not apparent to me?

Jo Moriarty: That would be a very controversial action which I am sure would get a lot of support from the millions of people who work in the social care sector. You are right that the Low Pay Commission is very firm that the national minimum wage and now the introduction of the national living wage has been a transformative element in social care for people who were underpaid beforehand. The one difficulty that employers are faced with is that it has led to a very flat pay structure so that, with a few very poor examples of organisations that underpay people by not giving them travel time and so on, you tend to find that most workers earn the national living wage, but there are very few opportunities to acquire increments or to be promoted. Sometimes that acts a disincentive to undertake further training and often it leads to people who have received training trying to move from social care into the NHS. Obviously it has been an incredibly important positive step, but there are difficulties in the actual overall pay structure.

Baroness Blackstone: How do we make self-care happen? What are the practical steps that have to be taken to make this a reality?

Professor Corrigan: As somebody said in the previous session, I think that practical steps are being taken in an increasing part of the country on this. GPs are now experiencing being overwhelmed in a way with which they cannot cope. So they are looking to change the boundaries of the work they do and trying to get assistance from different sorts of organisations. One of the ways that is probably growing fastest is something called social prescribing, which is simply a GP prescribing that you need some activity. GPs have been telling their patients—this happened to me two weeks ago—they have to go out and do more for some time—but they are only just beginning to realise that people do not. If you prescribe to a health trainer and the health trainer then puts you into a series of contacts either for exercise or group activity, then you are beginning to take some of the pressure off the GP and spreading the load to a whole range of voluntary sector organisations that are already there but need some money to make this happen. This is not a free good.

Baroness Redfern: Picking up on Jo's mention of pay structure and career progression, do you not think that good managers should be looking specifically at that to enhance those people who want to progress even more?

Jo Moriarty: Yes, absolutely. One of the positive aspects of social care is that it is one of the few industries in which people without qualifications can go in and make a career for themselves. It does happen but you often find that it is down to an individual. Somebody will tell you that they had a manager who had faith in them or they worked for an organisation that invested a lot in training.

Baroness Redfern: So you think more needs to be done with good managers really focusing on that.

Jo Moriarty: Yes, absolutely. I would add a small point to the point about self-care. Obviously, self-care is important but, looking at the age structure of the population, one of the things that has really happened in this blurring of the health and social care divide is end-of-life care. It is important to remember that with people's aspirations, sometimes it is not about self-care, it is actually about enabling people to make a good death. One of the mistakes that has been made in the past has been to assume that everybody has the capacity to improve, but many long-term conditions are terminal.

Q138 **Baroness Redfern:** I would like to put a question to Shirley following her very eloquent introduction. Looking at the public health workforce in 15 to 20 years, we know that public health comes into local authorities and there has been some really good work done there. How do you see the public health workforce in 20 years, particularly on prevention as well? I know it is difficult to measure prevention but, if we could tackle prevention, we could not only save some money but improve people's lives as well.

Shirley Cramer: There has been some work done on this. A new plan has been devised called Fit for the Future which was led by Public Health England but actually many stakeholders were involved: Health Education England, the Department of Health and other UK devolved Governments. It is very important that we have flexibility and mobility within our

workforce so that they can move between different countries. In this plan we were trying to have a multifaceted look at who should be doing what, where and when and how to bolster the capacity and capability for prevention. A number of things come. One is what I first mentioned, which is about a social movement for health. I do not think we should underestimate this, because some local authorities are doing excellent work in prevention and they have managed to mainstream it in all their activities with the voluntary sector, social enterprise, community interest companies, the private sector and their own staff. That is one thing we really need to work hard on.

Another is creating an attractive career. One of the things we have not done enough of is to have clear developmental career pathways for the public's health. That involves looking at experience people have had, looking at qualifications and looking at how that is standardised across the UK. We need clarification on entry. We need good apprenticeships in this area because we need a much more diverse workforce as well. We need portfolio careers: people who can work in different settings and have expertise in different settings where we recognise that their experience before counts towards the next stage of their development. That has been helped by the Public Health Skills and Knowledge Framework that has just been renewed. We can map to that and it is going to be extraordinarily helpful.

We need to inform children, and teenagers in particular, about the opportunities for existing health and care roles—and new ones, because we believe that new ones will be developed. Link workers and co-ordinating workers are some of the issues that have been mentioned. The issue about systems leadership is huge in this area, because in the future people are really going to have to manage work and lead across different systems. That has a different skill set and competency set. We need to get some of this work rolling; it is about joining up things.

Staff mobility has been an issue across the entirety of health and care, and that is around mobility between the NHS and local authorities. That has a lot to do with terms and conditions and things that somebody could go away and sort out that would make life a lot easier for recruiting this particular population to health roles. Regarding CPD for staff, cutbacks always happen first with training, but that be the last thing we cut, in our view on the committee. We need to equip all parts of the workforce with the skills they need to succeed, and that is about working across the new holistic system. The MECC approach—making every contact count—is now being rolled out in various places across the NHS. This is really good news because this is trying to embed prevention across a workforce that has been very siloed. We need to embed prevention in all undergraduate curricula. That feels like common sense.

However, none of this happening fast enough or urgently enough in our view—because these are things that need to be happening now. We have the STPs, the vanguards, the new models of care. These are underpinning issues and the wider workforce—the piece I mentioned at the beginning—is the piece that can help make the transformation that Professor Corrigan mentioned, because you then have a much larger capability. We are not suggesting that this group of people does not have any training. In fact,

the committee has worked out that there is a level of training that the wider workforce would need to build confidence in dealing with a whole host of different issues, but it needs to be the right training for the right people. It is about acknowledging that their work has a role in the public's health. It is about acknowledging the work they do and possibly having it in their job descriptions and then evaluating the work they can do on a place-based, geographic location which will lead and support the transformation.

Baroness Redfern: Do you think that, in enhancing that, we would be better working in clusters for career progression as well as clusters for acute sectors? It would give flavour, enhancement and more choice for people in their careers.

Shirley Cramer: That would really be helpful. We are seeing more and more of that in really good practice in various places where groups of people are working together, coming up with joint solutions, collaborations and decisions that are really helping people on the ground. Sharing data is very important, as are integrated budgets, as you probably know.

Lord Warner: This all sounds jolly good, but where is the driver? Who is in charge of this programme? We are already going through a row at the moment about whether public health money has been stolen to support the Government's claims on funding for the NHS. Who can actually drive this agenda? It is all very well having local pilots and developments, but where is the drive from the centre to come that will not be politically interfered with?

Shirley Cramer: I think that is a really good question because one of the issues that everybody has to deal with is joining things together. In my view, Public Health England is in the best position to do that at the moment because they are the ones with the plan and they are the ones with the energy around this issue. But it is working with Health Education England, and in fact they have been working well together, certainly around some public health issues, with the Department of Health. It would be easier if it did reside in one place rather than being stretched across various systems. Local authorities have taken a big leadership role in many of these areas and we have seen that across place-based initiatives. The system is quite complicated and therefore you need to have all parties at the table to make many decisions—and there does need to be a driver to put it all through.

Lord Turnberg: Thinking about a prevention strategy for 20 years' time, how much thinking is being done now about efforts to predict susceptibility? It depends so much on modern science and genomics, and on the ability to screen people, predict their susceptibility and do something to prevent them developing a disease. That is a whole new area which we have not covered.

Shirley Cramer: I know that Public Health England is doing a lot in this area and working across the piece with the Department of Health. It is a priority area and one of the things we have been told is that the UK wishes to remain in a leadership role in these areas and to be leading the charge on them. Although I am talking about place-based prevention, it is

very clear that for the particular skills moving 20, 30 or 40 years ahead, our system should be geared towards these areas where we would be able to have good screening programmes.

Lord Turnberg: Is there an educational programme amongst public health professionals on what the genomic agenda is?

Shirley Cramer: I understand that this will be in the curriculums for people who are training to be public health specialists: that would be the 40,000 public health workforce. Many in the top echelons of that workforce are the technicians and people who have all the particular public population health skills that will be needed.

Q139 **Lord Warner:** Moving back to the social care workforce, we learned at the end of the last session that there was no one in charge of this at national level. What are the key challenges for this workforce over the next 10 to 15 years? Do we need to produce more oomph in that national drive? What are the challenges that are going to be presented to the health service if we do not actually improve the effectiveness of that workforce?

Jo Moriarty: That is a really important point. The VODG, an umbrella group of voluntary organisations and providers, has estimated that by 2035 we will need another 400,000 care workers. That is on top of the most recent estimate from Skills for Care that there are 1.43 million people working in social care. Obviously there is huge increase in demand—but, as the Committee has already heard, there are reasons why it is not always seen as a profession of choice. It is often seen as being of low status. It has mixed problems with retention. People talk about problems with retention in social care as if they were everywhere, but that is not true. We have been very fortunate to have been funded by the Department of Health to do a longitudinal study of the social care workforce in four different parts of England. What is astonishing in the six years in which we have been doing the work and the three times we have been contacting people in the sample is how many of them are still either in the same workplace or still in the same profession. It is more variable than that and I think it is also about making the work more enjoyable—things such as giving people autonomy.

One of the difficulties about the way that social care is prescribed is that it is so task focused. The reason why that happened was that often families were finding that the worker was meant to assist the person to get up in the morning and then they would arrive late in the afternoon and find the person still in their pyjamas. So it gives more accountability for families but it means that workers themselves cannot act in an autonomous way. We had a really good example from somebody who took part in our research who was talking about how she went to see somebody who had been recently discharged from hospital. She had been home for two days. On the third day she was trying to encourage her to get up, have a bath and make her breakfast, which was obviously important in terms of her health outcomes. She had only been given half an hour to do this; she needed 45 minutes. When she phoned up the agency, they said that they did not have anybody else who could help. She ended up staying with the woman and working unpaid time. That is a cogent example of where

difficulties in the way that social care is provided have implications for the health service.

Lord Warner: Is that not a funding issue? Basically, you are saying that the funding does not enable them to do the job.

Jo Moriarty: It is partly a funding issue but it is partly about the way that those funds can be spent. It is about not giving organisations the autonomy to say, "Today you will have an hour-long visit; tomorrow you might be able to manage with a shorter one". Funding is a huge issue but it is not entirely funding based.

Q140 **Bishop of Carlisle:** You mentioned earlier that social care is something that you can enter without too many qualifications. That is one of the great advantages of it. However, as health and social care are integrated more and more, as we hope they may be, is that going to present a difficulty—and, with the recruitment of another 40,000 social care workers, what is going to be the problem there?

Jo Moriarty: There are certain statutory minimum things in terms of health and safety that people have to do once they enter. Obviously, successive Governments have put quite a lot of investment in training. A lot of the money provided for Skills for Care is allocated to developing training programmes for employers. It is more about making the training more relevant to the things that people are doing. Rather than it being the minimum, it is more about understanding issues such as the overlap in the example that Lord Willis gave of a mental health nurse not wanting to treat somebody for a physical condition. It is about people recognising the complexities of somebody's own health problem: recognising depression among residents of care homes rather than just assuming that they do not want to do something.

Professor Corrigan: The integration of a very heavily professionalised organisation called the NHS and an undertrained organisation such as social care means that the integration could be like this rather than like that. The respect that people have within the National Health Service, probably quite rightly, is around the range of qualifications, and therefore growing that respect for people in social care is crucial if the integration is going to be real.

Q141 **Lord Willis:** I think that point is very important. When you look at the Cavendish report, for instance, and my own work since then, the whole issue about trying to give care workers some form of qualification which is transferrable and transposable is absolutely essential. I recommended something similar to an e-passport: being able to accredit skills with an appropriate professional worker. However, the care sector was not remotely interested. What do we do to get the care sector, whatever that means, to engage with the issue of appropriate training, certification and passportability? Without that, we will not have the sorts of things we are talking about and it will just continue as it is at the moment.

Jo Moriarty: Within the care sector there is often a historical concern about red tape and people feeling that there is a lot of control over what they do. But things such as the Care Certificate are a really positive example of people trying to create a workforce that is capable of working

within the health sector and within the social care sector. The difficulty is that care workers are not regulated and therefore there is no impetus for them to keep their own records of CPD that they have done: that is also an issue.

The Chairman: We talked earlier about pay being one of the issues, particularly in certain areas such as London. If you were addressing the issues about pay, do you think the current model is sustainable fiscally?

Professor Corrigan: Given the degree of demands that we know will be there and given your emphasis on sustainability, if we roll forward the present structure of the health service to meet that additional demand with the same professionalisation, I do not think it is sustainable. The challenge has to be not just around pay but around how we spread the load of that amount of care with a range of different people who are not paid as much at the top level. I think all three of us have been saying that.

Another point about pay is that there is an enormous hierarchy from the best paid to a social care worker, but there are other incentives apart from pay. If you were to look at merit awards in the National Health Service, you would find that they nearly all go to consultants. That means that other people do not have any merit. That is not true, but that is where merit awards go. It does have money linked to it, but if we were to change the nature of merit awards into a more horizontal way, then it is an incentive. Why does a social care worker not get a merit award? They have a lot of merit. This is not just pay; it is a different form of incentive.

The Chairman: Merit awards no longer exist in the part of the country where I live, but I gather that in other areas they still do.

Jo Moriarty: I think funding is a huge issue. Last week the United Kingdom Homecare Association issued a report that claimed that only 20% of councils paid what they considered to be an appropriate rate for home care. The gaps are getting bigger between what the sector is saying is the cost of providing care and what local authorities are able or willing to actually fund. In the past, 20 years ago, we were more optimistic about the proportion of people who would fund their own care in their old age—but, with what has happened in terms of employment, the impact upon pensions, issues about home ownership, that will not be the case. A huge pressure, particularly for politicians, is on trying to help the public improve their understanding of what help they are likely to get if they need social care and support and what they think they are going to get.

The Chairman: We heard in previous evidence that as far as social care is concerned, we may require a workforce of as many as 1.3 million in the social care area. Are there people who would be willing to go into that and what will make them go into that?

Jo Moriarty: It is about making the job more attractive. It is also about apprenticeships and enabling people to see it as an interesting and attractive career path. Many of the people who go in have very high levels of job satisfaction. The work is varied and interesting and employers have tried to attract people on that level—trying to present it not so much as a well-paid job, because it is not, but as a job in which there are opportunities to make a difference to people's lives.

Lord Warner: If the Government woke up one morning and gave the publically funded adult social care sector £3 billion extra phased in, would that sector sort out all these problems itself or does there need to be some central driver to go with that money to produce the workforce you need with the skills they need for 2030?

Jo Moriarty: No. You need a central driver. One of the things that recent events have shown quite clearly is that the social care market does not operate as a true market. Many of the problems that happen within social care are because the market is not operating properly. There was a very interesting report from the Manchester Business School earlier this year which talked about the way that some companies that provide care homes actually have shell companies; there is a lot of offshore investment. The report argued that there was potential to use that money in a better way.

Skills for Care has worked very hard. It was a very positive development to set it up and it has worked hard on trying to get a coherent voice across the sector. The sector itself is quite diverse and if it was given £3 billion tomorrow, I think it would need some sort of central way. We know that often people replicate old-fashioned ideas, so if we look at the investment in people support, we know that care homes and nursing homes are still being built. It has been quite difficult to implement assistive technology in people's own homes, and all the work that has been done on assistive technology suggests that it is done better in countries which have perhaps a slightly more statist view of how support for people should be provided. In Scandinavia there is better infrastructure for assistive technology than in the United States.

Lord Willis: If we are aiming for an integrated health and social care system, why on earth would we have a separate organisation perpetuated for social care?

Jo Moriarty: One of the things that is quite astonishing is that you could get documents from the 1970s talking about joint integration plans and you could give them a new cover and a new logo, and nobody would know the difference; they would say that they had been published last week.

Lord Willis: It has to happen before my old age.

The Chairman: That is not far away.

Q142 **Baroness Blackstone:** What is the key single suggestion for change that this Committee ought to recommend to make the NHS more sustainable?

Professor Corrigan: There is a line of interventions, from pure prevention through to demand management, which is absolutely essential for sustainability. The NHS, as against local government, finds the notion of demand management a little bit immoral because its job is to meet demand. That is actually not its job; its job is to negotiate with that demand. But in the work that is done in health and well-being boards between local authorities—which have been very good for the demand management of social care—and the NHS, which has been very bad at it, the key is how we manage that demand with the consumers in such a way as to reduce the pressure on the system. Without that, all the other things we are doing mean that the system is overwhelmed.

Shirley Cramer: We have a very complex system and a lot of unintended consequences in the system. A much more joined-up system with integrated budgets and integrated data would help to loosen up all the things that need to happen to make the prevention agenda one that is at the top rather than the bottom. We need to prioritise, as I said earlier, people in social care, health champions, health trainers and people in the community who can help to prevent people going to their GPs or being in hospital. I have been at hundreds of meetings where people have said this is important. I have yet to see many people come up with solutions. We need to be a bit braver in the way we do it. How about training the wider workforce? It will not cost much: they are all in jobs already; they are all keen to do this work. Why would we not spend a little bit of money getting them geared up and seeing what difference that can make? We need to do a lot more implementation rather than just analysing the problem. That is my view at the moment.

Jo Moriarty: Not being an expert in the NHS, I feel quite reluctant to say this, but I would say that there is too much emphasis on recruiting people at an early age and not enough attention paid to those who leave, who have already been trained. We did some work looking at the costs of qualifying a social worker and one of the things we found was that it actually cost about as much to train a social worker as a physiotherapist or a nurse on a year by year basis. The problem is, because there is so much exit from the profession, you are constantly needing to retrain more and more people to make up for those who have left. Some of the practices in the NHS, such as 12-hour shifts, do not fit in with what we are being told from other parts of government about the need to have a more portfolio career, about a need to have a step-down retirement and things like that. The assumption is that they will recruit people at the age of 18 and will keep on recruiting them, rather than thinking that we actually need to train people for their lifetimes.

The Chairman: Thank you very much for coming today. It has been most helpful. If you have other material that you would like us to have, please send it to us. Something may occur to you during a conversation and we would welcome that.

NHS England, Royal College of Psychiatrists and MIND – Oral evidence (QQ 143-149)

Evidence Session No. 14

Heard in Public

Questions 143 - 149

Tuesday 1 November 2016

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Turnberg, Lord Warner, Lord Willis of Knaresborough.

Examination of Witnesses

Claire Murdoch, Director, NHS National Mental Health, NHS England; Professor Sir Simon Wessely, President, Royal College of Psychiatrists; Sophie Corlett, Director of External Relations, MIND.

The Chairman: Good morning. Thank you for coming to give us evidence. Although the last two sessions were related more to the workforce, this session is related more to mental health issues, but within it no doubt we will cover issues related to the workforce in mental health. This session is extremely important to us to get this teased out for long-term sustainability, which is the title of our inquiry, as to how mental health will feature given that we now accept the equal esteem of mental and physical health. If you do wish to make opening statements, please do so. Can I ask you to introduce yourselves, from my left?

Claire Murdoch: I am Claire Murdoch. Since June of this year I am the national director for mental health at NHS England. I am also the chief executive of Central and North West London NHS Foundation Trust and a registered mental health nurse of 33 years.

Professor Sir Simon Wessely: I am Simon Wessely. I am afraid I have got a slight cough at the moment, as you can probably hear. I am a consultant psychiatrist, an academic, the regius chair of psychiatry at King's, and I am currently president of the Royal College of Psychiatrists.

Sophie Corlett: I am Sophie Corlett. I am director of external relations at MIND. MIND runs services across England and Wales, as well as having a central organisation. Our chief executive, Paul Farmer, chaired the Five Year Forward View for Mental Health Task Force.

Q143 **The Chairman:** Thank you very much. Do any of you want to make any opening statements? No. We will kick off with our first question. What are the key issues in the provision and delivery of mental health care

services? Do you think they are being addressed appropriately currently?

Professor Sir Simon Wessely: That could go on all day, so I will pick up just two points. One of them is integration of services. Even during my lifetime the provision of mental and physical health services has got more separated, not less, sometimes for good reasons, sometimes for not so good reasons. When we did the Five Year Forward View, the task force, which you will remember, Sophie, and others, the consultation to start with had 25,000 respondents from patients and service users. The thing that was at the top of their agenda, which was a slight surprise, was wanting to have their physical and mental health care together. They did not mind so much where it was, but they did want it at the same time in the same place, and we are very bad at delivering that.

Where I work on Denmark Hill, we have King's College Hospital and I work as a liaison psychiatrist there, but within 20 yards of us we have at the moment the world's top psychiatry institution and research institute, the Institute of Psychiatry—we just beat Harvard, knocked it off its top spot, and we are the largest mental health trust and deliverer in Europe—yet most of the time I have been there we could be on separate planets. We have not integrated that as well as we could. The same story applies everywhere.

I would say the biggest challenge is, for example, to get CAMHS services so that they are linked in physically with schools, to get our expansion of psychological treatment services, which has been a major success story, except too often it is in the wrong place, it should be in primary care and in secondary care where it is needed, and to get better physical care for the scandal of the poor physical healthcare of people with serious mental illness, with common disorders—heart disease, smoking-related diseases, obesity and so on. Again, we have neglected that by separating out physical and mental. I would say that is our biggest failing.

I have just come back from Sierra Leone, and I would say we should also remember we have very good mental health services. I know very often we do not think we do, but if you go to a lot of other countries you realise that we are up there in probably the top two or three countries for delivering overall mental health services. We need to keep a sense of perspective on that. Although we are now going to talk about all the problems we have, internationally we do very well.

Sophie Corlett: I would like to come in next. I am not sure that our comparator should be Sierra Leone.

Professor Sir Simon Wessely: That is not where I got my cough, just before you all panic.

Sophie Corlett: One of the things we ought to be looking at is that what led the Government to agree to a commitment to parity of esteem is that we are so very far away from that at the moment. We know that we may have some great healthcare here compared to the rest of the world, but compared to our own healthcare in physical health we do extremely poorly. We have got to the heady heights of a third of people with mental health problems getting mental health care at the moment, which means two-thirds of people do not. That has risen from a quarter, but most of that is to do with the big expansion of cognitive behaviour therapy and

other talking treatments. That does not apply to all types of mental health care, just to the growth in that area.

We have a huge gap to fill in basic healthcare for people. That is the situation and there is now a commitment to doing something about that. Over the last Parliament, we have seen a more than 8% reduction in mental health funding over the five years 2010 to 2015, at the same time as we are trying to increase services to people with mental health problems. We have seen demand going up. Demand going up is partly due to complex societal issues, but we also have a problem within mental health care where shortage of funds and a feeling of being embattled, not having any way of meeting that demand, has meant that we have seen thresholds rise and people being turned away until the point at which they are most unwell, and that has had knock-on impacts on people's well-being and demand and cost going up. We have got ourselves into a slightly difficult situation.

The ideas and commitments in the Five Year Forward View for Mental Health are helping us move towards earlier intervention, but we have got ourselves to quite a difficult point, with the shortage of funds and the huge gap we have to cover and the difficulties that has created within the culture of people wanting to step back and not let people in.

Claire Murdoch: Just to build on that, the incidence of undetected, untreated diabetes in this country is something like 8%, so we have more work still to do to reach people around detecting and treating their diabetes, and of course now prevention. The incidence of undetected, untreated mental illness or mental ill-health is thought to be closer to 70% in this country. For me, the big issues are an approach to health and the NHS more generally that is an illness-based model of care with a hierarchy that puts big acutes and A&Es at the very top of it. If we are fortunate, most of us will spend a very brief amount of our whole lives in an acute hospital. The entire system needs to be focusing more on prevention, on understanding that human behaviour, emotion and psychology affect hugely how one treats health and lifestyle, and that ultimately tips over into mental illness. I would say in the hierarchy of health we do not pay enough attention to the whole person, how behaviour affects health and, at the extreme end of that, mental illness. We must change the way we think about our NHS as a whole. If we do it will benefit the way we think about and understand care in mental health services.

A second major issue is workforce. We spend so much time in this country talking about an NHS in crisis and a tsunami, a tidal wave; we are all drowning. Certainly it is the busiest I have known it in my 33 years in the NHS and the challenges are real. This country must have a debate about what it spends on health in its broadest sense that involves the public in the difficult choices that must be made. When it comes to mental health one hears so much that it is in meltdown and failing, who would want to come and work in mental health? So the second big issue which needs to be thought about, apart from the hierarchy, is that of workforce. As a mental health nurse of 33 years, working in mental health services is fantastic and your choices across the professions are incredible and your

ability to make a contribution is amazing, but somehow we fail to communicate that.

Lastly, the issue of transparency around spend on mental health is pivotal. Have we spent more or less? Last week NHS England published the CCG-by-CCG dashboard, which looks at investment, performance and outcomes. It is an unprecedented level of transparency around mental health in this country, I have to say. What CCGs are reporting is they have spent an extra 8.6% on mental health in the last three years. There it is in black and white: what CCGs are saying they have invested. The reason for getting those CCG dashboards into the public domain is we have to understand if they have spent more, where have they spent more? Is it in primary care, acute hospitals, with the third sector or the private sector, or with NHS trusts such as my own? This debate, in microcosm almost for mental health, needs to run across the country now: what are we spending; where are we spending it; what value do we get; what outcomes do we get? All the while there is a lack of understanding about whether investment has gone up or down, we are unable to fix or address the issues.

Finally, to be absolutely accurate, this country spends £105 billion a year on mental ill-health one way or another—days of work lost and the NHS—yet we know if we invest in proper evidence-based intervention with your cardiac problem, your cancer problem, your complex comorbidities in A&E departments, as Simon says, we save money and drive better value and outcomes for people.

I would like to end where I started: we need a fundamental shift in mindset around what we spend, where we spend it and how we spend it. Better spending on mental health will drive value and better efficiency into the system.

The Chairman: Do you agree with this figure of 8.6% more spent on mental health from CCGs?

Claire Murdoch: I am telling this Committee that NHS England has been working for the past several months on something called the CCG dashboard on mental health. It was published at 5 pm last Thursday. It is now out there for people to examine. I am saying CCGs have reported to NHS England a cumulative increase in spend on mental health of 8.6%. That varies across the country. If you look at that CCG by CCG you will see big variations. There are those who say they have invested more and others who have not met what was the parity of esteem target: in other words, they have invested less.

That is what has been reported and it is now the job of local health and social care communities to understand how that spend has been allocated locally. That is a really important piece of work to do over the next few weeks.

I should just add that those CCG dashboards will be updated quarterly, so we will keep publishing these every quarter until we are content that they are an accurate reflection of what is being spent.

Q144 **Lord Kakkar:** Perhaps I may pick up on something Sir Simon said. Do you have any evidence that as they are being scrutinised and published

the STPs are addressing the kinds of issues that you raised? If not, what pressure is being applied on those developing these STPs, which are at an immediate stage between a few years hence and 2030, to address the kinds of problems you have raised?

Professor Sir Simon Wessely: We have only just got some idea of what CCGs are doing. I think Claire was being quite diplomatic, as she should be, but nevertheless the variation is extraordinary between CCGs. Even more worrying is looking at the indicators of those that are planning on changing it and the large number that have no plans to increase their spending in line with what they are supposed to do.

The good thing, and it is a really good thing, is it is the first time we have been able to see this and not rely on FoIs as the only way we can find out what is going on. I think there will be changes from that because we are now able to scrutinise it. The picture is not a particularly pretty one at the moment, but the levers of change are hopefully there.

On STPs, we have only seen the ones that you have seen that have been leaked to the press. We know from our own work with some that lots of them originally had no mental health. You should say this because you are doing it, but we are promised that those that do not have a substantial mental health component will be sent to the back of the class and told to redo their homework. I hope that is true.

Lord Kakkar: Can we pursue that question? Is it the case that under the review in NHS England at the moment, if the STPs come forward and do not address these kinds of mental health challenges, which are clearly very important for the longer-term sustainability of the NHS, they will not be approved?

Claire Murdoch: I do not think STPs are approved. There is not a stop-go light. What has been said in more recent times is they are a work in progress and as much about getting a stakeholder community, whether that is local authority care or NHS trust, to work together to come up with the long-term plan. I do not think it is a stop-go. What I can say is that I have an extraordinarily good mental health team at NHS England, which I inherited in June. The people have impressed me enormously with their analytic capabilities and their commitment to this agenda. That team is going through the STP plans with a fine-tooth comb to look at where mental health sits.

I am charged by NHS England with delivering the Five Year Forward View for Mental Health to 2021. That is a growth agenda in terms of money spent on mental health and who we employ in the numbers of staff. Any STP that is submitted that looks as though it is shrinking its mental health agenda will absolutely have the feedback, and my team at NHS England will be working with them and the regions and their local partners on tackling that. You cannot address the plan that I have been charged to deliver by 2021 on an agenda of less. The investment will make savings elsewhere in the system and drive better value, but you cannot see 600,000 more people a year for talking therapies, 30,000 more women by 2021 for perinatal care and 70,000 more children, unless you are investing in your workforce.

The Chairman: I am going to ask for quick questions and quick

responses.

Lord Lipsey: There is the question of spending, but the fundamental question is one of effectiveness. Perhaps I could put it this way: 100 years ago doctors were not able to do much for people's health; they could tell you whether you were going to live or die. That is hugely transformed now. Where are we on the same spectrum with mental health? We hear a lot about talking therapies and new drug therapies, but, taken together, how effective are these new therapies and should we be spending more on them?

Professor Sir Simon Wessely: We definitely should. I remember when I started in psychiatry I worked at Queen's Square, the home of neurology, and all these neurologists used to say, "I can't understand why you're doing psychiatry; none of your patients ever gets better"—which is a bit rich from working at Queen's Square. The evidence for us is extremely good. When we have done the big comparisons of the effectiveness of medical treatments versus psychiatric treatments—it is not a distinction we really hold but you know what I mean—we come out just the same. Most of our treatments, like most treatments in medicine, are modestly effective, but with much better ratios. The figure we use of numbers needed to treat are often much lower in psychiatry than what is taken for granted as being normal in cancer or cardiology.

I use the words "modestly effective" and I absolutely push the point that in the next 30 or 40 years we will see therapeutic advances in psychiatry that we saw in neurology 100 years ago, beginning with disease modification in Alzheimer's, which will happen just about in my lifetime, and then later on in schizophrenia and bipolar. At the moment we have absolutely nothing to be ashamed of. The only thing we have to be ashamed of is the number of people who do not get reasonable treatments. We are not talking about miracle cures but reasonably effective treatments, and our record as a discipline in randomised controlled trials is that only oncology has a better record of patient recruitment.

Lord Lipsey: I wonder if you might give us one side of a piece of paper setting out some examples of effective treatments, as it is a very important issue that you have addressed very well.

Professor Sir Simon Wessely: With pleasure.

Sophie Corlett: Can I add to that? Investing in treatments at an early stage is much more effective than investing in treatments later. That is why it is so concerning that the rationing of services means that people enter later. Regarding early interventions in psychosis—one of you will tell me what the recovery rate is—if you intervene when someone has their first episode of psychosis you can make a phenomenal difference to people's prognoses.

Baroness Redfern: On Sophie's comment that half of all mental health problems are established by the age of 14, and Simon has mentioned CAMHS as well, where is the work to improve that? There is a lot still slipping through that net. To Claire, on STPs, you mentioned some have spent more money and I would like to know whether there are better outcomes for STPs that have spent that money. STPs have their priorities

and it would be interesting to know what their priorities are and if they include mental health issues?

Sophie Corlett: At the moment, about a quarter of young people with mental health problems are seen by child and adolescent mental health services. That means that many people are not getting treatments until their mental health problems have become, to some extent, established.

To remind people—I know it is in the title—the Five Year Forward View for Mental Health is only five years and, with an investment of £1.4 billion, will take us up to the heady heights of a third of people as opposed to a quarter. That means that two-thirds of children who could benefit from treatment still will not be getting it. You cannot just invest money and be there in a minute; it requires training and transformation. That is one of the most urgent things we need to do.

To talk again about the human cost, this is potentially a young person who might have an episode or very difficult period in their childhood or adolescence who is then given support and coping strategies to recover from that so that that does not become their life or they do not become someone with mental health problems.

The Chairman: I need to request that we keep questions and answers short. We have not moved on from question one. We will run out of time.

Claire Murdoch: The plan is to 2021 for children and we need to get the plan now for what happens post-2021. It says that we will treat 70,000 more children in specialist CAMHS and we will retrain the entire CAMHS workforce in evidence-based intervention. That has begun and is in hand. We are meeting the target of 60%—which is a low one: within two weeks of referral children and young people will be receiving evidence-based treatment. We are meeting that already on the access rate, but the evidence-based treatment needs more work, and early intervention in psychosis.

The final thing that we are doing, and this is an urgent piece of work, is looking at tier 4 beds. The Committee will be aware that we have an immediate problem of children and young people who need admission being admitted far away from home, which breaks continuity, increases distress and so on. We are working very hard now on plans to get local services for children and young people. All of those things combined is good work but we need to focus on what happens in school, downstream, and this needs to be a cross-government strategy, not just an NHS strategy.

Lord Turnberg: Are the talking therapy movement and the clinical psychologists having an impact? A few years ago I was involved with Richard Layard in trying to convince the Government that we need more of that. Is it effective?

Sophie Corlett: Yes. Many people talk about how it has completely changed their life. There is an ambition now to increase it from 15% of people to 25%. It does not work for everybody but it works for many people. We know that in many areas there is an imbalance towards CBT as opposed to the full range of evidence-based therapies, so that is something that needs to be sorted out. We recognise that it works and

the plan from NHS England now is to make sure that a wider range of people will have access to them.

Professor Sir Simon Wessely: The trials show that it certainly works, but people relapse and require different forms of support as well. Our concern is it is not always in the right place. Most people with mental health problems are in primary care and often not seen as part of a primary care team. Much the same happens in diabetes or community mental health services, et cetera. All the time we want psychological treatments to be integrated with the rest of the healthcare delivery team, not as a stand-alone service. It is the right idea but it is not always in the right setting.

Claire Murdoch: In addition to that evidence base, I know that thus far the programme has seen 3.5 million people being treated, with 2.1 million completing their whole treatment and, of those, 100,000 moving off employment benefits and back into work. Many of those people will have been in work anyway and been enabled to stay in work while they were receiving treatment, but 100,000 came off benefits and back to work. So there is a lot of evidence that says this is a relatively good intervention.

Lord Turnberg: We have focused an awful lot of on where we are now and what we need to do, but we have not got to how we sustain it in 30 years' time and what the difference would be. Is it just more money, because clearly it is a starved service?

Professor Sir Simon Wessely: Most of the costs in our world are not on kit: we do not use very expensive kit; we are quite cheap. Most of our costs are in workforce, in recruiting, training and then retaining a well-informed workforce. That is almost all the challenge. It is still difficult. It is curious because it should not be difficult because if you go to schools—and I have been going round all 35 medical schools in the country—there is a remarkable new enthusiasm for mental health among particularly young people that was not present when I was young. What we have not done is really harnessed that to get people into mental health professions. There seems to be a kind of drop-off in my business. Obviously I am a psychiatrist, so a doctor, but it seems to be when they get to medical school they get turned off. They are extremely excited beforehand, but it seems to be something we do to them that turns them off during their medical education. Much of what we are doing is to try and turn that round so that people come into mental health at all levels and stay there. I think that is the biggest challenge we face.

The Chairman: What is it that turns them off?

Professor Sir Simon Wessely: It is often the attitudes of other senior health professionals. I put that rather euphemistically, but I am sure you know what I mean.

The Chairman: There are several around the table, and you know them all.

Professor Sir Simon Wessely: Exactly. Yes, it is that. The people still will end up going into the kind of firefighting glamorous specialties.

The Chairman: In my specialty I encourage youngsters to go into my specialty; you encourage youngsters to go into your specialty.

Professor Sir Simon Wessely: I do.

The Chairman: Why do you feel you do not succeed?

Professor Sir Simon Wessely: Because some people in other specialities do not encourage people to go into my specialty, whereas in my specialty we encourage people to go into other specialties as well. We like them to do that because we like people to have done other things. Most people in psychiatry come in later.

The Chairman: The important question is about the future workforce in mental health care, the totality of the work force, not just doctors.

Professor Sir Simon Wessely: I totally agree with that.

The Chairman: We need to find a long-term solution, as Lord Turnberg has referred to. In the long term, what is the solution to this?

Claire Murdoch: I refer back to where I started in terms of fundamental problems. There is a hierarchy of what is important in medicine or the NHS and it is the wrong way round. It is a pyramid that needs turning on its head. What is really important is where most people live most of their lives and they take steps that keep them well. They receive early intervention if they are struggling from an evidence base to keep them well. We should not separate, as we do currently, the physical and the mental because they are so inextricably linked that we need to train differently. I felt joy yesterday when I had a spinal surgeon telling me—I thought it was time to retire—that he wished he had more mental health support for his spinal patients because pain management is a huge part of his ability to keep them well. Instead, he refers them for a whole raft of investigations that are expensive, and so on and so forth. It is about treating the whole person, changing the health hierarchy, valuing patients' responsibility for their own healthcare, and using more digital enablers as well. I think one can see a sustainable way forward, but the emotional, the behavioural and the psychological aspects to managing a health system need to be much more centre stage.

Q145 **Lord Warner:** Can we have a change of direction? What role do any of you see for employers in reducing demand on the system, given the volume of work absence from anxiety and depression which is work-related?

Sophie Corlett: We would see a huge role. We do quite a lot of work at MIND with employers. Those whom we work with are able to make quite a difference to their workforce well-being generally to make it a healthier workplace but also to support people who do develop mental health problems to stay in work. That does not necessarily always work because sometimes their employee cannot get access to the health services that they need in time, but it may be to hold a job open if somebody does have to fall out of work, to support somebody to work more flexibly while they are unwell or come back at a slower pace—all of those are things that an employer can do.

Professor Sir Simon Wessely: We were very pleased to see an acknowledgement just yesterday that now work is regarded as a health outcome for the NHS. That is quite an important step forward. Sophie is

absolutely right. We know that where people do develop mental health problems, where you integrate mental health treatment with occupational treatment you get much better outcomes. Where you do one or the other you do not. Things such as IPS, which is a way of delivering what you might call occupational psychiatry, I suppose would be the best way of putting it, or mental health support in an employment context gets very good results, but it is not often used.

Claire Murdoch: Could I add that this year NHS England has tried to incentivise the NHS as an employer, which is what you are saying. For example, a trust such as mine can earn an extra £2 million of CQUIN money if we can show improvements in how we treat staff in three key areas, and this is true nationally. That is around MSK provision—we do not look after people’s backs enough in particular—mental health and stress, and the third area is getting people to have their flu jab. If I can get more of my staff to have their flu jab and I can look after their stress levels and reduce their days lost to stress, and look after their well-being better, and if we can look after their backs and MSK issues better, we are being incentivised as an employer to do that.

The only other thing I would add on top is that we must acknowledge we are a society where more employees are in a caring role, not just to young children but to sick or frail older relatives. As an NHS, we have to lead the way in being an employer that supports staff in their caring roles. I do not think we are good enough at that yet, but we really must focus.

Lord Warner: What have you actually done with the CBI and other employer organisations to drive this agenda with the employers?

Sophie Corlett: We have done quite a lot. We work with Business in the Community and with the CBI. We have worked with the City Mental Health Alliance, which includes many of the big banks, law firms and management consultancies in the city. We have done a number of different things through our Time to Change work which we do alongside another charity, Rethink Mental Illness, and as MIND.

The Chairman: How effective has it been?

Sophie Corlett: The organisations come back for more. They find it helps their bottom line enormously.

The Chairman: Is there any evidence of reducing demand?

Sophie Corlett: For the NHS?

The Chairman: Yes.

Sophie Corlett: I do not know that they are necessarily collecting that. They are interested in keeping people in work and productive. Their employees are interested in keeping in work and well. Line managers are interested in support for how they line manage their staff. All three of those levels are coming back extremely happy.

Q146 **Bishop of Carlisle:** Sophie, you mentioned earlier on that there is an increase in the incidence of mental health issues due to complex societal problems of one kind or another. Can we turn that round and think about the way in which mental health problems are affecting people’s wider

health? This has been alluded to by a number of you. Claire, you were talking about the importance of treating the whole person. From our point of view, looking at the long-term sustainability of the NHS, clearly that kind of link-up is terribly important. Would you like to say a little bit about that?

Sophie Corlett: People with long-term conditions, such as diabetes, respiratory difficulties, any condition that is ongoing and particularly if it includes pain or reduced mobility, increased disability, will have a two to three-times increase in their likelihood of developing depression. That is the first thing. If you have got three or more of those it is a seven-times increased chance of developing depression. So there is an immediate impact.

The more complicated thing is the link that mental health will have on your physical health condition in changing the prognosis. For instance, if you have had a heart attack, your chance of the second heart attack coming sooner and being fatal increase if you have a mental health problem. Likewise with stroke. With diabetes the costs overall are 50%. That is partly presumably to do with your mood and well-being and internal immunity towards that condition—I am no expert on those—and people talk to us about how they find it difficult to manage the condition that they have. They are not able to get their head around their blood sugar levels and the exercise they need to do, or they are struggling to get up in the morning because of depression. Exercise and shopping well to cook well are not top of their agenda, so there are knock-on impacts. So if you can treat somebody's depression and support them with that.

Often people will not think about it as depression. We have not talked about stigma, but there is the impact of stigma. You have already got a long-term condition in diabetes that carries a stigma. You do not want to admit to having a mental health problem as well. Finding ways for people with long-term conditions to get support to cope and to feel better rather than maybe deal with mental health problems are hugely beneficial and reduce costs on the physical health services as well as on people's lives.

Professor Sir Simon Wessely: In a large trial done across the road, our group on diabetes showed that if you bring mental health treatments into a diabetes population you improve their mental health, which is not surprising, but you also improve their diabetic control. That is one of the reasons why diabetes has been used as an example of rolling out into greater physical and mental care—and it saves money.

Claire Murdoch: In addition to the prevention work that needs to happen, if I ruled the world, I think we underestimate the power of patient education programmes, so as soon as anybody is diagnosed with a new long-term condition I would make it an expectation of them that they would attend a training course that would often be peer led. We run one of the most interesting ones in the world in my trust, which I inherited, around HIV, which is peer led but backed by professors. Every newly diagnosed patient with HIV, for example, at UCLH will be referred to our peer-led education programme. It is five sessions that will help them understand the course of their illness, living well with their illness, what to tell an employer, where to link and get self-help, and how to understand the drugs they are on. When you look at what people report before and

after that diagnosis, it is extraordinary. I do not think we do enough to give people the information and tools they need at the point of diagnosis to manage themselves through informal networks better. In addition to the prevention agenda, that has to be part of a different, more sustainable NHS. Those programmes are terribly important and effective.

Bishop of Carlisle: Besides the impact on people's well-being, which is obviously the most important thing, there is a very strong financial incentive to get the prevention right at an early stage.

Sophie Corlett: Yes, and we are talking about billions of pounds to the NHS.

Bishop of Carlisle: That is very helpful. Thank you.

Q147 **Baroness Blackstone:** We know that there are big inequalities of outcome between those who are mentally ill and others. Those who have long-term and serious mental illness die 15 to 20 years earlier than other people. One of the issues that has been raised with respect to this is whether there is real parity of esteem between mental health and physical health. I know that the 2012 Act made it a legal requirement to try to promote parity of esteem. How far has that happened? There are things that you have said about hierarchies of status and medical students being put off once they get there in achieving greater parity. What do you see as the barriers and how can they be overcome?

Professor Sir Simon Wessely: Parity of esteem is a kind of slogan that covers a lot of different things, one of them being exactly what it says: the mutual respect that there is. I sometimes say if something is good enough on one side of the road, thinking of where I work in Denmark Hill, in terms of whatever it is—canteens, car parking, access—it is good enough for the other side of the road, and usually it is not. It would not take you very long if you crossed Denmark Hill to know whether you were in an acute sector hospital or a mental health sector hospital. You would spot it very quickly in all sorts of ways. That would be the first thing.

The second thing is we have to be very clear, and my bit of the profession takes responsibility for this, that we have neglected the physical health of patients with severe mental illness for too long. We have drifted too far away from our medical roots. We have forgotten that we also have a job to do on the simple stuff, such as cholesterol, obesity, exercise and smoking. Fifty per cent of all smoking products are sold to people with mental illness. That is a scandal, but that is the case. The biggest single killer of people with mental health problems is not suicide, it is not violence, it is cancer due to smoking. That is the biggest avoidable death. The next biggest avoidable death is heroin overdose, which we do not even think of as a patient safety avoidable death issue, but it is. The rate of that has doubled in two years. It has gone from 500 to 1,300 in two and a half years. We do not seem to be shouting from the rooftops about this. These are the things that are going on.

There is a lot we are doing. We are doing a lot with NHS England, with our sister colleges, in medical education, in curriculum development, in incentivisation of trusts to deliver better physical healthcare and developing things such as physician associates to help address these

problems, but we have got a huge amount of catching up to do. It is partly because we have accepted that it is okay for people with mental health problems to die 15 or 20 years younger. We have known about this for a hell of a long time but have kind of not bothered about it—just like we do with addictions to alcohol and drugs. We are not as fussed about it as we are about other areas.

Baroness Blackstone: Why should that be? Is it because people think it is their own fault?

Professor Sir Simon Wessely: Yes, partly it is that. Sophie has already mentioned stigma. There have been some reductions in stigma due to Time to Change.

Sophie Corlett: A reduction of 8.3%.

Professor Sir Simon Wessely: But anyone who thinks that issue is over or solved is not on this planet.

Lord Mawhinney: Would it be fair to summarise what you have said by saying that while this place here can pass legislation, like parity of esteem, it does not mean a damn thing in the NHS?

Professor Sir Simon Wessely: You are asking for a major change and that takes at least a generation. The answer to your question is what you have said would be fair.

Sophie Corlett: I think it does stand for something as part of the mental health lobby perhaps. Coming from a voluntary organisation, we have found it very useful to remind people that they now have a responsibility to get on and change things, but we have to make sure that those changes happen at a societal level where stigma still persists and people think it is okay for people to have to wait for years to get a service when they would not expect to do that for physical health. Even society's expectations will have to change. Even within the mental health provider sector, there is a tolerance of expecting to not get an equal share of the pot to provide the services that they know they could do, and actually it is all part of the same problem. Shifting people to a belief that we should and can do better, I think, is the first step. NHS England has played its part in coming out with a plan for five years of what needs to be done, but making sure that we stick to that plan will be quite important.

Claire Murdoch: It is an anecdote, but Chris Smith was the first MP to come out as openly gay in the House in 1983 and people will remember that it caused a big splash nationally. The first MP to come out as openly having mental health problems was in 2012, some 30 years later. For me, that spoke volumes about the ease with which we can talk about having mental health. Everyone in this room has mental health and sometimes our mental health is better than it is at other times. What we do around drinking, exercise, diet and seeking help from a GP is all affected by how we are feeling. I think that the issue of stigma and bringing a new literacy to our young, in particular, about how they talk about and understand the interrelationship between physical and mental health is terribly important, in my opinion.

I have personally stopped using the "parity of esteem" phrase. In the NHS England plan that was published in July of this year, you will not find it.

Again, in the planning guidance that has gone to the NHS, you will not find it. It is a controversial step I have taken, but I am saying that actually mental health services and the work that we do is not something just for that mental health trust to worry about but happens in primary care, schools and elsewhere, and there is an evidence base. It is time, in a sense, certainly from an NHS perspective, to stop feeling we have to campaign and we have much more an expectation that we will do what works and what is right for our population. That is a controversial thing to put before the Committee. I will not use it anymore; I have gone beyond it.

The Chairman: It is a pity that you do not use it because the purpose of introducing it was for the very reason of giving a higher profile to mental health care services.

Claire Murdoch: I think it has done its job and we need to push further still now into that thinking.

Lord Willis of Knaresborough: Given, Lord Chairman, that it was your amendment that created it in the Act, I think that is something we should gloss over very quickly, in the realms of diplomacy.

Claire Murdoch: I will go and insert it in the plan immediately.

Q148 **Lord Willis of Knaresborough:** When you actually look at the Five Year Forward View and the impact of the workforce on mental health services, there is not a single area where the actual demand has not gone up for staff, yet the overall workforce is going down. When we talk about this parity of esteem, which I still think is worth discussing, what we actually find is that there is an entrenchment by mental health professionals themselves of actually seeing their empire expanded. In the work of nurses in the shape of caring, and the discussion about the four strands, I have met people who had one morning only of mental health education as part of their three-year degree course, yet there was a protection to say, "We should not expand that to all staff". I just wonder what your take is on the current state of the mental health workforce and what we need to do in talking about a broader workforce who have the skills of mental health. If we do not diagnose it early, how on earth are we going to make any inroads? It is not by employing lots more psychiatrists.

Professor Sir Simon Wessely: We are obviously completely on that agenda, massively, and in two particular areas. We are working hard to increase, not decrease, the amount of mental health coverage in medical school curriculums and it is possible that the proposed expansion of 1,500 extra doctors a year will provide a very good opportunity to realign medicine and bring out a new type of medical school student who actually wants to do the most difficult job in medicine, which is of course general practice—which also carries the bulk of mental health.

The big change we have made and worked very hard for is that, whereas, when we were all qualifying, nobody did a psychiatry house job, they did not exist and it was not possible, we had the foundation year and it still was not possible, this year we have hit the point where 45% of all medical students will do a job in psychiatry. I can tell you the truth, that, when they are told that, they do not go around whooping with joy, but at the

end of it they really appreciate it, they have learned a lot and they say that they feel that they can do a better job—actually it is the third most popular job. We are going to keep pushing that until all medical students have done a foundation job in psychiatry. That will have the biggest effect on the delivery of healthcare, I think.

Lord Willis of Knaresborough: It will not if the 2,500 nurses a year, for instance, are being educated in four strands, three of which have virtually no mental health input.

Professor Sir Simon Wessely: I could not agree more. Obviously, I cannot speak for the RCN and nursing, but I can say that we are working with HEE to help it develop new curriculums for nurse training. Clearly, we are—and MIND as well. Why would we not?

Sophie Corlett: We have just today launched part of our primary care campaign exactly about GPs and practice nurses in primary care. Yes, less than half of GPs have any background in mental health, and that is in psychiatry, which is not the extreme end of what they do but the opposite of what they do, in one sense, because of how mental health works and who ends up in primary and secondary care. Nurses get even less, so the RCN is absolutely backing our campaign to say that nurses need to get more training and more on-the-job training because their access to CPD, once they are in practices, which is not the same as the NHS, can be quite limited and they can often not be released from the practice to do training. So it is not just that people do not get the training before; we have a cohort of people already and getting them trained up is also a real problem. It is a massive problem, particularly in primary care, I would say, but actually it is across the workforce. We have talked about diabetes and respiratory problems, and those people also need to have an understanding of mental health. Otherwise, I think we are going to struggle and continue to struggle to meet the need.

Claire Murdoch: First responders, who can be teachers and might be the police, a whole tranche of people, need good enough mental health awareness to be able to spot it. The training programme and the awareness programme that you talk about needs to go very wide, bringing it back closer to the professional groups. I completely agree with you that a generic core foundation around physical and mental health is essential. When I trained as a mental health nurse a long time ago, I also did a long stint at the Royal Free on a medical and orthopaedic ward and I had to know the basics of good physical healthcare. That was a real asset and we need to see that across the professional groups.

I do worry about those professional groups, such as school nurses and health visitors, who are fundamental to good child health and are now broadly commissioned by local authorities and outside of the NHS purview. I think we have to think very carefully when we think about the future of the NHS about those elements of provision that have moved firmly outside of the NHS reach into local authority hands. That may be a good thing overall, I do not know and I will not express any more opinions, but, whatever one thinks, it is a vital area of the workforce that we must be sighted on. I think we are less so at the present time and we need to stop that drift going further still.

Professor Sir Simon Wessely: What has massively influenced my viewing of these things over the years is that I am a psychiatric adviser to the Army and there we changed the systems of dealing with soldiers who have trauma, who used to be seen by external professionals, psychologists, counsellors and people like me, and we did the trials that showed that it made them worse. When you support the management and they get the support to do the things they should be doing themselves by people of the same culture, background and uniform, you get good results and you get better mental health. That is the model I have worked my whole career by.

Similarly, with schools, I do not want every child in school to start seeing counsellors and mental health professionals, et cetera, but I want there to be CAMHS people in the school to help teachers do just that, just as my life is about helping other doctors to deliver better mental health care, rather than us doing it all ourselves, which we cannot do.

The Chairman: Normally, that is done by an institute of higher education developing programmes of education which they can target towards teachers and other employers. We are not doing that, are we?

Professor Sir Simon Wessely: We are doing that, but, even more important is what I said about IAPT earlier about working in a team where there is a psychologist as a part of the team on the same rounds and having coffee with you to whom you can then say, "I have this really difficult problem. What should I do?" You should have the people with the mental health skills and training as part of the group, not in another hospital 20 miles away, and not in another system with its own IT system that does not talk to you when you need to refer. That is where you get a cultural change and the normalisation of mental health as part of the wider team. We have done quite well with the Armed Forces, and we are already hearing tremendous enthusiasm for putting CAMHS people into schools.

Sophie Corlett: You are right, it is also about people in other front-line jobs, such as teachers, youth workers, police, employers and line managers knowing how to spot and support people in a general way and then how to signpost people on.

The Chairman: That is exactly what I was trying to get at. We run all kinds of courses in the institutions of higher education, including universities, where departments of psychiatry might run such courses. Why do they not?

Professor Sir Simon Wessely: We do run these courses. One of the few ways we make money is by running these courses, so we do. But that is not in itself enough.

Sophie Corlett: I do not think it is always psychiatry. You do not necessarily want a teacher trained in psychiatry; you want them to understand mental health, so it is the sort of thing that we deliver, and there are other training courses specific to teachers or to different groups.

Q149 **Baroness Blackstone:** What is your single key suggestion for change that the Committee might recommend to make the NHS more sustainable?

Professor Sir Simon Wessely: I will end where I started, which is integration of the mental and physical. You can call it parity or whatever you want, but it is the integration, not separation, of the mental and physical at all levels, from training right through to service delivery.

Sophie Corlett: I would go back to the money.

Professor Sir Simon Wessely: Yes, and the money.

Sophie Corlett: I am sure the money is a given in all that we are saying. We need to see the money that has been committed get through to the front line and we need to see a promise of further money after these five years because we need to see a trajectory where we are actually moving from the current position to something that resembles parity. However many years that takes, we need to see that it is a constant commitment that people are absolutely determined to reach. It is about the forward commitment to the money, the money at the moment getting through to the system and it is the people who work in the system having the confidence then to say, "Okay, we will deliver what's being asked of us". At the moment people are still in that position where they are not quite sure that the money will get through. There is a lack of confidence and, therefore, potentially, the jury is out for some people as to whether they are going to make the changes that are required.

The Chairman: What is yours?

Claire Murdoch: Probably transparency. I agree with what both of my colleagues have said, but I think too little is known or understood about mental health, the spend against it or the value that it adds. We need education and transparency so that we do understand the evidence base more, the outcomes and what value a pound spent here might bring to a patient journey where you might save £4 there. Last Thursday at 5 pm when we published the CCG dashboards, it was not just the money that was published, the investment, it was also performance and outcomes, which will enable us to look in a more sophisticated way at which health systems are deriving greatest value. It is transparency and education that will bring the biggest benefit, I think, not just to mental health services but to health, the NHS, as a whole.

The Chairman: Thank you, all three of you, for coming today to give evidence; it has been most useful. I think you have promised to send us some treatment data that Lord Lipsey asked about, and we will welcome any other evidence that any of you may wish to send. Thank you for coming today.

Nuffield Trust, Department of Health and Professor James Buchan – Oral evidence (QQ 150-157)

Evidence Session No. 15

Heard in Public

Questions 150 - 157

Tuesday 8 November 2016

Watch the meeting

Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

[I](#): Candace Imison, Director of Healthcare Systems, Nuffield Trust, Dr Graham Willis, Head of Research and Development, Workforce Analysis, Acute Care and Workforce, Department of Health; and Professor James Buchan, School of Health Sciences, Queen Margaret University.

Q150 **The Chairman:** Good morning. I am extremely grateful to all of you for coming today to help us with our inquiry. We are looking forward to your evidence. Although we have some questions, feel free to say anything else you wish to add. It would be helpful before we start if you will introduce yourselves, and if you represent any body please say so. If you want to make an opening statement, please also do so. During this session, members of the Committee may well declare their interests before they ask their questions.

Professor James Buchan: Thank you and good morning everyone. My name is Professor Jim Buchan. I am a professor at Queen Margaret University in Scotland, the country just north of here.

The Chairman: We know where it is, yes.

Professor James Buchan: Most of the work I have been doing recently has been international. I spent a couple of years working in Australia for the federal Government Health Workforce agency. More recently I have been working as a consultant to various organisations such as the World Health Organization, World Bank and, within England, mainly with the Health Foundation.

I was aware that I was able to make a brief statement and I have three short points that were very much in my mind when I received the invitation. Obviously much of the focus on sustainability is driven by the recent funding and financing issues. We are all looking at a sector that is

labour intensive, and the reality is that it is partly about money but it is really about workforce and staffing. Therefore, the sustainability of funding is also about the sustainability of the workforce. We can look at the demand side and look at population growth and population complexity driving the process, but the solutions very much have to come from the workforce side.

On that basis I have three points. First, if you look around the world there is, generally speaking, a correlation between how much countries spend on health and the size of the health workforce in relation to population. A few countries vary, but generally speaking that holds. That does not mean that the country has the best workforce or the workforce with the right skills or that qualifications are in the correct place.

I know you are looking today at the skill mix, and probably my main message would be that we need to look at building the current workforce, enhancing its skills and enabling it to work effectively in teams. I am saying that against the background of recognising that according to the Council of Deans of Health we are currently looking at a reduction in CPD budgets of somewhere between 13% and 45% for the current workforce. I cannot see how we can improve and enable skills of the current workforce against that type of funding cut.

Thirdly, there are challenges in planning and health workforce planning in the UK, but the reality is that the government policymakers in England have their hands on more policy levers when it comes to health workforce than in virtually any other country. We fund health professional training. We employ virtually all health professionals when they are in place. We decide how much to pay them and up to a point we decide where they should work. The policy levers are there if the Government of the day wish to use them. Part of that is obviously also about the level of funding given to the NHS.

Dr Graham Willis: Good morning. My name is Dr Graham Willis. I am head of research and development in the workforce analysis branch at the Department of Health. Prior to that, six months ago, I was also head of R&D in the Centre for Workforce Intelligence. I believe that some of the work we have been doing is of interest to the Committee. It might be helpful to lay out the background to our thinking at the CfWI. The approach we are taking is that we are dealing with a complex and large health and care system. We know that. We have tried to avoid trying to forecast workforce supply and workforce demand. Instead, our approach was to think more about the different ways in which the future might unfold in order to understand the forces and factors driving it. They are going to be different today from what they were six months or a year ago, because they are constantly changing.

We then develop a set of scenarios for the different ways in which the future might unfold. You can think of those as plausible but challenging. Once you have that idea you can use it to test your plans, your policies and your options to see how they perform across this range of futures, and hopefully to create an option that is robust in the sense that it works best across that set. I think this gives you a broader range of insight, because you will see that some futures are more desirable and some are less desirable; some you might have control of and you can use levers in,

as Jim was saying, and some you cannot. It is about recognising that trying to predict 15 to 20 years ahead is going to be very difficult. A better approach is to think about the uncertainty of the future, use scenarios to stress test your ideas and then strive for robustness rather than perfection, because there is no perfect solution.

Candace Imison: Good morning. I am Candace Imison. I am director of policy at the Nuffield Trust. I have a long-standing interest in workforce in a policy context which began when I worked at the Department of Health where I led their contribution to the Wanless review on the workforce. That modelling, maybe for the first time, tried to include skill-mix changes. I worked with Anita on that. I then worked at the King's Fund with Jim on a review of workforce planning. We looked internationally at that, and what it really tells us is that workforce planning is a very difficult thing. No country gets it right, but I would support Jim's point that this is about thinking about it in a much broader way than predicting numbers; it is about managing the whole workforce. Also at the King's Fund I did a major piece of work looking at future trends, and again we thought about the future of the workforce. Since coming to the Nuffield Trust, we have done a major review of the opportunities relating to skill-mix change.

As an opening comment, I would echo Jim's welcoming of the fact that you pay good attention to the workforce because without it there is no healthcare, so it absolutely fundamental. Recognising that we are not alone in the challenges that we are facing with the workforce, I was really struck by a chief executive of a big chain of German hospitals who said that we are moving from an era where we are competing for patients to an era where we are competing for staff. The pressures that we are facing are felt across the board. There is a rising concern about whether staff are equipped with the necessary skills. A big OECD review looking at the workforce recently said that we are seeing a shift from a focus on numbers to skill mix. That, again, would underline the need to develop the skill mix in the current workforce.

My final point is to recognise the current productivity challenge, which, while you may see it as a short term issue, is a very real threat to the long-term sustainability of our workforce. We are seeing threats to morale and numbers across the piece that will not be easy to repair. The raiding of the workforce training budget in order to support revenue budgets I see as a very short-sighted and very risky manoeuvre.

The Chairman: Thank you for your opening statements. Of course they have prompted questions that members of the Committee may wish to ask you. I know Lord Willis wants to ask a question, but I hope he will hold his fire until he gets to his question, because your statements have raised some issues. I am going to pick up on one of them now. I would like to know what you think are the workforce issues that are the greatest threat to long-term sustainability. This is about looking into the future. I hear what you said, Dr Willis, that it is difficult to predict what is required in the future, but we need to know with some degree of certainty how many, who and how we should train people to provide the workforce that will be needed. I also hear that other health services also have this problem, and while I hear that I have to say that it is not our problem. We need to fix our problem. So that cannot be the excuse for not trying

to get it right. On that basis, who would like to pick that up?

Professor James Buchan: The starting point for future assessments clearly has to be: what is the likely demand for healthcare going to be? In that regard it is possible to have a greater degree of if not precise accuracy at least a direction of travel against which you can then match funding and workforce. It is apparent, not just in the UK but in most high income countries—OECD countries—that population growth, population ageing and more people living at home are all pointing not just to a growth in demand for healthcare but to a growth in types of complexity of demand, home care, chronic disease, musculoskeletal, et cetera. You can put approximate numbers against those, and you can with some degree of certainty look ahead at what that means.

The bigger unknown is how much funding is going to be allocated to try to meet those needs and how you translate that into workforce. One of the points I made in my introduction is that I would be concerned if the focus of skill mix and workforce planning were just calibrating that we need more of the same. A recent example of that is the announcement of 1,500 more doctors to be trained. I am not aware of what the planning behind that assessment has been, but meeting that from current budgets means that there is an opportunity cost somewhere in the form of what will not happen because of that decision. Therefore, it is not just more of the same, but equally it is not just looking at introducing new roles or new types of worker as the solution.

The NHS has not had a good track record over the last 20 years in introducing and enabling the effective use of new types of worker. The physician's assistant is one example. Another is the associate practitioner. We are now hearing about nursing associates being introduced. Having spoken to people and read what is going on, my understanding is that the introduction has not been very effective so far.

Guiding yourself between those two problematic areas, just looking at more of the same or just focusing on new types of worker, a lot of the emphasis has to be on enabling the current workforce to be as productive as it can. That is, in part, about looking at enhancing its skills, enabling it to work more effectively in teams. I am aware that in some ways that is a low-tech solution and perhaps not one that is so attractive to Governments, because you cannot pronounce it so easily on the front page of a newspaper. However, if we do not put effort into those areas, the real concern is that we will be using the limited funding in the least effective manner, not just for workforce growth but for workforce productivity increase.

Dr Graham Willis: I will pick up on the comments that I made earlier about uncertainty. This does not mean that you cannot plan, but when we do our modelling we see that demand changes across the workforce groups, and for some workforce groups in the future we see a much bigger rise in demand than for other workforce groups. That would give you a focus of attention. We also see the rise and the changes being more uncertain in some areas for some workforce groups and less uncertain in others. You can use this to think about which workforce group you should focus your attention on. They might be the ones where we see the biggest

growth in demand but are perhaps the most uncertain about how big that growth is. It is a way of focusing your attention.

The Chairman: Give me some tangible examples. If you were looking at what workforce we may require in 2030, both in healthcare and social care, what does your model tell you?

Dr Graham Willis: That leads us onto the Horizon 2035 modelling. Would it be helpful if I start explaining that?

The Chairman: Yes, please.

Dr Graham Willis: In Horizon 2035 we were asked to look at the whole health and care system, which is health, social care, public health and informal and voluntary care. That is the whole system involving about 11 million people if you include 5 or 6 million people in informal care. We looked at it to answer the question: how might skills change in 20 years' time, and what does that tell us for policy? We developed a framework to think about how skills might evolve in the future. We looked at a number of different sources of demand that were driving those skills, i.e. long-term physical conditions, long-term mental health conditions, learning disability and acute oral health. There are about seven or eight different categories.

We know what the workforce is doing today and we mapped that to a skills framework. When we run the model we see that the demand for skills changes in the future. We see some workforce groups having a much larger increase in the demand for their skills than others. It is very polarised around the lower level of skills, so the largest increase is around informal care, level 1, which is basically unskilled. The skills increase for all groups, but it is much bigger for level 1 and level 2, which is some small training. It decreases as you go up the skill levels. We see that about 90% of that demand comes from an increasing and ageing population. It is driven particularly by long-term physical conditions, which is the biggest driver followed by long-term mental health followed by learning disabilities. Taken altogether, the overall picture shows an increase of about 35% between 2014 and 2035. We are using 2014 data; we do not have the up-to-date data.

The Chairman: Is this workforce in healthcare, not in social care?

Dr Graham Willis: It is the whole lot.

The Chairman: So it is a 35% increase from what it was in 2014.

Dr Graham Willis: Yes, across health, social care and informal care—a whole system increase.

The Chairman: What does that look like in numbers?

Dr Graham Willis: We have to do an translation, which we do not do again through a forecast. We quantify some of the parameters we need for our modelling by getting expert panels together and they tell us what they think the answer is, but they also tell us how uncertain they are. We ask them to think about where the future might be but we only use that as a kind of reference point. We have created a set of scenarios and we ask them to quantify the range of scenarios. We have a spread of uncertainty here, 35% in terms of skill hours, which is the unit of

currency that we use in the modelling. It is not numbers of workforce; it is an hour that a skilled professional is using to deliver a service. It is an increase of over 3 billion skill hours, which is roughly equivalent to 2 million FTE people. That is across the whole system, which includes informal care.

The Chairman: Some 3 million full-time equivalent people.

Dr Graham Willis: It is 3.5 billion skill hours, but equivalent to about 2 million FTE people across the whole system, which includes informal care.

The Chairman: Roughly you are saying that this is not a tablet of stone, but from the models it looks as though we will need 2 million more people working full time in health and social care by 2035.

Dr Graham Willis: You can use the term “work”, but of course some of these people are informal carers, so it is not paid work.

The Chairman: Is that not work?

Dr Graham Willis: It is not paid work in that sense. Also, the population is increasing in that same period. I think it is about a 14% increase in population from 2014 to 2035, which is roughly 7.8 million.

The Chairman: That will depend. Candace, do you have any comment?

Candace Imison: The point I would like to get across about future sustainability to leave in the Committee’s heads is the degree of skills mismatch that we currently have in the workforce. A very powerful study was done across the whole OECD that showed that 51% of doctors and 43% of nurses felt they were underskilled for what they are currently doing, whilst 76% of doctors and 79% of nurses felt that elements of their role were overskilled. That tells us that our roles are not designed correctly for the skills of the staff that sit within them. There is a major challenge going forward in understanding what skills are needed in a role and then being much more intelligent about aligning staff to that.

Another worrying point is that, of the healthcare support workforce, nearly 20% have said that in this country they are being asked to do things beyond their scope of competence. There is a big role redesign piece there and that comes back to the need to have adequate money to invest in training and development of staff and really understanding what those staff need. A classic example would be what we are currently expecting junior doctors to do. This is not good training for junior doctors, and often does not result in good outcomes for patients either. We have not adequately thought about the roles in hospitals to deliver good outcomes for both staff and patients. I would commend that as being something to take away.

On the workforce planning piece, when you look across the challenge of workforce planning not enough attention is played in understanding the current position. Workforce plans tend to take the current position and roll it forward rather than thinking about how we get the current position to be the place that we need it to be. As Jim said, when we have done skill-mix change in the past we have tended not to do it very well. We have tended to layer roles on rather than, coming back to role design, thinking about how the whole team works. Often you find that roles that were

hopefully substituting end up supplementing. As I described earlier, support workers are left doing things that are beyond or below their competence, because the team does not understand what each other's roles are in care.

The Chairman: Thank you very much. Before I open the question up—Lord Willis, Lord Warner and Lord Lipsey have supplementary questions—Dr Willis, you gave me a figure that included unpaid workers, the carers.

Dr Graham Willis: Yes.

The Chairman: Can you give a figure that is solely based on paid employed people, and what that number will look like in 2035?

Dr Graham Willis: I do not have that figure in my head, but we have it from the models.

The Chairman: I would be very grateful if could let us have it.

Dr Graham Willis: Yes, no problem.

Lord Willis of Knaresborough: I should declare my interests, as we have been asked to do. I am a consultant for HEE and the Nursing and Midwifery Council, and I chair the graduate apprentice nursing implementation programme and the Yorkshire and Humber collaboration for leadership in applied health research and care.

Professor Buchan, I was particularly interested in your opening comments, and one that you slipped into your opening comments, about the amount of CPD resource that is actually available, given that roughly 50% of the current workforce will be operational in 2030. At the moment, somewhere in the region of 90% of a roughly £5 billion budget is spent on medics on their training and continuous professional development in order to operate. That, in many ways, answered Candace's comment that at least they have an opportunity constantly to be up to date through that programme.

However, the amount of money spent on the bulk of the workforce—the nursing, midwifery and other allied health professionals, forgetting the care assistants just for the moment, which is another huge issue—is incredibly small, yet that has been cut by between 10% and 40% in some cases. What is your solution to that? There is a large pot of money, which is being allocated in a traditional way yet needs a constant change in order to move it forwards. I would be very interested in the panel's view on how we shift that money.

Professor James Buchan: There are two elements that I would suggest need to be given more consideration. First, my experience as to how the current budgets are allocated is not dissimilar to yours. It tends to be historical and it tends to be targeted at certain groups. It is not driven very much by identification of needs for training as set against our skills deficits or what the new skills that are required to deliver healthcare are going to be. We need to look at how we can turn that around so that the budget allocation is driven much more by training needs assessment. That has to be across the workforce, partly because of the issue you have raised about whether or not there is currently fair allocation. But, more

importantly, there is a need to look at allocating this funding so that it encourages team-based working.

The second question is: is the relative size of that budget compared to other funding streams appropriate given the level of challenge in improving the skills of the current workforce? To my mind that leads to the answer that we need to look carefully not so much at reducing it but probably at increasing it.

Lord Warner: I declare my interest as the Minister responsible for workforce planning 10 years ago, so probably some of the disastrous decisions I took then have led to where we are now. However, I would question whether in reality we have quite as many levers in Richmond House.

I would like to explore this 2 million more care workforce people or full-time equivalents. At the moment there are only about 3 million paid staff in the health and social care workforce, so how much of that 2 million is, as the Chairman asked, equivalent to the 3 million that we currently have as paid workforce? You may not have these numbers to hand, but we also need to know what the numbers are at the higher levels—the doctors—and at the level of the nurses and the scientists. Dare I say it, we also need to know a bit more about the managers, those much-maligned people who on the whole make a lot of these systems work. Is your system for Horizon 2035 going to give us that kind of data? What we say about that paid workforce is going to be very different from what we could say to the Government about the unpaid workforce and the role of families. If we have that data, that will be critical to the Committee's work.

Dr Graham Willis: If we were to plot the data on a graph as to where that 2 million goes, the line on the graph would go up. On the left would be the lowest increase at the highest level of skills—trained hospital doctors and consultants. The biggest increase would be level 2. Then there is level 1, which is informal care, untrained care workers. Where does the bulk of that 2 million go? It goes down to the bottom end, because the graph goes up. It is not a straight line, so it may be that 80% or 90% of that 2 million is seen at those level 1 and level 2 skills.

Lord Warner: Are they in our current system, or are we talking about families and volunteers?

Dr Graham Willis: Yes, you are. Our modelling for 2035 was tasked at looking at the whole system, including informal and voluntary care—people caring for people at home. Because you are dealing with a lot of people delivering care to relatives, the numbers are large, but our knowledge of what they are actually doing and the detail needed to put it into a model is not as good as it should be. However, it shows you in broad terms that the lower the level of skill, the greater the increase. That is where the bulk of the 2 million goes.

Since we know that the numbers coming out are so skewed, in other words that the biggest increase is at the lower level of skill, and that the increase is driven primarily by three areas of demand—long-term physical health, mental health and learning disabilities—we could look at those areas and try to put more detail in. We could perhaps break the groups

down more. Perhaps rather than dealing with long-term physical conditions as a big lump you might break it down into diabetes, heart disease or whatever. In the same way we can look at the lower level of skill, level 1, which is informal care—care at home, if you like—and perhaps do more work in that area, because that is where the big increases are seen. That would allow us to put more detail and hopefully get more accuracy in the model.

Lord Warner: I think that would be extremely helpful to the Committee.

The Chairman: Would you be able to let us have those details?

Dr Graham Willis: Yes, we have the details. I should give two health warnings, if you like. One is that the numbers we have run the model on are from 2014 data, which we are currently updating to 2015. The other is that this is for what we call the reference future, which is the future that our expert panels have said they think is the way things will be. We tend not to think of it as a forecast; we tend to think of it as a point at which we ask them how that might vary across a range of scenarios. We use the reference future as the starting point. We say to them, “You said it was this in the reference future. In scenario 1, how does it change?”

The Chairman: Who are these expert panels?

Dr Graham Willis: They are between five to eight people. When we were at the CfWI we put them together for their expert subject matter knowledge, and we asked them to quantify certain parameters that we need for our modelling that we do not want to guess. If we want to know for a particular scenario in the future how might productivity change—

The Chairman: You said they are experts. Experts in what?

Dr Graham Willis: They are experts in a particular field about which we are asking the question. If we are asking about future productivity we will gather five to eight people together, which is generally about the right number, who can help us to answer that question. It is important to understand that the experts not only tell us what they think the answer is, they give us a range of uncertainty, which goes into the model, and they give us their reasoning as to why they said it was that. It is very much as the ONS might do population forecasts: you clearly have to put a number on what birth rates and mortality rates might look like in 20 years’ time. They ask experts, they get the uncertainty, but they also get the reasoning.

Lord Lipsey: I am sorry, but this probably seems to you to be an incredibly innocent question. As I read these documents I felt as though I was cast back into Stalin’s Russia looking at the 10-year plans. Of course, in practice they do not work out at all, partly because of contradictions, so we are now going to train many more nurses because you projected that we need more nurses, but we are going to take away the subsidies for training and substitute loans in a way that will give a very big disincentive to become a nurse. I see very little in any of this about prices. If there is a shortage of social care workers, you do what you badly need to do anyway, which is increase their wages. There will be certain consequences, but you increase their wages. You will then very soon deal with the workforce gap. Why are we doing all this centralised planning?

Candace Imison: It is really important to spot the gaps that might be coming. A good example is the US, where they looked forward and saw prospective huge gaps in their nursing workforce. They upped training and have now brought their nursing workforce back into balance. For me, that is what workforce planning is about. However, it is also about thinking intelligently about the sort of questions that Lord Willis was talking about. Where are you deploying your training budget? I do not think we have had nearly enough debate about that. High-level figures are that the NHS spends £627,000 training a specialist. The specialists themselves will end up spending over £100,000 on their fees and living expenses, whereas after the bursary introduction we spend £19,000 on training a nurse while we are expecting the nurse to pick up £60,000 of cost. The equivalent investment on a nursing associate is £13,500. You can see this incredible imbalance. A lot of the investment in doctors actually comes from the subsidy that is paid to providers who host the doctor for their post-university period. That can very quickly accumulate to a large sum of money. I do not think we have thought deeply enough about how we deploy that. It also creates a scenario where trusts become very dependent on junior doctors for service which is of questionable benefit anyway, as I was saying earlier. I think there are some really profound issues to look at there. These are big sums of money.

Lord McColl of Dulwich: When dentists qualify as dentists, they are fully competent and get on with the job. That used to be the case with medical students, so when they qualified they had actually been doing all the practical things and it was not a big change. With nursing, again, by the time they qualified as a nurse they were fully qualified to do things because we had the apprentice system. Do you see any way of us getting back to that?

The Chairman: Yes or no? It is not in the plans, is it? The answer is no.

Lord McColl of Dulwich: Thank you.

Lord Willis of Knaresborough: That is not quite so. We are bringing apprentices back. The nursing workforce will be apprentice-led, as will the care workforce, as in fact will the junior doctors soon because they are going to be apprentices in reality because they will be claiming through the levy. It is a very pertinent question, because the use of the levy of 0.5% of your workforce payroll will have a significant effect on the issues that we are talking about.

Candace Imison: Yes, that is a very good point.

Lord Willis of Knaresborough: I am sorry to answer that question.

Lord McColl of Dulwich: Thank you very much.

Lord Willis of Knaresborough: It is nice to be of help.

The Chairman: Can we get back to the witnesses? Do you have any comments?

Candace Imison: The increasing focus on growing your own in the workforce is really positive. Pulling in people from your local community and using the healthcare workforce as a means of training and advancing people has health benefits of its own. I sit on the board of a large acute

trust and what we are having to pay out for the apprenticeship levy versus what we get back in again does not seem to work. It is not creating quite the incentives that you would want in an ideal world. My sense is that we are potentially losing out from the apprenticeship levy, although clearly there is an incentive to make the most of it. It is costly and difficult for trusts to manage the apprenticeship through.

Q151 Bishop of Carlisle: I was going to ask a question about the rationale for changing the skills mix. You have already gone quite a long way down the track of answering that. I have a further question about what kind of composition would make most sense for the future. Dr Willis has already indicated, if I have understood it correctly, that we are going to need many more at the informal lower end and fewer skills at the higher end. Focusing back on this question of levers, Professor Buchan, you mentioned that the Government have the levers. Lord Warner asked if they were really there and said that there might not be as many as we think. If we are determined to change the skills mix in the workforce, how can it best be done?

Professor James Buchan: First, I think I was very careful to say that the Government have more levers than in most other countries. That does not mean that they have used them or have necessarily always used them effectively. However, I think they are there. When it comes to a skill mix change, I would start from the point I made earlier about looking at how we can enhance and improve or update the skills of the current workforce rather than look at completely new roles.

Picking up on what Graham said about projections of where future demand will be, it is very clear, if we are looking particularly at significant growth in the provision of care to the elderly, many of them at home, that the focus, also in relation to the so-called informal or unpaid workforce, will have to be on primary care and community care. Despite the message of the last 20 years that that has to be the policy focus, we still seem to be running with a system that is very much focused on secondary care, even where new workers are being trained to function initially. In recent years, there has been no significant growth in community nursing, for example, compared to growth in acute nursing. The number of district nurses has dropped radically.

There are opportunities to allocate funding to try to trigger more training of those types of worker or to trigger current budgets to retrain nurses in the acute sector, for example. Again, my emphasis would be on looking at how we can shift to more primary care and more community care. Much of the management of care and of carers will have to come from nurses and others in allied health who are working in primary care teams. That points particularly to supporting many more nurses to work in advanced roles such as nurse practitioner. We are developing relatively quickly in that area, but we have a long way to go if we compare ourselves to the United States, for example, which has proportionately many more nurse practitioners working and has been doing it for much longer. We have some way to travel. The focus for me is primarily on building up the skills of the current workforce rather than looking at introducing radical new roles, because they take so long to have an impact here.

Bishop of Carlisle: Do we have the capacity? Do we have the people around who can do that kind of training?

Professor James Buchan: I am always surprised that the education sector seems to find capacity when there are budgets available. That is a slightly facetious response, but there are constraints if you look at some education staffing in some schools, colleges and universities. The age profile of nurse educationalists is very old, for example, so there is a replacement challenge there. The other challenge is the bottleneck in clinical placements and effective, well-managed and well-supervised clinical placements. However, I think that innovative solutions can be developed and introduced there.

Candace Imison: I would certainly echo those points. The nursing workforce in particular is an area that has been underinvested in as a country. I was really struck when comparing our growth in the nursing workforce to that across the OECD. Our nursing workforce has grown by 10% since 2004, but across the OECD it has doubled. We are way out of that. Our 1:8 nursing ratio compares to 1:4 to 1:6 in America and Australia. Those are very crude figures, but my sense is that currently on the wards today we do not have enough nurses. We need more advanced nurses. In our skill mix report we mapped out the skills by level, and the top levels, as Jim was saying, are like a skinny tree at the top, with very small numbers. Again, we underinvested in the support workforce underneath who can be a productive support to nurses, particularly in an out-patient setting, in primary care or in the home, but they are not a substitute for nurses on the acute wards, which is a big issue.

On the levers for changing the workforce, we have a really big problem with the productivity challenge. The comments made by the Migration Advisory Committee were interesting. They questioned why we had not thought of pay as a lever in trying to address some of the shortages. We are now in this vicious cycle of paying large amounts of agency fees to cover our vacancy level. Might it not be more cost productive just to pay better? As we head into a period of what looks like continuing austerity, I worry enormously about this. Staff have paid the price for austerity. They have paid it in real-terms cuts to pay. They have paid it in the extra work that they have had to take on. They are facing five more years of it. They are already showing signs of burnout and we are asking them to do more.

The problem with some of these levers is that they are very interdependent with finance. If you have strapped finance, you cannot start to use some of these other more creative levers.

Bishop of Carlisle: Are you suggesting that having another 1,500 doctors or whatever might not be the best way forward?

Candace Imison: Yes.

Bishop of Carlisle: Thank you very much.

Candace Imison: We were talking about it outside, but I have not mentioned here what £1 million buys. A £1 million straight headcount will buy you either seven doctors or 23 nurses or 45 healthcare assistants. People do not think nearly enough about the opportunity cost of making global decisions to invest in doctors. In fact, that doctor figure is probably

an overestimate, because the reality is that doctors come with a lot of on-costs associated with them and can actually be a driver of demand as much as a meter of demand. There are really important reflections that we need to make. We made some drives about 24/7 working in the absence of evidence that tells you that more intense consultant staffing helps outcomes, whereas we have very good evidence that more intense nursing staff improves outcomes.

The Chairman: At that point I should declare an interest. I am a professor of obstetrics, chancellor of the University of Dundee, fellow of several medical Royal Colleges, fellow of the Academy of Medical Sciences and fellow of the Royal Society of Edinburgh.

Professor James Buchan: I have a couple of points to reinforce what Candace said. Obviously the timeline to get a well-trained doctor into the workforce is 10 years plus, four years for nurses and a few months for a care assistant. We have to factor that into the process.

To pick up on the point about pay, we also have to recognise that there is almost a generation of nurses who have never worked apart from under a pay freeze, but they have worked in an economy where there has been low inflation and we are now beginning to see inflation picking up. That will add to the pressure on hard-pressed staff and the extent to which they can continue to be well motivated in that circumstance.

Q152 **The Chairman:** Candace, we have received evidence from medical royal colleges, the GMC and others about the tremendous shortage of and the need for primary care GPs, and the need, therefore, to train more doctors who will become GPs, psychiatrists, geriatricians or others. What is your response to that?

Candace Imison: If we carry on working the way we are currently working, there will be very obvious gaps in the medical workforce. You have heard from all of us this morning that there are ways of thinking differently about how you work. In primary care we know that there is really good use to be made of pharmacists, physiotherapists, mental health nurses, children's nurses. You can go for a very different skill-mix model in primary care. When I sat on the Primary Care Workforce Commission I was very struck by practices that had gone down that different skill-mix route—I have to say because they were forced to—but actually they ended up in a better place. They ended up feeling that they were better meeting the needs of their patients and often had a double win from this richer skill mix. We went to one practice that was making use of a pharmacist, and the pharmacist was also driving a broader improvement programme in that practice. I was struck by the energy and sense of, "We can improve things for patients. We can do things differently". That is a very real issue.

In hospitals, there are some very profound issues about how we are currently managing the acutely sick patient, and that is driving up the need for more medical staff in hospitals. At the Nuffield Trust we are doing a very interesting piece of work on this in smaller hospitals. We are discovering that in smaller hospitals we have now created multiple doors into the hospital and multiple rotas, which is magnifying the number of doctors who you potentially need. To staff each of those rotas we need

many more doctors. This goes back to my earlier point that we need to think much more profoundly about the roles that we need in our different care settings and how we might do that. In my view, there are real opportunities to use staff other than doctors to manage patients who are acutely sick and in the community. We need to go back and have a really profound look at it.

The Chairman: Are you saying that we fundamentally need to look at the systems of delivery of care as we have it?

Candace Imison: Absolutely.

The Chairman: The model of the NHS that has obtained for so long needs to be looked at again.

Candace Imison: I would not stretch it to the model of the NHS. I would certainly say that you have an interdependence with the staff you need and the way in which you expect them to work. We have not thought profoundly enough about that, in my view, which means that we are often asking staff, as I said earlier, to do things that do not align to their skillset and are fundamentally inefficient. In a very resource-constrained environment we need to think much more sensibly about it.

Q153 **Lord Warner:** We have been over Horizon 2035, and I would like to build on some of that in my question. First of all, how fit for purpose is the architecture of all the players in education and training, given that you are all saying that we need to emphasise much more the retraining and reskilling of the existing workforce? Secondly, if the education and training budgets are very vulnerable, as I agree they are, when there is a financial crisis, how do you protect the education and training budgets?

Candace Imison: Interestingly, my observation would echo a comment that Jim made earlier, that there are some really positive collaborative arrangements currently in play between higher education and trusts trying to do role redesign and new ways of working. It seems to me that the education side of the equation is actually able to respond very positively to demands made upon them. Again going back to the trust where I am a non-executive, I am seeing really positive collaborative arrangements around developing the roles of nurses and other workers within the trust.

What is much more of an issue is the resource that is available to support the training in those environments and in trusts themselves. I see a lack of capacity in trusts themselves to support and develop staff. The HR function in NHS trusts has traditionally been a bit of a pay and rations function as opposed to something that thinks more broadly about workforce development and planning. However, protecting training budgets is a political issue, it seems to me, and, sadly, the current Government have singularly failed to do that. We have seen a decimation of them in a way that we had not anticipated.

Lord Warner: Just pursuing that, government has never really controlled how much individual trusts under your model spend on education and training, for example.

Candace Imison: No, but they are controlling the overall pot. We have seen now that the pot available through the broader central functions offered by HEE has been completely cut back, and it is that pot that trusts have called upon and certainly, going back to my own trust, used positively to help to develop these new roles.

Lord Willis of Knaresborough: Picking up Lord Warner's point here, whilst we accept that there is a central pot that goes into the training and post-graduate budgets, the trusts themselves surely have a much more significant responsibility for the training of their staff. It costs £78,000 to train a nurse. Roughly half of them have left within three years of taking up their post, so the trust has to go abroad to find people at a 25% premium or recruit new people from scratch. I do not understand why the health economics model does not come into play here to say that if we actually invest in our staff more we will keep them and they will be more productive to us. That does not seem to form the equation; it is "Give us more money from somewhere else".

Candace Imison: The more money bit is when you are trying to get something very novel. The approach of managing your staff well is something that trusts need to do for themselves. However, I go back again to the interdependence with the broader financial environment. When budgets are squeezed as tightly as they currently are, the amount of flexibility is very limited, and those budgets can be very vulnerable to cutting.

Lord Warner: Going back to my original question, what should this Committee say about protecting education and training budgets to give the capacity to reskill and retrain existing staff in the system? That is the exam question.

Candace Imison: At the very least you should be signalling that what is currently there is protected, but actually it should grow. You counterbalance that with investment in understanding those training needs. That is the bit of the equation that has been missing from our workforce planning environment. It is double-edged.

Dr Graham Willis: We talk about the skill mix and what skills workforces should have. However, the skill mix depends on the model of care you are employing. For different models of care you might need different skill mixes. A constant here is that we have talked a lot about team working and possibly different roles. Flexibility in the future will be important. One of the key areas for training is interprofessional skills, whereby you have people working together in mixed teams who can share their skills, decision-making and the burden of the work. It is an area of great interest and much debate in other countries, but we have less debate in this country about the scope of practice and interprofessional skills. A lot of the professionals at the higher skill levels are trained in their profession, but they may not be trained as much in how to work with other professions in joint decision-making. This is a big area of debate in other countries. I mention that, as it might be helpful.

Q154 **Lord Scriven:** Before pursuing that point, I declare my interests. I am a member of Sheffield City Council, and a managing partner of Scriven Consulting, whose clients include Carillion plc and Cumberlege, Eden &

Partners. I also have a lapsed declaration that I have kept on for transparency, which is Maximus UK.

I have listened very quietly as you have talked about workforce planning and training being by organisation rather than by place or where people actually live, which I think is about patients rather than about organisation, which would lead to some of the kinds of changes that we need of the existing workforce. Would you like to explore that a bit further with us and say whether you see any potential in that rather than it being under the existing structure, which just seemed to replicate the status quo?

Candace Imison: I would completely support that. A piece of work we are thinking about doing as a trust is about what a place-based approach to workforce planning would look like. The STPs offer an opportunity into that. My sense is that they have actually had difficulty grasping that opportunity, so the aim of our work is to try to understand what the obstacles to that have been and how they might be overcome. You are right that that is the basis on which you should look at the workforce. When Jim and I did our original work on workforce planning, the big mantra was to go from uni-professional workforce planning to multi-professional, but now it is look across the whole care pathway and then to think about things in a much broader way. You are completely correct.

Q155 **Lord Bradley:** I will declare some interests before I ask about international comparisons. I am a non-executive director of the Pennine Care NHS Foundation Trust, independent chair of Manchester, Salford and Trafford NHS LIFT Company and independent chair of Bury, Tameside and Glossop NHS LIFT Company.

You have referred to comparable countries overseas and the work they are doing on workforce planning. Are there good examples that compare to the challenges facing the NHS? What lessons could we learn from those international comparators to influence how we go forward in our own workforce planning?

Professor James Buchan: First, I would echo the Chairman's point earlier that arbitrarily looking abroad and assuming that what one country does is translatable here is risky at best. However, there are examples that are worthy of consideration, given how our system looks and what the challenges are.

Picking up on some of the debate that we have had in the last 10 minutes on the primary care workforce, the national approach to workforce planning in the Netherlands is developing from single profession to looking across the piece. In particular, they are beginning to look at an approach that is not just, "We will need X number more general practitioners", but, "We can have Y number of general practitioners, but we are also looking at nurse practitioners and the balance across the piece and calibrating roughly that the nurse practitioner can safely do about 70% of what a GP does but at lower cost and lower timing". That is an example of where a country is beginning to break down the barrier between different parts of the workforce. At the national level, people around the table who are stakeholders discuss and debate not just "We

will have X GPs and Y nurse practitioners”, but, “We will look at the best mix for the future training of these goods”.

The Chairman: Are you saying, Professor Buchan, that we need to look at our current model of primary care?

Professor James Buchan: No. That should drive the workforce, not the other way round. The example I am giving is just a technical approach to planning, which is looking at GPs and nurse practitioners as two roles that currently exist, but doing it in a more rounded fashion than is the case now in the UK.

The other example I was going to give was more about the roles and scope of practice and looking at how different professions and other workers in healthcare can interact more effectively because each of them is clear about their role, their role boundaries and where the overlaps are. I think the best examples in that field are in Canada, which is probably a world leader in that area of work at the moment. Their healthcare system has some differences from here, but issues relating to health professional education, role delineation, getting the different professions and other stakeholders around the table to agree what should be done in this space are worth considering.

The Chairman: What about the retention of nurses, for instance? We see figures that tell us that the percentage of nurses leaving increased from 6.8% to 9.2% in 2014-15. What are the issues for the retention of all staff?

Candace Imison: Those figures almost certainly relate quite strongly to the workload issues that I talked about earlier. However, we also have evidence from initiatives such as the Magnet hospitals in the US that if you invest heavily in nurse leadership and management in a trust, you can have a very significant impact on your retention rates. Crucially, and interestingly, you also have to invest in the continuing professional development of staff. That is a critical retention factor.

Lord Willis of Knaresborough: I am very interested in this whole issue of retaining staff, because we appear to have a leaky bucket. Clearly we have a shortage of staff. However, we cannot continue to have people drain at the current rate. I wonder whether it is just a matter of morale. Is it just a matter of pay? Is it a matter of training? How do we actually change all that? That is the frustration for me. I would like to see every trust being held to account for its retention of staff, not simply its recruitment of them. What are the answers here, Jim?

Professor James Buchan: I agree with your analysis. When a specialist nurse leaves a trust, the cost equivalent is about two years’ salary. That gives you a metric for lost productivity and the time to replace them and bring someone up to the same level of contribution. We talked about costs earlier, and that cost is never articulated effectively. There is no budget to address the retention issue in the way there is to address initial training, for example. If we can get that metric into the decision-making, that would help a lot.

Looking at any health system and at any healthcare labour markets, you can see that some employers are better than others at retaining and

motivating their staff. Irrespective of the external labour market conditions, when you analyse what is going on there and what makes a good employer, you can see that in the kinds of examples that Candace gave, such as Magnet hospitals and participation in decision-making, effective management, access to continuing professional development, flexible hours, working with peers who respect you, reasonably good pay, the ability to feel that you are contributing and continue to contribute and that your concerns are being addressed. On one level it the sorts of things that you would expect from any good employer in any sector. It is just that in healthcare in the NHS there is a spectrum, a continuum. Some are very good, some employers are less good. In part, that is about how effective management is, but it is also to an extent the external labour market conditions varying across the NHS. London is very different from Cumbria in the opportunities to move and work anywhere else, for example.

Q156 Lord Warner: This morning has been very interesting. So far we have tended to look very much at what workforce planning and development should be done at the national level. What has come out for me from the answers you have been giving has been the whole issue of the key role more locally of employers and local health economies. Is there any evidence that we should start to consider something like a percentage of budget that should be spent in local health economies or local employers on education and training in order to try to get some coherence in their roles, particularly with STPs coming along?

Candace Imison: That is a really interesting idea. I am aware that in the private sector people have a set of benchmarks that they often work to. They feel it is very important that a percentage of their budget is invested in HR in the same way in which a percentage should be invested in technology. We have not talked at all this morning about the interdependence with technology in the workforce, which is also a big issue and a big morale issue. Grappling with the early implementation of technology is not easy in a healthcare setting.

Dr Graham Willis: One thing that we have not really talked about this morning is self-care. We have seen increases in the demand for informal care in the system and the impact that self-care could have perhaps on reducing demand.

Lord Bradley: I note the international comparisons between national, regional and local decision-making. Do you think that the devolution of health and social care budgets is an opportunity to look at how the workforce can be developed across pathways of care in a particular area?

Dr Graham Willis: There are probably great opportunities to do further work in that area, definitely.

Q157 The Chairman: The key theme for this inquiry is the long-term sustainability of the NHS, so we are looking beyond 2025, 2030, 2035. Focusing particularly on today's discussion about the workforce, if I were to ask you to tell us what one recommendation you might have for the inquiry that would impinge on the whole of the issues related to workforce that may focus our minds on the future sustainability of the NHS, what

would you say? What would your recommendations be?

Professor James Buchan: That is a difficult one. I apologise in advance. It would be to focus less on workforce numbers and more on the skills that are required.

Dr Graham Willis: I would say that it is to focus on the big drivers of future demand and long-term thinking about what we might do to reduce them by interventions.

Candace Imison: I would build on Jim's point by making the point that we need to have a much deeper understanding of what we are asking our workforce to do and what patients need. A really good starting point would be to get that understanding. Then you can build a way forward from there.

The Chairman: Thank you all very much for coming today. Dr Willis, you said you will send us some figures. If any of you have anything that you think about, please do send it to us. You will get a transcript of today's evidence. You cannot change it, but if there are any glaring mistakes or inaccuracies, feel free to let us know. Thank you for coming today it has been very helpful.

UNISON, Unite and British Medical Association – Oral evidence (QQ 158-170)

Evidence Session No. 16

Heard in Public

Questions 158 - 170

Tuesday 8 November 2016

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of Witnesses

Christina McAnea, Head of Health, UNISON; Dr Stephen Watkins, MPU Section, Unite; and Dr Mark Porter, Chair, British Medical Association.

Q158 **The Chairman:** Good morning. Thank you for coming to give evidence to this inquiry. Before we start it would be helpful if you would introduce yourselves—and if you represent an organisation, please say so. If you want to make an opening statement please feel free to do so; otherwise, we will go straight into questioning. We are broadcasting, so if you have any private conversations—this applies to Committee members, too—they might get picked up. But I doubt that you will have time to have a private conversation.

Christina McAnea: I am Christina McAnea. I am head of the Health Group at the trade union UNISON. We are the largest health and social care trade union in the country. We have about 450,000 members who work in the NHS or who are providing NHS services, either directly employed by the NHS or with the voluntary sector or private providers. They do everything. We have senior managers, nurses, midwives, occupational therapists, cleaners, caterers, porters. We have the full range. We do not recruit doctors or dentists. We also have around 300,000 members who work in the social care sector, mostly as social care workers but social workers as well. We have about 60,000 who work in the community and voluntary sector.

We have always supported the NHS. We think it is the most efficient way of providing healthcare, which is borne out by a lot of the evidence that is around. We are not a union that is averse to change and we have participated and worked with Government and employers in the past. Major changes have taken place within the health sector. Our main

concern at the moment is around funding but the big issue for us as a trade union is the impact that the massive changes and the funding cuts in both social care and in the health sector have had on the workforce and, inevitably, what that impact has on patients and the care that they are able to provide. I am sure I can come to some of the detail on what our main concerns are in the questions.

Dr Watkins: I am Dr Stephen Watkins. I am a public health doctor and I am here today representing Unite which is the largest trade union in the country and the third-largest trade union in the NHS. I am here to present two pieces of evidence: Unite's main evidence and the evidence submitted by our medical section, the Medical Practitioners' Union.

We make a point in paragraph 19.9 of the MPU evidence that one of the distinctive features of the medical profession is its tendency to make decisions on when guidelines are applicable. It therefore will come as no surprise to you that Unite's main evidence is laid out as an answer to your question, whereas the medical evidence is laid out as a free-flowing, freestanding statement in answer to the fundamental problem. That reinforces the point we make in paragraph 19.9.

We would like to emphasise a few points today. Firstly, we would like to emphasise that the NHS needs more money. We have gone into some detail in both sets of evidence on why it needs more money. We have gone into some detail in both sets of evidence on why the best place to raise that money is through general taxation.

Secondly, we make the point that further spending on the NHS may well be self-financing because there are a lot of studies showing Keynesian multipliers for health spending of 3.6, of 4.0, or anywhere between 5.0 and 10. If the Keynesian multiplier is in excess of 2.5, the spending will lead to the raising of more taxation than is actually spent. Therefore, we believe that more funding of the NHS and of social care could be entirely self-financing.

Thirdly, we make the point that investment in prevention is necessary to contain spending on health and social care, that spending on social care is necessary to contain spending on healthcare and that spending on primary care is necessary to contain spending on hospitals. We refer to some of the cuts in those areas of spending as stripping the lead off the roof in order to make buckets to catch the rain.

The fourth major point we want to make is that markets are not a solution to the problems of the NHS. We go into some considerable depth, particularly in the MPU evidence, on why markets are not a solution to the problems of the NHS, and what the specific faults and flaws in markets are that make it inappropriate as a solution to the problems of the NHS. We say that the development of markets and procurement has gone too far.

I will make a very important point here. The MPU argued for commissioning long before it was fashionable. We first argued for it in 1988. We have some claim to have made a major contribution to shaping the form of clinical commissioning that was introduced in 1997. When we say that commissioning has gone too far and has become a procurement bureaucracy, this is not just some ideological antipathy to commissioning;

it is actually a statement by an organisation that played a major part in bringing commissioning into being. Those are the main points we wish to make in our evidence today.

Dr Porter: Good morning. My name is Mark Porter. I am the BMA Council chair, which makes me the senior elected representative at the BMA. I am also a consultant anaesthetist working in the National Health Service.

You will be given, you are being given—I have looked at your website—and you have been given huge amounts of evidence, sometimes rather complex. But there are some central ideas which shine through that evidence and I would like to consider them for a few seconds now.

After years of cost restriction and growing demand, the NHS is more efficient today than it has ever been and yet its provider arm has slid into deep deficit and is expected to remain so. The Government's response has been to demand further efficiencies, which nobody believes will be delivered, while allocating insufficient resources to fill the growing black hole. Instead, as detailed in the Department of Health's own evidence, it is pursuing a regime of financial control totals, special measures and intervention regimes that can only be designed to force money to the front of the minds of every board of directors in the National Health Service. I can understand that, but you will be aware where many fear that could lead. At the very least it absolutely impairs the ability of those boards to undertake and supervise the transformations that are necessary and have always been necessary for the continual improvement of patient care.

Instead, the BMA believes it is incumbent on Parliament to hold the Government accountable for their deliberate underfunding of the NHS, restating the principles that the NHS should be free at the point of use and be properly funded for the service it gives to the people of this country.

Q159 The Chairman: Thank you very much. Although today's session was mainly to try and get your views about the workforce issues that may in the long term affect the NHS and social care workforce, two of you particularly, but all of you, mentioned the pressures related to finance. It would be unfair not to allow you to comment briefly on this. I am going to change my question slightly towards funding issues, but we will keep it brief, I hope, so that we can get back to the main issues today.

We have had evidence, and you heard the statement from the Secretary of State last week, that, compared to the OECD, we have higher GDP spending on health and social care than some OECD countries, countering the argument that they do not have enough money; and, secondly, that any further funding should come, as you said, from general taxation. We are told that when the public is asked where the money should come from, they say taxation. But when they are asked to pay more taxes, they are not so keen. We are still looking for an ideal settlement for social care because we have been told in evidence that it is the social care pressures that are currently putting the pressures, as you mentioned, on healthcare and that therefore impinges on healthcare finances and maybe even the workforce. We are told that things such as co-funding are not a good

idea. We are told that the possibility of a hypothecated tax is one way to look at it—but there are cons about that, too. So, briefly, from each of you, which funding model are you favouring and why?

Christina McAnea: We would definitely favour a direct taxation model. But the key point has to be that it is not just about funding the NHS, as you have already said, but about funding social care as well to a level that means that you can actually meet need. Over the past few years we have seen a 25% cut in the funding for social care, a 25% reduction in people receiving social care, and an even greater cut in the actual overall budget that is going to local authorities. That has had an immediate impact and an ongoing impact on NHS services. We have also had the lowest settlement for the NHS over the past five years—something coming out at 0.9% in real terms—which goes nowhere towards meeting the cost of both inflation within the NHS and rising demand. As you know, traditionally the NHS has needed between 4% and 5% a year to keep pace with that. It has not been receiving that so that cumulative effect of the ongoing funding restrictions has meant that we are now facing an absolute crisis. The money that has been saved from the NHS has, by and large, come from squeezing the tariff but also from imposing pay restraint within the NHS, which is now beginning to bring its own problems in terms of impact on the workforce.

We would favour a taxation model and we would favour having a cross-party debate on how you deal with social care, particularly in England—there are differences across the UK, but certainly in England. There would have to be cross-party support for how you actually deal with the issue of funding for social care, social care services and where you raise the income. I have heard many suggestions, including taxing people when they die, so you tax the estates that are left. I think all of these would be controversial in their own right and in their own way, but if you could get proper cross-party consensus on how you would actually deal with the social care funding crisis, I think it is the only way to go forward.

Dr Watkins: First of all, if the Keynesian multiplier for health and social care spending is in excess of 2.5, then the problem goes away because the increased spending will raise the taxation that is needed to fund it. There are studies showing it to be 3.6, studies showing it to be 4.0, studies showing it to be well in excess of 5.0. Therefore, our first contention is that this is not really a problem.

We understand that perhaps not everybody will accept that proposition and so we address the question of taxation. It is true that people resent increasing taxation. They probably also resent increasing energy bills and increasing rail fares. In fact, people resent being asked to pay for anything. Nonetheless, I am not sure they resent that increase in taxation to the point of not actually wanting to see the services which it funds. There is a perception amongst the public that taxation has become less value for money for the individual and that is because it has, because of the fall in the levels of taxation paid by multinational corporations. Our first claim as to where taxation should come from is that multinational companies trading in this country should pay their fair share of tax.

There is no doubt that the introduction of free social care, which we strongly advocate, would necessitate increased taxation and it would

necessitate increased taxation of individuals. But it must be noted that people deeply resent the risk to their savings involved in the current systems of social care charges. I think it ought to be possible to persuade people that they are getting good value for money out of the taxation that is necessary to pay for the introduction of free social care. That would be our response.

Dr Porter: The debate on how to pay for public services always, to my mind, focuses excessively on oversimplistic calculations as to cost. For example, income tax is less than one-third of general government receipts and yet it is general government receipts that fund that National Health Service. In other words, put up the public spending to support a public service that people want. In the debate on this you, as parliamentarians, really have to get away from the idea that you can calculate an amount going in, how many pennies in the pound that converts to in income tax and that is what the country is being asked to vote for. I do not believe it is as simplistic as that. Aside from the fact that people have in the past responded to various political calls for various forms of hypothecated taxation, some of which were unwise, there is a general sympathy for the provision of public services that can and should transcend the debate we are having here.

There are other things that we can look at that can also help to constrain the cost of a public service that the people want. Probably at the top of a very long list I might include the very unwise decision to go into private finance initiatives over the last few years. I should declare the interest that I work in a hospital built by the private finance initiative. It is very good and so forth but, nevertheless, the inflexibility it brings to local healthcare economies up and down the country is one of the reasons for the major problems that occur in some of those healthcare economies when you look at how to fund the unitary payment. That is a dive into a very specific measure but it is also questioning that, despite what I said earlier about the NHS being very efficient, which I still stand by, there are still areas where we could make major savings by actually regarding the NHS as a public investment rather than as something that has to be paid for by some interaction with private industry.

Q160 **The Chairman:** To get back now to the workforce issues, again looking longer term, to 2025, 2030 and beyond, what do you think are the key pressures on the health and social care workforce?

Christina McAnea: You have your evidence and I hope this will come through. We have already talked about rising demand, pressure on both social care and healthcare, lack of funding and what has happened to the funding. One of the other key things is about staff shortages. We have some key staff shortages across different parts of the NHS, and geographically as well. We do an annual snapshot survey of our nursing and healthcare assistants. About 200,000 of our members fall into the nursing family. Some of the statistics that we get back from them, just this year, showed that nearly two-thirds felt there were not adequate staff to deliver safe and dignified care. That was up from 45% the previous year. Sixty percent were unable to take any or all of their breaks on any given day and 70% reported not having enough time to spend with the patients they look after. There is a whole load of other statistics which I

will not go into but they are there. If you look at what happens with the Ambulance Service, we have a disconnect between demand—there is an almost constant 10% shortage of paramedics. It is higher in certain parts of the country; it tends to be higher in London. That puts additional pressure; if you do not have staff to deal with some of the crisis points, it puts pressure on the whole system.

There are specific issues in social care in terms of impact. One of the key things in social care which results directly from previous policies of cutting the funding that is going to local authorities, thereby cutting the funding that goes to social care, is that they elect contracts usually driven by cost, which has an impact on the staff. We see a turnover of staff in social care of around 34.7%, which is not sustainable. That means that at any given time at least one in three of the staff who are out looking after the most vulnerable in our society have either just joined or are about to leave. There is this constant churn within the sector. We also have massive issues around pay in the social care sector. We have fewer than a quarter of councils who make it a condition of the contract that staff have to be paid for travel time. We have huge numbers of staff working in social care who are actually earning less than the national minimum wage. That is one of the reasons why you get this huge turnover. There is a crisis in social care which has to be dealt with which has a wider impact across the health service.

I have another two interlinked points about areas of major concern and key pressures. One is about pay restraint and the impact that has had on morale and people's ability and willingness to stay in the service. The other one is this huge change that is happening in the sector. It seems that we are in constant change. From 2012, when we had the massive reforms in England, up to now, when we have the proposals coming out from the STPs, this means we have vanguards, new models of care and all sorts of different initiatives taking place. Yet, because of the system we have had since 2012, we have much greater fragmentation. No one has taken responsibility. There is no single organisation that has responsibility for an effective workforce strategy. You might say that that is difficult to do in a fragmented system, but there should at least be some overarching workforce strategy and no one will take responsibility for that. That is a major issue.

Dr Watkins: I agree with much of what Christina has said. Indeed, there are similar findings in the Unite evidence from our own staff surveys: similar comments about social care. I would like particularly to echo her point about reorganisation of services. We have members in the Ambulance Service, many of whom are experiencing competitive tenders and privatisation. Almost all health-visiting services will be going out to tender or have gone out to tender as a result of the procurement regulations. To those who say that when we argue for the abolition of the current market structure that this will mean a major NHS reorganisation, I have to say that the market is itself the cause of constant reorganisation of the NHS—an unnecessary reorganisation and a reorganisation which does not further the improvement of services.

Staff morale is extremely low and we give some examples in our evidence. We describe the background to the low morale of junior doctors

and the low morale of GPs. There is very low morale amongst health visitors who have seen their service built up over the last five years and now see those changes about to be reversed as a result of the Government's cuts in public health funding.

We see very low morale among staff, partly because they see the service as inadequate and inadequately funded and because they see themselves as being blamed for that. They are not to blame but they see themselves as being blamed. I was present for part of the discussion before this and I heard discussions of the leaky bucket and the staff that we are losing. We really have to do something to make the NHS something that people want to stay in.

Dr Porter: I would like to raise one or two particular things in relation to medical staff. There is a background that many people here will be familiar with about the increase in medical specialisation recently, driven mostly by the need to serve patients better. I will not go in and question that and say it is going in the wrong direction. However, it does remind us that there are 15-year lead-in times between recruiting someone on a training programme and them actually working in a career grade post in some specialities, for example my own—shorter perhaps than one or two others but nevertheless with a long lead-in time. I think this interacts with some of the choices that we have made that that make that challenge worse. One of them, for example, is investment in general practice and the way in which we support GPs working within the service, which at the moment is undergoing something of a crisis of confidence, leading to one of the highest vacancy rates ever recorded for general practice posts at 10%. The Government have promised 5,000 new GPs within five years and I am not aware of anybody who really believes that is actually going to happen. One can try for it but whether it will happen is something about which most people are sceptical.

We have a profound demoralisation amongst our junior doctor workforce. There are 55,000 across the UK and 45,000-odd in England. We are not just talking about the new contract for junior doctors for 2016 in England but about everyday occurrences such as the 90% of rotas that have gaps that the junior doctors deal with on a permanent basis. In other words, there are unfilled posts that the other people are simply expected to fill. It is an experience that happens at all times in all walks of life but it is so routine for junior doctors that I am really concerned that we are approaching a situation where we are completely alienating and demoralising the next generation of medical leadership within the National Health Service.

In line with that, I will finish on the specific problems by mentioning those of overseas staff. We are saying something quite new and quite profound to the members of NHS staff who came here from overseas. We are even tipping towards telling them that they are not welcome here at the moment. I believe that is completely wrong. The situation following the Brexit vote has unsettled quite a number of staff in the NHS. We are talking here about tens of thousands of doctors and many tens of thousands of people working in nursing and therapist posts and so forth. That was compounded by the recent Government announcement that we should aim for self-sufficiency in medicine—something which I think is

both wrongly conceived given the international learning community that medicine is, but also something which speaks to those people who are here at the moment and says, “You are not valued and not wanted”. We are seeing that being reported back in what people tell us about their experience in the service. People do not know what their future is, particularly because the Government is not revealing or talking about any of its negotiation objectives in relation to the retention of staff from overseas.

This goes beyond EU staff, to speak to those staff who came here from all over the world. There is a state of considerable disquiet at the moment that is unable to be resolved and, I think, is being exacerbated by some of the announcements being made at present. That is one of the reasons why the BMA has joined the Cavendish Coalition, a coalition of employers, providers, local authorities and so forth. We are very concerned about what we are saying to the members of staff who work in the NHS and social care and have come from overseas, wherever they have come from, and the real need to support them at the moment.

You ask about the long-term challenges. That is a very new one but I believe it is a challenge that will play out over the next 10 or 15 years to the detriment of health and social care.

Q161 Lord Warner: Can I bring you back to the longer term? In asking these questions we have a great deal of sympathy with the kinds of points you are making about the current situation, but our remit is sustainability in the long term—2030 and beyond. Admittedly there are implications for that in what is going on currently, but we have to focus on the longer term as well. I want to ask you some questions about the current pay system. I should say that I was a Health Minister for four years when the NHS budget was going up by 5%, 6%, 7% in real terms. I was also the workforce Minister. I did not see a lot of flexibility in the NHS workforce in that period of great growth when it came to addressing issues around new skill mixes as the services changed. Is there something inherent in a rather siloed national pay system which actually thwarts change? Putting it very brutally, has the national pay system outlived its usefulness at a time of great change in service development? Can you project forward and see whether there are issues in that kind of territory?

Dr Porter: My answer to your question is that I do not think so. Partly I will talk generally and partly I will specifically address doctors and my colleagues will address the other NHS staff. I think there are slightly different considerations and one of the things I must bear in mind is that the job and recruitment market for doctors is much more widespread than for non-medical jobs. It covers the UK and to a certain extent it covers internationally in a much more robust way than many of our local recruitment efforts for people at the junior end of, for example, nursing or therapy actually are. I think they have a much more mobile workforce and would want to keep it that way. That is one important point that needs making about national pay systems.

Another really important point is that the point of the pay systems is not so much to enable people to pay their mortgages as to support the existence of the health service that we want. The health service that we

want is a comprehensive one with universal provision across the nation and such that we actually can have confidence that we are delivering a health service to similar standards in one part of the country to another or, in those parts of the country that before the establishment of the NHS might have been very much more or very much less attractive. We have chipped away at a lot of those differences but if they still exist they will need to be moved on.

My real fear about moving to local pay is that we develop local markets that take us back to the days when people would choose which part of the country to work in based on the pay that was available rather than based on the opportunities for serving patients, which is what certainly most of my members would prefer to think about at the moment rather than competing one hospital against another or one practice against another in terms of pay. That is a really important thing to lay down.

On your point on flexibility, I will answer this purely by example. I mentioned that I am a consultant anaesthetist in the NHS. I work in a way which is utterly transformationally different to the way in which consultants worked when I was a junior doctor. There was nothing about a national pay system that stopped me doing that. The way in which I have changed my work and the way in which I have seen my colleagues change their work is based on the knowledge of what we can do to help patients and the best ways that we can do it. It is not about what the hourly pay at any one particular time is or about whether that pay is dictated from Whitehall or the DDRB or whether it is separate in Devon and Cornwall or anything like that. I would challenge the assumption that there are few changes and little flexibility. I would not necessarily peg it so closely to the period when you were a Minister and say that it all happened then—although I say to your colleague next to you, I was sitting in your office 23 years ago discussing the new deal and how to bring in flexibility for junior staff at the time.

The journey that we have been on, which is mirrored among other staff, is one where we have adapted our way of working and I do challenge the thought that there is very little flexibility these days in the way that people develop their careers and jobs.

Lord Warner: I am thinking about nurse prescribing and the doctors' reaction to nurse prescribing and nurse practitioners in surgery.

Dr Porter: We wanted it done properly. There are many such people working in the place where I work.

Dr Watkins: I agree with most of what Mark has said. Many of the points he made are relevant to other groups of health workers, too. We say in Unite's evidence that we believe that the health service system of pay should be extended to cover social care as well, as we believe it could help solve many of the problems that Christina described. So I would agree generally with that.

On your point about flexibility, we do believe that flexibility is important. I do not think that the resistance to flexibility that you are describing is as strong as you say. There have been massive transformations in the way people work and massive transformations in the skill mix. Perhaps they could have gone further, but I am not sure you can point to, as it were,

national pay bargaining being in any way the obstacle to that. So I would support Mark's point.

I would also draw attention to the point that I drew to your attention jocularly at the beginning, but I will do so seriously now. The point we make in paragraph 19.9 of the MPU evidence is about the distinctive role of certain professional groups, including medicine, dentistry, non-medical public health specialists and senior scientists, in not simply following guidelines but in determining the scope and extent of their applicability. That is quite an important point that needs to be borne in mind when we develop the skill mix.

Christina McAnea: I am also chair of the NHS Staff Council, which brings together 15 trade unions. This is a debate we have quite frequently with the employers, with the pay review body and with the Government. A few years ago the Government asked the pay review body to look at regional pay. We all submitted evidence to it. It did visits, et cetera. The pay review body came back and said that it could not see any argument for having regional pay. I have to say that I dispute that the pay system itself invites inflexibility. It is a question I sometimes put back to employers by saying, "Name something you want to do in your workplace that Agenda for Change stops you doing but that does not involve cutting the pay and conditions of the workforce?" That is the thing that people say to me: "We want to do these things, but Agenda for Change stops us". No one as yet has been able to come back to me with an example of something they wanted to do in terms of service delivery or skill mix or doing something which is about deploying the workforce flexibly which has been stopped by having a national pay frame.

I would echo the points that Mark made that for many staff this is a national workforce. We have shortages of certain key skills, certain physiotherapies, various therapies, radiography et cetera. There is an element of it being a national workforce. It is also about maintaining standards. Stopping leapfrogging is the other one—we would get competition between trusts. We already see a little bit of that creeping into it at the moment in terms of nursing shortages where some will try and offer a particular package to recruit. I understand why they do it but I do not think it is good. If you are talking about long-term sustainability I think introducing a system which makes that easier will just make it worse in the long run in terms of being able to attract and retain good-quality staff.

On the issue of skill mix, we are totally up for skill mix discussions. I was not part of the group that went around doing health at the time when that was negotiated; I am assuming you may have been. When Agenda for Change was negotiated there was an expectation that there would be further gains to be made from a benefits realisation from further skill mix discussions. That has not taken place, but not because we have stopped it. We are constantly up for a discussion around this but there are no resources. It is difficult to bring in massive change or even minimal change at time when you have such a restrictive pay policy.

Q162 **Lord McColl of Dulwich:** First of all I want to declare an interest. I am a trustee of the Wilson Foundation, professor of surgery at the University of

London and author of the McColl report that transformed services for disabled people.

My questions are on poor morale which you have already dealt with quite a bit. How should poor morale be addressed? What are the risks to the long-term sustainability of the NHS of not addressing poor morale?

Dr Porter: I will dive in. Morale is not something that can be addressed by a single announcement or a single initiative, et cetera. It is to do with the long-term valuing of the workforce. In that I do not necessarily only mean valuing by government Ministers, for example. I mean it in the sense that many people who have worked in the NHS and in social care have a profound, lifelong feeling that the services they give are valued. They might be valued in different ways by different people. I think I give a very good service to my patients. I think they value the service I give and that gives me an enormous amount of job satisfaction. As it happens, I have also had opportunities to be involved in various aspects of planning care in my hospital which can be quite rewarding. Some people do not, and that might not be.

However, I think it also depends on how the service itself looks at and treats people. As you mentioned, I have alluded to the way in which junior doctors and GPs think at the moment, to the way in which they feel that the service treats them as a commodity rather than something to be valued as a long-term investment, something you can turn on or off when needed, put to one side, and change the conditions when they are a little bit inconvenient for the moment. The problem is that that sort of feeling compounds with the longer-term feelings of whether or not public sector workers are valued in general to give people at the moment a feeling that, "Well, do you know what? I am not sure there is a long-term career here. I am not sure there is a long-term something that is going to sustain me through decades of public service".

Certainly a lot of the younger people coming in to the NHS whom I talk to, having now sadly reached the age where people ask me to reflect on my career and so forth, talk about whether it will be the same for them. I do not detect the feeling that people believe that. They believe that the services are under threat long-term, that the promise that is made to the people is not something that is written in stone, if you will forgive me borrowing a metaphor there, and that the future is rather more uncertain than it has ever been in the past. All that contributes big-time to a feeling of a demoralisation that is palpably surrounding me as I talk to people not about what their work is like today but what it is like stretching into the future, and what it will feel like when they come to be at my point in life and look back on things.

I apologise for giving a very general answer but I genuinely think that it is something to do with how we value and motivate people for a long-term career in public service rather than necessarily what we do from minute to minute and the announcement that has been made that day or next week—albeit that those things contribute. I mentioned Brexit and the overseas doctors thing which I think will become a really important theme over the next few years.

The Chairman: Do you have some suggestions for what the solutions

might be?

Dr Porter: It comes back to what we have all said in our different ways. At the moment the palpable feeling is that the NHS is dominated by cost control, by a feeling of crisis, by a feeling of demand that is out of control. A lot of that is contributed to by successive Governments that have given the impression that the NHS is a drain on the public purse and needs to be somehow constrained, forced to become more efficient, controlled and corralled for the future, rather than celebrated as something which is, forgive me, one of the reasons to be British.

Dr Watkins: I think Christina made some very important points at the beginning about pay and conditions. That is very central to morale and I agree with that. Mark made some very important points about the way people are valued. I agree with that—and, had he not already said that, I would have said that as my first point. Since both of those things have been said, I am going to add two further things to them.

My first point is the sense that Christina did actually mention of the idea of whether there is a long-term effect of pay freezes and of the idea that you will squeeze pay. I have spoken to people who have retired because, had they continued to work, the addition to their pension from the extra years they had worked would have been less than the increase in their pension due to inflation had they retired. They were actually damaging their pension by continuing to work. That is a real indication of how pay and conditions have been squeezed.

I would also like to refer to a point which we make at some length in the MPU evidence in section 9 called “The History, Distortion and Future of the NHS”. We point out there that when the NHS was originally set up, it was set up as a partnership between the people, the professions and the people who work in the service. Over a period of time it has been progressively turned from that model first of all into a more Morrisonian model of nationalisation and then into a model of privatisation. One of the processes of that has been the breakdown of that relationship between the people and health workers upon which the success of the early NHS was so strongly predicated. We think that it is time that power moved back from bureaucrats, bean counters and business operatives to Parliament, the professions and the people. We make some concrete suggestions as to how that can be achieved in our written evidence.

Christina McAnea: As part of our submission to the pay review body we carry out a fairly extensive survey of our members. This year we surveyed 21,000 members who work in the health service. We asked them a lot of questions about their pay, about morale et cetera. You have that in the pack but I will just pull out a couple of things. One of the things that surprised us was that something like 80% came back and said they had thought about leaving the NHS. We get people saying that but it does not actually mean they will do it. We dug a bit deeper and asked follow-on questions to try to get to the heart of whether they actually meant it. Almost half of them said they had seriously or very seriously considered leaving the service. We asked the reasons why and the top three things that came out were increased workload, stress at work and feeling undervalued. We have to accept that this feeling of being undervalued has a serious impact on how people feel about staying in

their chosen career, profession and the organisation they work for. Those are the emotional reasons why it is important.

The reason why I mentioned pay restraint earlier on is that I think it feeds into this feeling of being undervalued. It also has a significant, emotional and real impact on people's lives. Some of the information we got back from that was the high percentage of staff who responded to our survey, who had had to do things like go to payday loan companies or pawn their belongings. About half had had to ask family and friends for financial support. About a third had had to either move home or re-mortgage their house. All of that will have an impact on how you are feeling about the organisation you work for.

I will give another example which may seem minimal. The Government have promised a 1% pay increase for the next few years in the public sector, to the end of this Parliament, but in the health service what they are saying is that the cost of the Government's new national minimum wage has to be funded from that 1%, which means that the majority of staff in the NHS will not even get 1%. Whilst that may only be a fraction of a percentage, that sends out a message that they are not even worth the 1% that is being given to the rest of the public sector. The cost of paying that would be roughly £280 million. That sounds a lot but it is just over £1 million per trust in England. When you think that trusts are spending £25 million to £30 million a year on agency costs, a tiny fraction of that would make a difference to people and to their morale.

Lord McColl of Dulwich: I speak a lot to general practitioners and I have worked for many years closely with them and in GP hospitals. One of the things that they say is that they are demoralised by the vast amount of paperwork they do. One, for instance, spends the whole of Sunday filling in forms. Then they have inspectors coming around who make the most inane remarks such as, "Ooh, yes, we've found an ampoule that is two weeks out of date". They say that that is what is really sapping morale. Do you have any feelings about that?

Dr Porter: You invite me to agree and I certainly would not not agree. There is a profound feeling amongst GPs, as you particularly mention, considering the way in which general practice is essentially run as a series of practices in local areas—as relatively small businesses. Whether they are partners or salaried GPs within the practice is less relevant to that feeling that you are describing, which is that at the moment the inspection regime has become over-intrusive. There is an adage often bandied about that you cannot inspect quality—and people repeat that back, particularly after they have been subjected to the sort of visit you described. Not every visit is like that. Not every bit of content of every visit is completely non-directed towards quality of patient care. I would not say that. But too many of my colleagues say all the time that they really resent the time spent preparing for the continual inspections.

Lord McColl of Dulwich: They have to pay for it, too.

Dr Porter: We all have to pay for the regulation system in one way or another, even if it is only the GMC fees and so on. Each individual provider organisation also has to pay CQC fees, the CQC being the organisation you are talking about. At the moment, the CQC, like other

parts of the regulation system, has been asked to become more self-funding. Becoming more self-funding means raising more funds from the people it inspects. The fees the GPs are paying to be inspected in this way are increasing. There is a consultation out at the moment about further increasing them over the next few years. That is one small part of the valuing and the demoralisation that we have been talking about.

Q163 Lord Lipsey: What long-term effect on morale do you think the sad saga of the junior doctors' dispute has had and what lessons should we learn from that for the future?

Dr Porter: I think it has had a profound effect. I mentioned earlier—and I will mention again—that we have taken the next generation of medical leaders and almost deliberately set out to upset them in a profound way, beyond anything that has been done before, in pursuit of an objective that I do not believe is worthwhile. When I say I do not believe it is worthwhile, what I mean by that is that the objective of providing proper treatment to patients as they need it around the week is one shared by the medical profession and by doctors. We have been at the forefront in actions over the last 25 years to put that in place. I do not believe, and no junior doctors believe, that this contract is actually directed at that because, if only for the most simple reason, if you walk into a hospital at weekends you will find junior doctors staffing it. The problems we have are related to other resource problems, not to junior doctors.

I do not want to say too much about the actual detail of that because at the moment we are trying to find our way, as you would expect in any form of dispute, towards a resolution that allows us to go forward and do what I believe is the shared objective of everybody in this, to care for patients. The diversion into thinking that the contract is a way of resolving the problems of caring for patients is something that will leave a lasting bad taste in the mouth, the minds and the memory, not just of junior doctors but of people who work with them, consultants and other doctors, but also the other members of staff who fear that the same approach will be coming for them next.

Dr Watkins: I will add two points. I would like to draw your attention to appendix 2 of the MPU evidence which addresses this issue of excess weekend death rates. The dispute has made junior doctors very angry and it has damaged their morale. It is very important that their anger is channelled appropriately. As an active trade unionist I am determined to do that. They were chanting, "Save our NHS". I hope they continue to chant that.

Q164 Lord Warner: I would like to ask a question about the issue of recruitment agencies. I have spoken to a number of staff in the NHS and in local government and what they say is that they have moved to a lifestyle of working through recruitment agencies rather than employers. This is not much to do with pay restraint per se. They get a bit more money but it is actually about control over their life. Are we living through a period where actually people want more control over their life than they can get through employment status? Is there something going on that we have not really mapped?

Christina McAnea: Yes. When we have asked our members that, the two things that come back around why they go to agencies are flexibility and lack of flexibility in the standard NHS contract. That is the biggest reason and the other one is always pay. They do get more money for it but the key one is flexibility. There are a number of trusts which have actually tried to address that by introducing more flexible working for their staff. We have had trusts where a nurse has come back from maternity leave and asked if they can do a four-day week and particular shifts and they have been told they cannot. They then go to an agency and they are given precisely that shift because that is what they want.

Some trusts are trying to address that by having a package but obviously they have to ensure that they have good cover. We are happy to work with them on that. We have given a commitment to NHS employers on behalf of all of the trade unions that we want to work with them to try to reduce the agency staff bill by trying to come up with incentives or more inventive, imaginative ways to look at rostering, to look at the kinds of contracts that staff have and to agree better flexible working packages. You are absolutely right; that is what has happened.

Lord Warner: There is an issue there.

Christina McAnea: There is a massive issue there.

Dr Watkins: You linked that to employment. It is absolutely possible for a competent employer and a competent manager to arrange flexibility for their staff if they choose to do so—and they are going to have to do so if they want to address this problem.

Q165 **Lord Willis of Knaresborough:** I would like to pick up from Lord Warner's comments but concentrate on the workplace itself. What has rather depressed me about your answers this morning is not that you have concentrated on pay—I fully expected you to do that and it clearly is a really big issue—but that you have not actually balanced that with saying that there is a lack of ownership of decision-making, there is a lack of trust, there is a risk-intensiveness within the professional people. I have not met a professional yet who does not want to have ownership of what they do, to be trusted in what they do. I wonder if you could comment about what we could propose in our report which would bring the professional back into the professionalism of the job.

Christina McAnea: This is about everyone. Not just staff who would be seen as professionally qualified but everyone who works in the NHS would probably share the sentiment that they want to be involved in the decisions and they feel that the job they do impacts on patient outcomes and patient care. One of the things we are asking for, particularly at this time when we have STPs and, as I said earlier about models of care and all the rest of it, is that there is a disconnect. People are beginning to feel that all these things are happening up here and at some point I am going to be told what I am going to be expected to do and I may have to change my working practices, change my workplace, change the patient group that I look after, et cetera. If it is discussed with them in the sense that it is good for patients, then most would be happy to go along with that. They want to feel that they are co-producers of the change, that it is not just something that is happening to them.

One of the problems is that the system that we have now means that that is very difficult to achieve. We have registered strategic health authorities. Simon Stevens is trying to introduce 44 STPs to bring a bit of order back into the system—I hope. People are still nervous that those will be seen as vehicles to make the savings that they have been told to make and therefore that they will result in massive cuts. What we are saying is that now is the time to have a new discussion with staff in the workforce—either a new compact or a new workforce agreement. I do not mean going back to the old Agenda for Change or indeed the doctors' contract. I do not mean one that necessarily will encompass all terms and conditions, but one that give them some certainty that engaging in the discussions around the necessary change to improve the care that is delivered to patients, to meet the integration agenda and all the rest of it—that they are not then putting at risk their own employment contract. We should give that kind of certainty to staff: that actually you can take part in these discussions, you can engage in change, you can look at what is best for patients and change your professional working practices, but at the same time that will not result in completely undermining your terms and conditions. Quite frankly, they look across to social care and they think, "I don't want that to happen to me. If that means I have to retreat into the acute sector, that might be what I will do".

Lord Willis of Knaresborough: When I go into a Magnet hospital in the States, I see exactly that with the nursing workforce. They do feel empowered; they do feel in charge. It does not seem to be a quantum leap from where we are to get that into our system. That in itself encourages people to stay, it cuts down budget and it gives employers the opportunity to pay more.

Christina McAnea: Sorry, which hospital did you say?

Lord Willis of Knaresborough: Magnet hospitals in the States, where that model is operating. It creates a budget through the health economy to actually give better terms and conditions because people are not spending out fortunes on agency staff.

Dr Watkins: Unite's evidence has not concentrated on pay and conditions. It has obviously mentioned it but it has not concentrated on it. It has concentrated very much on this issue that you describe of how we re-establish partnership between the professions and the people. Within the MPU part of the evidence it contains some very concrete proposals on how we can do that.

Dr Porter: There is one counterexample that the Committee will find relevant, specifically about general practice, which is that we are approaching almost half of people who work as GPs who are not contracted principal partner GPs but work as locums, sessional, salaried. When you ask people who move into that mode of delivering general practice, not the universal but a very important reason given by many people is that they can no longer cope with the completely open-ended and unlimited commitment that the NHS currently places upon partners in general practice and thereby they regain control over their lives by deliberately choosing to go salaried or sessional or work as locums.

I know people who have worked for decades as partners who have taken the deliberate decision to move into this work now in order to bring themselves a control over their life that they feel has been completely lost by the demands being placed on them by the NHS at the moment through the contractor route. This is not an argument for doing that. Many people would rather that the NHS was able to offer GPs better employment or better circumstances than it does at present and they would rather go back to work as partners, being able to have a control over the professional end of their lives as well but can no longer cope with the workload and business aspects that are driving them out. That is something that should be of great concern to us all.

Q166 **Lord Scriven:** We started to get onto what I want to talk about, which is new models of care. This morning you have already mentioned it. Clearly, as demographics change, as technology changes, new models of care are going to have to come around. I have two questions. First of all, looking at the long term, what do you think your role as professional bodies and trade unions can be in helping bring that about? Secondly, what will the NHS have to do? You have mentioned money, pay and conditions and I do not want to talk about those. What else will the NHS have to do to help the workforce in terms of that change and in terms of a new model of care? What is the role that you can play as professional bodies and trade unions in helping bring that about? What are the key issues that you need to address or will bring to the table? What will the NHS have to do, other than money, funding and pay and conditions which we have already heard about in your evidence?

Dr Watkins: Certainly Unite would be very keen to encourage our members to participate in discussions with the local community about the nature and the model of healthcare that is required in their local area. We place a great emphasis in our evidence on this idea of local partnerships between the people and the professions in devising the most appropriate way to develop models of care that suit the needs of that locality. It is also important that there is continuing emphasis upon an evidence base. It is one of the things that most angers me about some of the initiatives that have come forward recently: they have not been evidence based. There needs to be that genuine belief that we can make the service better and we can work together to do that. This is not something that should go on in some closed committee room and then we come out with some edict that everybody has to follow. It has to be something that we are all committed to and we all work to achieve.

Dr Porter: One key thing to say is that new models of care are not necessarily something that only arise when there is a specific national initiative so to do. I can think of any one of a number of things that have happened in my own professional field over the last 25 years which have come from entirely within the profession. They have been promulgated almost without anybody in the NHS management knowing about it and suddenly care is transformed because we have some new ability to help patients, a new clinical standard or some new way of organising ourselves, directed towards patients. There is a continual ferment of change in the NHS. Sometimes it falls behind a little and needs pushing along in a co-ordinated way; sometimes it needs active support.

The role of any professional body—and we do this, we have a session in a couple of weeks' time doing what I am about to describe—is to get together a number of our members to look at and discuss the new things that are happening at the moment in how the NHS is organised and how doctors can take the best advantage of that for themselves and their patients. We then write this up as a narrative, circulate it and talk about it with our members. We take part in the learning community that is allowing people to develop as they move through and as the services move on. I think that is the role of any professional body such as the BMA, such as the trade unions, the royal colleges, professional associations, et cetera. It is something that is part of our core role: to help our members so that they can help patients.

That is something that we have to hold on to, rather than sometimes, which can be a temptation, to resist anything that is new simply because it is seen as or badged as something being done to save money. I know you said not to talk about money and I am not going to. But I will say that at the moment one of the big problems that anything called new models of care or anything like that suffers under is that it is seen as part of the Government's approach to drive efficiencies through the health service rather than being seen as something which is there to improve patient care.

Lord Scriven: How would you change that? The issue for this Committee is to make recommendations about how to cut through that. If you feel that frustration, what is it from your perspective that would need to change to make the new models of care be seen as more about patient care rather than cost?

Dr Porter: Do not have them driven in national initiatives that are directed towards efficiencies. We are not here to talk in detail about sustainability and transformation plans, but nevertheless they are there. About nine of the 44 have been published; more will be published as we go through. They will inevitably be seen, because of the debate that is happening at the moment over public investment in the NHS, as a way of making efficiencies and driving towards that 5% per annum efficiency target that the NHS has been inappropriately tasked with finding. We should be driving that and celebrating it as a way of improving service for patients rather than having it pegged to next year's financial targets.

Christina McAnea: I agree with what my colleagues have said about what our role is. We are primarily a trade union but, having said that, we have various professional groups; we have an ambulance sector, a nursing sector, an occupational therapy group, et cetera. We work very closely with them in producing good practice and guidance. One of the key roles for us is to be there to reassure our members and give them the confidence to participate in discussions at local level on these kinds of changes and not necessarily be seen as obstructionist. This goes back to what I was saying. I think it has to be done in a managed way. To be able to give our members that confidence to participate and take part and see things in the best interests of patients rather than think about what will the impact be on them, we have to remove the fear that people have that changes are being introduced to drive down costs and will therefore inevitably have a detrimental impact on them.

One of the key things the NHS has to do is to improve communications and get back to having a system where staff engagement means genuine staff engagement. One of the big problems we have with the STPs, and there are probably good reasons why this happened, is that it feels like it is being done in secret. It feels like something that happened behind closed doors and now they are saying that they need to engage the staff and the workforce in this. That should have been at the heart of it at the beginning; they should have been open and out and discussed it with staff. That just has not happened.

Dr Watkins: Could I add one further point? The STPs should not just address the question of what the health service can do to solve its own problems; they should also address the question of what the broader society can do to address the problems of the health service. Healthcare demand and social care demand are capable of being altered by areas of public policy. We give examples in our evidence of the commercial determinants of health, of the role of welfare policy, of the significance of healthy ageing. We give evidence of how you can help slow down the creation of dependency. Those things ought to be a centrepiece, certainly for a committee which is looking at long-term sustainability, of the question of how public policy is driving the growth of a dependent elderly population with obesity and diabetes; it has to be central to sustainability and transformation programmes. The professional associations and the trade unions cannot be accused of not raising those kinds of issues, but when we raise those kinds of issues we are patted on the head and told, "Go away; can we just settle down to this real, immediate problem of balancing this year's budget?"

Q167 **Lord Bradley:** For this session I should declare that I am a retired member of Unite—very retired. Looking at new models of care and the integration agenda, Steve, particularly as a public health director in Stockport, which is part of the Greater Manchester devolution deal, do you see the new models of care and that integration agenda not only between health and social care but between physical and mental health as something that you, in workforce terms, are involved in, and that you can influence the direction of travel within those changes? Do you see them as exemplars of what can be done nationally and then in the long term for addressing many of the issues you have raised this morning?

Dr Watkins: As a director of public health I can be involved in that. Whether I could be if I were at a more junior level in the system, I do not know. I doubt if I could. I do not see a great amount of staff involvement. I see a great deal of staff suspicion of what we are doing in the Greater Manchester process because they do not know enough about it. You can ask me if that is not my fault as much anybody else's. I am not here as a director of public health today—but, yes, I am sure I could have done more. The Greater Manchester process is driven by a concept of public sector reform which is based on developing resilient communities. It is based on the optimisation of the use of all public resources and it is based on a very close collaboration with industry around the development of the economy, around a welfare to work programme which is not punitive but is around supporting and helping people into work. I am actually quite proud of what we are going to do in Greater Manchester.

I do not necessarily think that Unite would be as confident of my saying that as I am. There is still some suspicion around that process. But, speaking personally, I am very proud of what we are trying to do in Greater Manchester. Whether it will succeed, I do not know. I sometimes think government does not want it to succeed and would rather blame us for the collapse in the system than see us succeed in making it work. We will see.

Q168 Lord Willis of Knaresborough: For someone so young, you are so cynical. We received evidence earlier this morning from the Centre for Workforce Intelligence which basically said there that another 1.432 million professional healthcare workers will be required for 2035 and another 1.329 care staff at that level. Given the fact of current vacancies, given the fact that we have never, ever been able to accurately predict workforce needs, what suggestions can you give the Committee as to how, by, say 2030, we can have a sustainable workforce, properly planned and executed? Just give me three ideas, each of you, which we can recommend to the Government: "If you do this, we will have an appropriate workforce in 2030/2035". It is a simple question.

Dr Porter: It is a simple question that demands, and indeed has, a simple answer. I am afraid it comes down to funding levels now and projected into the future. I would propose that if we can restore proper public funding of health and social care it would be better directed at the crisis in general practice, at the hospital deficits, at reversing the cuts in public health and propping up the terrible, inadequate funding in social care. But, at the end of the day, nothing is more important than recognising that we underfund these areas rather than trying to find a non-funding solution.

Dr Watkins: There is also something about consistency of policy. In my evidence I mentioned that we spent the last five years building up the health visiting workforce and the school nursing workforce because they were perceived as being a very important preventive service. We are going to spend the next five years running them down again because that is what the public spending result of last year was in terms of the public health grant. That is a nonsense. It is an absolute nonsense that we cannot adhere to a long-term strategy. We need to be prepared once again to have a properly planned health service with properly planned manpower needs. We need to stick to those and not depart from them to meet short-term problems.

Lord Willis of Knaresborough: Who should do that?

Dr Watkins: First and foremost the Government have to set that in place in terms of the funding arrangements and in terms of the willingness to commit to a long-term strategy.

Lord Willis of Knaresborough: Unless the Government know the workforce they will need to provide, they cannot do the former.

Dr Watkins: The Government cannot predict perfectly. There will be some factors which they cannot predict but there will be other factors which they can predict. They should certainly make the best predictions that they can and stick to them, and they should offer people long-term,

secure career prospects based on standing by the predictions they have made.

Christina McAnea: I would say a serious commitment to reforming the social care workforce and investing in the social care workforce. One of the things which is in our evidence is that we would ask for a commitment to the Ethical Care Charter that sets out the blueprint for how you deal with this. Evidence is now coming out from councils that have adopted the Ethical Care Charter that they have seen improvements in the care and outcomes for people who are using the services, and also recruitment and retention of staff. For us, that has to be one of the key ones.

I would also say having a fair reward package: not just net pay but having something which lets staff know that they are actually valued for the job they do—so having a long-term commitment to having a fair reward package and not one that is constantly being chipped away at. We were in the process of trying to negotiate new redundancy terms within the NHS when the Government brought in their new proposals a year or so ago. That kicked all of that out and made people feel a bit uncertain and we saw a bit of a rush of people trying to leave. Things like that do not help in terms of long-term sustainability.

Training is central to this as well—and having training which allows for a much better skill mix. There are some interesting developments taking place just now around apprenticeships and nurse associates, et cetera. Investing in staff who are capable of doing much more could make the NHS much more efficient. You would have a wider pool of people to attract and a wider pool of people to take them from.

Q169 **Lord Warner:** This question is really directed more towards Christina and Steve. What are your two unions doing on the whole issue of portability of qualifications, particularly on reskilling and retraining? What initiatives have you taken?

Christina McAnea: I sit on the Skills Academy for Health and we are working very closely with the academy, particularly around training on the bands 1 to 4 and trying to develop training packages that go across a wider range of people and trying to ensure that we get much better investment in those staff because we think it will actually improve things for the bands 5 and upwards—the professionally registered staff, as it were. I am not quite sure what you mean by portability.

Lord Warner: An in-service training course in Manchester that would carry commitment in Cornwall.

Christina McAnea: We are trying to push very hard to say that with the developments in apprenticeships, particularly the higher-level apprenticeships, there should be a national standard for them. The problem at the moment in the way apprenticeships can develop is that practically any employer can come forward and any provider and say, “I want to run an apprenticeship” and, provided it meets fairly broad criteria, they will get the go-ahead to do that. Some of our concerns are that the quality will be hugely variable. Some standards have been set so people can provide the training in some of the NHS apprenticeships, but they have been set as something like “adequate”. That is the only

standard they have to meet and we would argue that it should certainly be higher than that. So we are doing a lot with the organisations. We work quite closely with Health Education England and the Skills Academy for Health to try and make sure we get consistent standards for those staff across the board.

Dr Watkins: This question raises the very important issue of why we need to maintain some kind of national planning and national pay system. We have a problem in public health at the moment that the National Health Service, Public Health England and about half of local authorities operate one kind of approach to the grading of public health specialists and the other half of local authorities have a different view. That seriously affects the capacity of public health specialists to move between those two different markets. It also means that those authorities which have chosen to not recognise the professionalism of public health specialists are not getting the best public health specialists, and they may well be the local authorities which need the best public health specialists. I do not want to see that problem duplicated across a whole range of professional groups, as might happen if we had more local pay systems.

It is important that education is properly planned so that the validity of the certificates issued by one employer can be recognised by another employer. Portability is predominantly a question of having effective quality control. I do not mean silly inspection systems, I mean proper quality control of the nature of the education that is offered and then of a willingness by employers to recognise that. Certainly we would support that.

Q170 **The Chairman:** I have a feeling I know the answer you will give to my last question—but let me try. On the basis that this inquiry is about the long-term sustainability of the NHS, what one suggestion might each of you have that we might adopt as a recommendation that will deliver long-term sustainability of the NHS?

Dr Porter: You are quite right that we have all emphasised again and again the importance of the commitment to proper funding. There are a whole variety of ways of funding health services across the world and many of them work very well. I would not, for example, say that the health service in Germany is not a very good one, and yet it is funded in a completely different way to the one here—and there are other examples everywhere else.

Along with a commitment to proper funding we need a restatement of what the health service offers to the people of this country and what it is for. For me the most important part of that is the comprehensiveness of what it offers, the universality of the offer and the way in which the entire country sees it as something that is offered to people at the time of their greatest need. To me the single thing that this Committee could do to support the long-term sustainability of the NHS is to re-emphasise that its founding principles must not change: that a temporary, I hope, problem with funding of public services does not translate into retrenching away from an idea that was a good one when the NHS was introduced, has remained a good one throughout and will sustain us through into the 21st

century. In other words, a service that is free at the point of need, for the people who need it, when they need it.

Dr Watkins: We have gone a long way from it, so we must return to the original concept of the National Health Service as a socially provided mechanism by which the people pursue their health as a social goal supported by their professional advisers. That involves addressing the determinants of health and it involves providing healthcare and social care planned to meet need.

Christina McAnea: Everybody has talked about funding so I am not going to mention it. I think there needs to be a clear recommendation of the recognition of the link between social care and health and that you cannot have one without the other. Running down social care has a direct impact on the long-term sustainability of the NHS. I would make two points on that. One is that we need, as I mentioned earlier, something like an ethical care charter to ensure that you have a long-term sustainable workforce within the social care sector. For the NHS, given the size of the challenge, the change that is coming and being planned about integration, et cetera, then again we need something like a new charter for staff to give them a feeling that they are in it for the long haul and that they can engage in change without putting at risk their own employment status.

The Chairman: Thank you very much. Thank you for coming today to help us with this evidence. If, following the conversation we have had, you feel there is some other material that would be helpful, please feel free to send it to us. We will get a transcript in due course of today's session. Please correct any mistakes relating to accuracy, but you cannot change the content. Thank you for coming today; we appreciate it.

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Evidence Session No. 17

Heard in Public

Questions 171 - 177

Tuesday 15 November 2016

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Members present: Lord Patel (The Chairman); Lord Bradley; Lord Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Dame Julie Moore, Chief Executive, University Hospitals Birmingham NHS Foundation Trust; Sir Michael Deegan, Chief Executive, Central Manchester University Hospitals NHS Foundation Trust; and Sir Andrew Cash, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust.

Q171 The Chairman: Good morning, lady and sirs. Thank you for coming today. We are looking forward to your evidence because the future sustainability of the NHS is crucial to us.

There are two things I have to say to start with. First, we are broadcasting now, so any conversations you or Members have might be picked up. Secondly, if anything comes up that you want to submit as future evidence, feel free to send it to us later.

To start with, perhaps you could introduce yourselves, and if you want to make an opening statement, please do so—it might be very helpful—and then we will go straight on to questioning.

Sir Andrew Cash: I am Andrew Cash, chief executive at Sheffield Teaching Hospitals.

Sir Michael Deegan: Mike Deegan, chief executive, Central Manchester Foundation Trust, and current chair of the Shelford Group.

Dame Julie Moore: Julie Moore, chief executive, University Hospitals, Birmingham, and currently interim chief exec of Heart of England NHS Foundation Trust.

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The Chairman: Thank you very much. Would you like to make an opening statement?

Sir Michael Deegan: Thank you, my Lord Chairman. We are really grateful for the opportunity to appear before the Committee on this crucially important subject. We are giving evidence this morning on behalf of our own organisations but also the Shelford Group. If I can speak briefly, my Lord Chairman, about the financial position of the NHS now and in the future, Dame Julie will address the workforce challenges and then Sir Andrew will outline some of the demand pressures.

First, I thought it may be helpful to outline the Shelford Group's position within the NHS. We represent 10 of the largest, and indeed the most successful, university hospital groups across the health service. In aggregate, we deliver services worth approximately £10 billion per annum, which is about 10% of the entire NHS, and a significantly higher proportion of highly specialised services. As biomedical research centres, we are hubs of research, education and innovation. We are sometimes referred to as the "backbone of the NHS" and, as such, we are as committed to its future as any other stakeholder group.

With that perspective, we see the NHS as approaching a crossroads. To be clear, our view is that the current path we are on is taking us rapidly towards an unsustainable position. However, we see no reason at all why the NHS cannot be put back on a path to long-term sustainability, if there is a will to do it.

At a national level, the most fundamental concern is how much, as a country, we are willing to invest in health and social care. I think it has become abundantly clear that there is not enough resource for the service to meet the legitimate demands of the patients and communities we serve. Between 2010 and 2015, we have had to cope with the lowest levels of growth in the history of the NHS. Critically, that low growth is projected to continue for the next five years; so for the period up to 2020, average real-terms growth will be less than 1% per annum. That compares with a longer-term average of about 4% in the history of the NHS, which has enabled us to keep pace with demand, technology and patients' expectations. Even the 3% last year was barely enough to keep the show on the road and we are deeply concerned about the next three years, which, in our view, fundamentally threaten the sustainability of the NHS.

Clearly, there are important considerations about the percentage of GDP spent on health, and our position does seem relatively low by western European standards. But, my Lord Chairman, some of the debate around GDP and baselines leaves me a little cold because I think it obscures the realities of the impact of this on front-line service provision.

Moving to that, my Lord Chairman, we are aware that you will have heard descriptions when you have been sitting as a Committee, such as "year of plenty" and "feast and famine". As the Shelford Group, with over 150 years of collective experience as chief executives, we can absolutely assure you that on the front line it does not feel as if any of these years have been plentiful and there has certainly been no feast. The only question is how severe each year's famine is. The underlying deficit of the

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NHS provider sector at the end of last year was in excess of £3.5 billion. Now, when one or two trusts are in deficit, you can look to local issues and solutions. When eight out of 10 trusts and nearly the entire general hospital sector are in deficit, that points to a systemic underfunding issue. It does seem to us that we are creating a dependency culture in which even successful organisations can survive only on bail-outs or central funding, and that is utterly corrosive for good financial or clinical management.

Clearly, there are opportunities to improve efficiency, and I would be happy to talk them through with the Committee later.

The Chairman: We have a question about funding, so we will come back to it. I know that both Dame Julie and Sir Andrew are also going to make statements, so try and keep it succinct and then we will come back to the questions.

Dame Julie Moore: My Lord Chairman, thank you for the opportunity to talk today. In short, workload complexity has grown and, although the staffing numbers have grown, they have not grown to match the same level. We employ over 100,000 staff between us. I am very proud of the way that the NHS staff rise to the challenges and the increase in work we have seen, but actually it is getting to a difficult point now. We have seen cuts in training budgets and national manpower planning has not reached what we need it to do, so there simply are not the staff there to employ any more. Some trusts are running with vacancies of about 10% to 15%. My own Trust does quite well around vacancies, but we still have nursing vacancies of about 6%. We are often told that we need to curb agency staff and employ them as full-time staff. The problem is that they are not real people; these are our own staff working in their days off, so we already employ them and, although they work an extra day or so a week, they are not there to be re-employed.

Also, we have traditionally looked to the international market to come, but Brexit has sent a bit of a shockwave through some of the staff we would have traditionally recruited. In fact, I have had some staff from the EU, southern Ireland, looking to go back. Of great concern to me are some of the incidents of racist abuse that my staff have suffered from patients following Brexit. If we wish to attract international staff over here, we are going to have to think very carefully about the messages that we give and how we treat our staff. It is not just that we want to use them as a workforce; I think the exchange of knowledge and research are vitally important to our NHS. We have benefited as a country greatly from international collaborations and I would hate to see that lost in all of this. At the moment, I would say that we do not have enough nurses, doctors, clinical professionals, managers—anybody, at the moment—and I am not confident that we are training enough to meet that demand.

The Chairman: Thank you very much. Sir Andrew.

Sir Andrew Cash: I think the reason that NHS finances and workforce are under such pressures is that demand has fast outstripped supply. Primary care is not delivered at scale and we still have a number of small practices of variable quality; therefore there is not an effective universal check on the demand for hospital services. In the first six months of the

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year, A&E attendances were up by approximately 6% nationally and non-electable, emergency admissions are up by 4% nationally, which, in turn, has put elective waiting-time targets under severe pressure. Bed occupancy is around 91% nationally in the first quarter of 2016 and we know that we need to keep it at around 85%, otherwise we get the risk of cross-infection. At the other end of the pathway in a hospital, it is difficult to safely and consistently discharge medically fit patients on some occasions because of the issues we are facing in social care.

Against that backdrop, it is no surprise that the hard-fought access targets that we have gone for over the last decade are suffering, which we see right the way across in A&E and the RTT of 18 weeks and so on, and cancer targets.

The response has been regulatory pressure. Front-line organisations now feel quite stifled about the burden of reporting and performance management, and the clinical leadership model—the clinical director model—within hospitals is also suffering; a number of people do not want to be clinical directors. People who have been successful in the last decade have not suddenly become bad leaders or bad leadership teams, but it is more the systemic failures that we see that are affecting people.

As my colleagues have said, we feel we are at a crossroads. We do need either to invest more in health and care services to sustain their long-term future or accept some sort of degradation in the quality and the availability of those services. It is very difficult for people who have dedicated their entire professional lives to watch this go on.

Looking at the work of the Office for Budget Responsibility and others, we see no reason why a tax-funded, high-quality NHS should not be sustainable for the longer term, but we do feel that spending levels will have to return soon to their long-term average of closer to 4%.

Q172 The Chairman: Thank you for that introduction; it helps to set the scene in all the areas of questioning we have. Before we get down to the detail of the questions, we are looking at the long-term sustainability, beyond 2025 or 2030, as opposed to trying to solve today's problems, so we would like to hear your views on how we can make the NHS and social care sustainable in the long term.

Sir Michael, you have painted a picture of the financial situation, so let me ask you about that. What do you think might be the solution in the long term to make the NHS and social care sustainable financially?

Sir Michael Deegan: Longer term, the direction of travel that we are moving in, for example in Greater Manchester, around far greater integration between health and social care, is an absolute must for me, but that needs to be on the basis of properly funded health and social care arrangements. We need to be far clearer on the accountability, which again we are working through in Greater Manchester, and we need to make sure that our overall regulatory framework actually enhances and supports the levels of collaboration to have health and social care working together.

Lord Willis of Knaresborough: What does "properly funded" mean? It is just words. What does it mean, so that we have some idea as to what

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we should be recommending?

Sir Michael Deegan: As Sir Andrew touched on in his introductory comments, the OBR estimates seem to suggest that, if we were to return to a level of 4% growth per annum, which looks a sensible level to take on board the demand pressures in the NHS, the technology and the innovation, which is the historic level of the NHS going back to its inception, that will be appropriate.

Lord Willis of Knaresborough: That 4% will cover health and social care?

Sir Michael Deegan: I feel it is important that we do not look for differential settlements.

Lord Willis of Knaresborough: You have just said that you wanted integrated health and social care. I am asking you what the figure is.

Sir Michael Deegan: I think the OBR estimate of close to 4% is certainly at the correct level.

Lord Warner: I know the historical figure, but if your economy is not growing at 4% or anywhere near 4% per year, the only way you can sustain the NHS at that figure is by cutting other public services. Do you accept that?

Sir Michael Deegan: Given my accountabilities to another foundation trust in central Manchester, I look at the impact of the financial settlements at the moment and we will no longer be in a position—

Lord Warner: I am not talking about the financial settlements now. You are claiming that the NHS needs a 4% real-terms increase per year stretching into the future. That is what I am querying. Is that what you are really saying?

Sir Michael Deegan: I am really saying not—

Lord Warner: For ever?

Sir Michael Deegan: I do not think we can ever talk of for ever, but for the foreseeable future.

Lord Warner: Let us say 10 to 15 years; so your formal evidence to us is that we need to recommend an increase of 4% real-terms increase a year up until 2030? Is that what you are saying?

Sir Michael Deegan: I recognise the point behind your question as to the political difficulties of that, but when we look at the realities of front-line service provision, a level of growth at that level—

Lord Warner: That sounds to me like yes.

Sir Michael Deegan: I said yes at the outset, my Lord Chair.

The Chairman: We will move on to the next question and Lord Kakkar.

Q173 **Lord Kakkar:** Lord Chairman, if I may, I declare my interests as chairman of University College London Partners, a practising surgeon, professor of surgery at University College London, honorary consultant surgeon to University College London Hospitals NHS Foundation Trust, director of the Thrombosis Research Institute in London, business

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ambassador for healthcare and life sciences, a fellow of the Royal College of Surgeons and a fellow of the Royal College of Physicians.

I would like to turn, if I may, to the question of the sustainability and transformation plans that we are seeing emerging at the moment. There appears to be a view that these may offer the principal solution to challenges facing both health and social care in terms of financial problems, variations in care and outcomes and the changing needs of populations. I would like you to address three issues, if you would be so kind. First, how confident are you that these STPs are going to achieve all those objectives? If you are confident that they will, how soon do you think we will be confident in seeing the evidence that they will provide some contribution to the long-term sustainability of the NHS? If not, what alternative solutions would you suggest are explored if the STPs will not be that bridge to long-term sustainability?

Sir Andrew Cash: First, on how confident, the 44 sustainability and transformation plans probably break down into three groups at the moment: those that are ready to go; those that need more work; and those that are in parts of the country where the systems have already broken down, there have been success regimes and they are now being switched into a sustainability and transformation plan. In terms of confidence, people in this service look at the three main aims of an STP. The first is about health inequalities—excellent; I think they are a great way to do that, but that is a slow burner. The second is to look at equality of access, things like all sorts of treatment—which is patchy, and different in different parts of the country. The third main aim of the STPs is about finance and efficiency.

To return to the evidence, first, health inequality is a slow burner. This is a 10 or 15-year piece and it will need backing because, as you produce a plan, the lifetime of a Government is, of course, five years and there will be difficult decisions to take on those things which then need supporting. Quite often the difficulty when you produce a plan is that it does not have local support because sometimes the plan you are producing is different, and we see that time and time again. It is excellent that we are connecting the sectors of health and social care first, and then, secondly, improving choice, opportunity, employment and education and those sorts of things. I think we can get to equality of access quickly across each of the 44.

On finance and efficiency, the issue is £22 billion. Lord Carter's excellent report said £5 billion, if that was absolutely put in. This is a huge ask, and the big difficulty about the STPs is that they will be moved into, "This is just a finance and efficiency issue", if we are not careful. The evidence, I think, is that they are longer term and they are a 10 or 15-year plan.

On alternative solutions, I think we will have to address the current regulatory framework, which is the 2012 Health and Social Care Act, which is essentially based on competition— to short-circuit that. We are trying to move to a system under STP which is effectively, at the moment, a coalition of the willing of a number of organisations coming together and agreeing things, and then edging towards a different sort of

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governance. In terms of a sustainable future, we are going to need to look at that regulatory framework.

Lord Kakkar: Just on that point about regulation, if I have understood you correctly, you would have a view that, unless we fully address the fundamental issues around the regulation of a health economy and the need to promote competition rather than work collectively in organisations looking at a population and delivering needs on that basis, the STPs are unlikely to be that bridge to a sustainable long-term NHS?

Sir Andrew Cash: Correct; so in the top third of the organisation of STPs, the top 12 or 15, relationships are very good. They are normally more stable economies. We are trying to get away from a curative, hospital-based system and, down the track, integrated to a preventative, population- and capita-based system—but correct.

Lord Kakkar: With regard to the focus on social care, do you have evidence that the STPs have had a sufficiently rigorous focus on the social care element to address the concerns about the discharge of patients from the hospital environment? Is your view that the well-formed STPs have got that particular part of the relationship between health and social care properly integrated?

Sir Andrew Cash: Yes. I lead one of the 44 STPs and can only speak for my own, but we now have a plan about how we can do that over the five years of the plan. Financially, I have £727 million to make up, and I think about £154 million of that is social care issues. We are busily working now at the plan on how we do that. It is a huge ask to make up that sort of figure on a £3.3 billion budget.

The Chairman: There are some quick questions from some other Committee members, but would either Sir Michael or Dame Julie want to add anything to what Sir Andrew said?

Dame Julie Moore: I would like to add a bit about the competition issue. We took over management of Heart of England NHS Foundation Trust because it was in significant deficit, heading for between an £82 million to £100 million deficit last year. We curtailed that at £65 million and this year it will deliver a £13 million deficit, which is a big thing to ask. As we move towards trying to consolidate and become one organisation, the hurdles we have to overcome in competition are massive. Indeed, the fees alone are millions just to achieve that, so we are working hard, doing two jobs. Part of our STP is maintaining the standards we have as well as equality of access across Birmingham, but we have to do two jobs to do that in two separate organisations because of competition, and it is fiendishly difficult to pick your way through that minefield of competition law while you are trying to run two big organisations as well, as well as expensive.

Baroness Redfern: Chairman, first, I declare that I am vice-chairman of the Health Alliance. My question is to Sir Andrew regarding social care and emphasis on social care. I am from a local authority background. Do you think that STPs could work more collaboratively with local authorities in delivering a better social care system? It seems that decisions are taken without probably one of the main partners being fully involved.

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Sir Andrew Cash: Yes, I think they could definitely work more collaboratively; and it varies, as I said, from STP to STP, and I can only speak for my own.

The Chairman: The question is whether it is workable, first, with the local authority.

Sir Andrew Cash: The answer to that is yes, they can. What we know is that people who are in social crisis end up in the health service and, therefore, the obvious first part for an STP is to bring health and care, ideally, together.

Baroness Redfern: So your plans are for more integrated working with local authorities? Is that correct?

Sir Andrew Cash: Absolutely, yes.

Lord Warner: What do you say to the chief executive of Birmingham who said that the STPs are much too NHS-centric?

Dame Julie Moore: We did have this discussion last night with the chief executive, who pointed out that he was talking about national and not local, where indeed he is the leader of our local STP. We have been working for the past few months together on how we do integrate and come together a lot more readily. There is a lot of duplication between health and social care; when we say that a patient is ready for discharge and have assessed the patient, then the social worker comes in and does the same assessment, so part of what we are doing in the STP is reducing that duplication to save money and, most importantly, time for the patient on both sides. On his behalf, I would clarify that we have been working very well together in Birmingham and his intention was to talk about the national picture. I would emphasise that in Birmingham we are working very closely together—the local authority, the health providers and the commissioners.

Lord Warner: So he may be right in national terms?

Dame Julie Moore: Probably in national terms. If you look back at it, it has taken a lot to get local authorities and the NHS to work together, and that has been a real step forward. I think there are still issues around how we do work together. We both have different regulatory frameworks, different everything, and their world is different from our world and vice versa, but we are learning about each other and working together quite well.

Lord Mawhinney: The STPs are obviously fundamentally linked to the 4% per year increase in funding that Sir Michael talked about. Can I just clarify one bit that was unclear? We have to produce a report. If we produce a report that mirrors your evidence and says, "We recommend 4% per year", the first question will be, "How much of that should be at the expense of other public services and how much of it should be through increased taxation?"—and your answer is?

Sir Michael Deegan: Actually, with the greatest respect, my Lord, that is not an issue for the Shelford Group, where the funding is sourced from. We are presenting evidence on what we feel health and social care requires to meet the legitimate expectations of our patients.

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Lord Turnberg: I have to read out my interests. I am a retired physician from Salford Royal, professor of medicine at the University of Manchester, ex-president of the Royal College of Physicians, currently a trustee of the Medical Research Charities and scientific adviser to the Association of Medical Research Charities.

I want to ask Sir Michael about being first off with Devo-Manc and whether you have actually managed to succeed in merging the budgets, as they did in Salford Royal, for example, and whether this has produced some savings. Have you demonstrated that it actually is worth while?

Sir Michael Deegan: I feel, my Lord, that we are demonstrating that it is worth while. In Greater Manchester, we have spent the best part of the last two years establishing robust governance arrangements across health commissioners, health providers and local authorities, as providers and commissioners of social care, so we can address issues in localities, such as Salford, Manchester and Oldham, on an integrated basis. We are far from having concluded this journey, but we are aligning accountability for delivery with the accountability for planning. We are working through the regulatory issues which Sir Andrew mentioned earlier and our whole basis in GM is around collaboration, so we are having to match that with a regulatory framework that has a strong competitive element. Within our localities, places such as Salford and Manchester can point to benefits. Whether that would meet the test of evidence on a longer-term basis, I suspect we are not yet at that stage.

Lord Turnberg: How do they get round the competition story?

Sir Michael Deegan: For example, in the City of Manchester at the moment, we have developed a local care organisation that will pull together some local hospital services, out-of-hospital services, mental health, social care and parts of primary care. Our commissioners have developed a prospectus for those services which ultimately will be procured, so, as a group of providers, we would be part of a procurement process, bidding for that work on behalf of our organisations and our local communities. That gives an insight, I think, into the sort of work that Dame Julie talked of earlier.

Lord Turnberg: Expensive.

Q174 **Lord McColl of Dulwich:** Where are the greatest workforce pressures and what are your solutions to addressing those pressures? What changes do you want to see in the way the system plans for the workforce? Should providers have more control over workforce planning? Lastly, are unreasonable levels of bureaucracy still hindering patient care to which GPs would say yes?

Dame Julie Moore: In a very short answer, I would say yes to most of your questions, my Lord. The biggest, most problematic area of shortage at the moment is in the middle-grade doctors. In previous years, about two-thirds of doctors completing their foundation years went on to speciality training. It is now about half, so we have huge gaps in our middle-grade rotas—the registrar grade of doctors that we used to have. Traditionally, we have filled those by a variety of roles, international recruitment and creating some speciality doctors. That is getting harder

and harder to do. So what we are doing at the moment is creating doctors' assistants, physicians' assistants, associates, a variety of grades of staff to help doctors in their work, but there comes a point when you have to have a doctor. We talk about hands-on care, because you need the hands of the doctor to put on the patient. So we are, I think, facing difficulties.

Manpower planning is notoriously difficult because when you take medical students and you do not say, "What are you going to be when you finally finish?", you do not know. In the past, when I worked with the Future Forum, one of the things that shocked me greatly was that 20% of doctors who qualify do not ever practise medicine. I think manpower planning is really difficult. I am really pleased that we will try to train a lot more of our own doctors, but that is going to be a long time coming—10 to 13 years away. I would like more control and for the junior doctors to belong to us so that we own them and can look after them. Sometimes they pass through our organisations in as short as four or six months, so they do not really belong anywhere. Workforce is something that we need to nurture and care for for the future and not treat it as a commodity, which is why I do not like the term "human resources". They are not human resources, they are people. I would like to look after our own more, but when you get them for three months and they are gone, it is very difficult. I would like a lot more control.

Lord McColl of Dulwich: What would you do about the 20% who leave?

Dame Julie Moore: I think we need to find out why they want to leave. I think there is a lot of pressure on people academically sometimes to go in, but we need to look at how we offer careers to doctors. For a long time, I have been a believer that we should offer lifetime job plans and not expect somebody, when they become a consultant at 35, to have the same job plan and do the same levels of on-call when they are 65. I do not think that is sustainable. If you become a consultant at 30 or 35, it can be quite daunting to think that you are going to be doing exactly the same job for the next 40 years or so. They are onerous jobs. Of great concern to me is the accident and emergency department—they are very difficult jobs; they are not attractive to people coming out; there are lots of vacancies, and people can choose other places. We have to think about how we treat people, long-term job-planning and actually letting us do more of it than having it so centrally controlled.

The Chairman: We have heard that one aspect of tremendous pressure on the workforce is primary care. You, Sir Andrew, referred to the primary care model. Very briefly, is the current model of primary care the one that we should be pursuing in making sure that it is properly staffed, or is there a different model? You talked about integrating social care, working with local authorities.

Dame Julie Moore: Actually, we ask a lot of our GP colleagues and the model that we expect them to operate sometimes is no longer fit for this day and age. The demands placed on primary care are huge and demand is outstripping that. We need to look at new models of primary care and how we work more closely together in 24-hour services and actually relieve some of the pressure. We know that the current crops of GPs

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coming out, wanting jobs, want different working patterns, and we are not in a position where we can determine models without looking at what people themselves want as well, so we have to accommodate people who want part-time work, but I think we can only do that by working in bigger centres, working together and providing round-the-clock access that patients now need. I think we need to look again at the whole model of provision.

Lord Willis of Knaresborough: I would like to go back to this issue of retention—and I declared my interests earlier just to show that I have some. It staggers me that, in 2014-15, some 9.2% of all nurses left the profession. It staggers me that for every nurse we train and employ, within three years the equivalent number have left, so we are basically standing still. I would like to ask all three of you: how much attention are you giving, as the Shelford Group, to actually saying that unless we can retain more of the people, not within your organisation but within the NHS and other healthcare providers, we are absolutely stuffed and we just cannot have a sustainable healthcare system?

The Chairman: Dame Julie is an ex-nurse.

Dame Julie Moore: Yes, I am an ex-nurse.

Lord Willis of Knaresborough: I know, and we are very proud of her.

Dame Julie Moore: We are very concerned about retaining people. The pattern of turnover is different for our hospitals. In teaching hospitals, you expect some turnover, and the way it is measured is people moving within our system and locally within our hospitals, which is okay. Some of the hospitals which have been in trouble that we have helped have been in small towns, away from major cities, and their employment of nurses is their local population. When we helped the George Eliot Hospital a while back, we had to employ from the local population. It is really important that you grow your home-grown talent and try to retain that there because it is not likely that you are going to get a lot of people moving there, unless it is for lifestyle, a house there or whatever. We do exit interviews and we try to maintain all that, but actually young people now are pretty free to choose their jobs. Worldwide, there is a shortage of healthcare professionals. Some people want to take the equivalent of gap years and go and work abroad, and what we are trying to do is to have retaining schemes so that people can come back after a year and make sure they stay there. We have had years of restraint now on pay and one of the ways we managed in recent years around managing the budgetary pressures was by keeping a downward pressure on pay. When people can choose where they go to work, people are making those kinds of choices now.

Lord Willis of Knaresborough: But we are actually moving into a situation now where we are going to be charging nurses, to concentrate on them, £9,000 a year to train, yet I have not seen one single trust, including the Shelford Group, which has said, "We will actually pay for those fees and bring golden handcuffs in to retain you". If that is the case, it is much cheaper for you to spend £27,000 paying fees and giving them fee-free courses rather than, in fact, finding another nurse who costs you £75,000 to train. I do not understand the economics, yet it is

not being done.

Dame Julie Moore: It is being considered. We are going through that at the moment and looking at how we could do that. Sometimes, we do support nurses through their training, particularly our own staff who started as healthcare assistants or auxiliaries, where we pay them while they go through their training.

One other scheme we are trying to do in Birmingham—sorry, Andrew, I know you are trying to get in; I can feel it—is to try to help people where we operate a learning hub where we take people who have been long-term unemployed and try to get them into careers in health by offering them interview preparation, CV preparation and on-the-job training. So far, we have managed to get 3,000 long-term unemployed people back into work mostly in the health service. That is not just to feed our workforce but because joblessness is a determinative of ill health as well, so it is part of our wider social responsibility.

Sir Andrew Cash: Perhaps I could address the primary care part of it. Of course, we have a Five-Year Forward View for general practice, and a number of the Shelford trusts have integrated community services with the hospital services. The model through the STP that we are looking at is to change that pyramid between the GP, the nurse and the healthcare assistant. So let us say that, typically in our local universities, 600 nurses qualify a year, we take maybe a fifth of those nurses and make them into advanced practitioners—the best ones. Similarly, about 150 therapists come out, so we take a fifth of those. Then, on the health inequality issue, we go into a kind of psychological contract with them that they will stay, by looking at the payment of doing additional courses that they may need to be advanced or whatever, and then to put them long-term into areas of higher deprivation. That is the typical scheme now. We are all looking at this; but to be frank with you, the day-to-day operational, annual budgetary pressures of keeping an organisation in budget and able to make those sorts of investments are the things we face day to day. So we are running two systems, trying to transform a system at the same time as still running it. Of course, you are responsible to your governors and board for keeping an organisation in shape at the same time as changing it. They are the practical issues that we face, but they are the sorts of things we could do.

Q175 **Lord Scriven:** I have declared my interests previously, but, seeing as Sir Andrew is in the room, I am actually a member of Sheffield City Council, so I think it is important that I do reiterate that.

I have listened to the issue regarding the 4% increase, but you have said nothing about productivity and variance. We have had lots of evidence previously, including the fact that the NHS over the last three years has had a 0.96% decrease in productivity. There is huge variation. Right Care, for example, says that there is £15 billion-worth of funding that could be released from low-value care to high-value care. What is stopping productivity gains in the NHS, in particular in your sector? What is going to have to change, be it either at local level or national level, for a sustainable NHS to unlock the levers of productivity which, clearly, are not being used at the moment?

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Sir Michael Deegan: There is lots of work across the Shelford Group; for example, on the procurement—how we can develop a far more powerful presence. In one of our projects, which Dame Julie or Sir Andrew may wish to talk to, we are looking at a £200 million saving through procurement by punching our weight far more effectively. Our chief pharmacists are currently coming together in a similar vein, so there is lots of work at the Shelford Group level and, again, at a Greater Manchester level. We are not addressing the Carter savings as individual institutions, but looking at how we can address them across the whole of Greater Manchester, so there is a significant amount of work. At a high level, on Patrick Carter's estimates, that generates about £5 billion of the £22 billion, so there is still a step beyond that.

I would come back to the earlier comments from Sir Andrew on the nature of the regulatory framework—that if we can operate some of these issues on a far greater collaborative footprint, that offers more utility.

Lord Scriven: What is stopping that? You do not need legislation to work collaboratively. What needs to happen to make this collaboration work, because it starts at your level? What is stopping this?

Sir Michael Deegan: In Greater Manchester, it is starting to happen.

Lord Scriven: Let us forget where it is working. We are really interested in where it might not be working as well. What needs to change?

Sir Michael Deegan: There is a disjoint between the accountability for planning and the accountability for delivery. For example, if you are part of a collective set of arrangements and the benefit may accrue elsewhere, if you are a single statutory body, you do not derive any of that benefit. Part of this is creating that broader common purpose. I think that needs to be place-based as we develop this.

Lord Scriven: If we are making a recommendation to the Government on that, what recommendation would you say would actually help that to happen?

Sir Andrew Cash: Three things are stopping it: capacity, capability and leadership. On the last issue, there is a growing leadership issue within the NHS where a large number of chief executive positions and executive director positions, for instance, are held by interims at the moment and people are running worried of these very challenging jobs.

In terms of what has to change, what would be very useful is if the guns of the NHS in terms of our marching orders were to change some of the targets, if I can put it that way, to working with, for instance, the most vulnerable in our society. You might look at people in care homes to make sure they all had a co-ordinated plan between all the agencies and you might look at people with multiple long-term conditions, given the high numbers of people living longer over 65 and over 85, away from access targets—which are now in a pretty good shape, but the entire NHS is concentrating on those. So we have to get up front. That then leads you into a capita-based solution for the allocation of funding based on a place, a neighbourhood within a city, and you begin then to concentrate on primary care, the model and the integration, and connect the pathways of

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primary care, community services and hospital together, that sort of thing.

Lord Warner: Are you saying, Andrew, that payment by results has outlived its usefulness?

Sir Andrew Cash: Yes, I am. We have different incentives in the system and the STP, as a system, plays against payment by results. My own view is that you need to incentivise hospitals in a different way.

The Chairman: Would Sir Michael and Dame Julie agree with that?

Sir Michael Deegan: Ultimately, I think we need to move to a capitation-funded system. Whilst we have PbR, we need to make sure that the costs are reflected in the tariffs, but we need to move to a capitation-funded system.

Dame Julie Moore: Could I return to productivity? I think that the NHS has become more productive in many areas. When we moved into our new building, we moved from 24 day-case beds to 95 and we have had to open up another day-case unit, so we are doing far more work as day cases. However, we are now seeing 7% more patients coming in through A&E and we have more people we are unable to discharge for all the reasons we have talked about. Currently, in my hospital, 100 beds are occupied by people who previously would not have been there. Whereas length of stay was coming down quite considerably, it is now starting to rise again, with these problems. It is not just social care; it is delayed transfers of care. As the surrounding hospitals become full, we are unable to discharge people back who we have done the specialised care for, and when they are going back for the secondary care, we cannot get patients back to those hospitals as well. It is starting to silt up.

In terms of how you measure productivity—I think there is someone over here who is probably better qualified to answer this—I think it is notoriously difficult. When you look at the new techniques we introduce, such as split liver transplants—in the past, you used to take a liver and put it in the patient, but now you cut it in half and put it in two people—it is constantly increasing the complexity of what we do.

Another point I keep returning to is that the NHS has been successful. The problems we are facing are due to the fact that more people are living now into older age with more complex conditions, and actually I think there is a price for us all to pay for that. That is not for me to say; it is clearly a political decision for the Government. But if I were to say to my parents, “You’ve got an extra 10 years of life over what your parents had”, I do not think they would ever think of it in that way, but it is right.

The Chairman: That is a good point at which to move on to the Lord Bishop of Carlisle’s question.

Q176 **Bishop of Carlisle:** I want to declare some interests as well, as lead bishop for health and social care, patron of Eden Valley Hospice, Hospice at Home North Lakeland and Burrswood, and I am an associate of the Faculty of Public Health.

I would like to return, if I may, to this whole business of the integration of

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the NHS and social care, which has been mentioned frequently in our discussion. Sir Michael, you started off by saying that you felt that the integration of the two was essential for the future sustainability of the NHS; and Dame Julie, you talked about the duplication that there is at the moment. A number of our witnesses have indicated that, even if the two were integrated properly, it might improve quality, and almost certainly would, but would not do much for finance; in other words, it would not be any cheaper. I would be grateful for your comments on that.

I have another question about how some of the existing obstacles in the way of integrating health and social care can best be overcome, and you have already given some indications of that in terms of what you are doing at the moment.

Dame Julie Moore: Perhaps, my Lord, I could give a concrete example of when I first became interested. It was some years ago when my aunt was dying at home. I watched as the social care person was in her home, feeding her, making food and giving her that, and the community nurse was stood waiting for her to finish, which was dead time. I thought then that this is huge duplication. I think quality will improve and that it will become less costly to provide a service in that form of integration, which is what we are talking about in Birmingham, to remove the two people visiting, one from community services and one from social care.

Actually, there is a lot to be said as well for multi-skilling people. A very good scheme we operate in Birmingham for the Royal Orthopaedic Hospital, for example, is that nurses can do the physio following patients having joint replacements and the physios can do the wound care and you have one person visiting instead of three or four, which happens elsewhere. That is a very simple example.

Do I think it will solve all the problems? No, because we have an increasingly ageing population. We need to find ways. One of the things that gives me great hope in the STP is that it is not just about social care and health coming together but about the wider public sector. In one part of our STP, for example, where the fire brigade go in to fit smoke alarms, they are also looking for other signs of ill health and feeding that back in. We are having good discussions with the police and a whole range of other agencies about how we pool our intelligence, the information we get, and work together in a better way. That is the first time that has happened, so I am really pleased.

However, a growing population with chronic diseases are going at some point to require care. We extend life expectancy—we do not save lives, we prolong them. So actually, at some point, people are going to require care. We all know that the last years of someone's life are the most expensive part of it. I do not think that we, as a society, can avoid that.

Sir Michael Deegan: I would support entirely what Dame Julie has said. In terms of the cost in our Manchester locality plan, we are viewing any inappropriate hospital admission as a fault of the system. We operate from a new PFI-funded hospital which is expensive in terms of bed days, but it is, I think, both more clinically effective and cost effective and better meets the needs of patients for care in either a home, hospice or

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care setting. We are currently in the stage through the STPs, in initiatives such as GM devolution, of working through the cost-benefits at this stage.

Bishop of Carlisle: That is very helpful, thank you. The obstacles that are preventing people in the NHS from working more closely with social care, are they simply structural?

Dame Julie Moore: I think it is history and habit. Some of it is structural, but now that we have started to get over that, it is starting to break down a lot. Also, when times are hard, people start arguing over whose fault and responsibility it is, which has happened quite a lot. Social care sees us, the NHS, as placing demands on it by having all these patients ready for discharge. We see social care placing demands on the NHS. But actually it is nobody's fault; it is nobody's responsibility; we need to work together to try and find the best way of doing it. We will make things better, but I do not think we will make them perfect.

The Chairman: The Care Quality Commission report suggested that there needs to be a new look at how social care is delivered. What is your answer to that?

Sir Andrew Cash: The obvious point, which has been around for many years and is probably the biggest in terms of productivity gain, is that, if you look at any hospital, there will be people who probably do not need to be there. The issue is how you solve that. The hospital should be the last port of call, but it is an incredibly fragile system that we live in. The care home issue is about to break and is breaking all the time, and the last port of call, of course, will be hospitals, so we have to change this system somehow, and one of the obvious ways to do it is to integrate social care and healthcare. Under one organisation, there is a chance that you can begin to keep people in their own homes, supported by assistive technology, et cetera, for longer periods of time.

Dame Julie Moore: In recent months, we have seen a third of the nursing care homes with the most complex patients close in Birmingham. I think you are entirely right, my Lord, that actually the social care model in terms of particularly private care and nursing care homes is not working at the moment and we are seeing lots of homes go out of business. That is a huge problem.

Lord Bradley: I have previously declared my interests, but I have additional interests as an ageing resident of the City of Manchester.

Within the financial context you have described, Sir Michael, are you confident that the devolved budgets, which I am a supporter of, actually allow you, through the £450 million Transformation Fund, to address the underlying deficits which you have rightly identified? Do you believe that not only the integration of health and social care—where, for example, in the current spending round, there is a £27 million shortfall just in the City of Manchester in social care, with the expectation that that will be down to the NHS to fund—but the further integration of physical and mental health is another efficiency that could be delivered within your STP and locality plans?

Sir Michael Deegan: My Lord, the GM devolution settlement is the most exciting initiative I have been involved in in my entire career in the NHS. I

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think it affords us the best chance we have to address some of the underlying issues through a process of connectivity and collaboration across Greater Manchester. Whether it will fully address all the financial problems, I am unsure, but I think that, at its heart, it is about how we develop a place-based approach as opposed to an institution-based approach. I think that gives us maximum mileage moving forward. You rightly draw attention to the critical role of mental health integration in this, and again, my Lord, as you are aware, in GM we have all the different partner organisations coming together under GM devolution.

Lord Scriven: We have been talking about integration for 30 or 40 years. In terms of going forward to make this real, could you make one recommendation on what would have to happen with budgets and with structure? Sir Andrew, you mentioned one organisation. What would have to happen with targets and behaviour? What needs to change to make it happen?

Dame Julie Moore: I think that you could not take away from local authorities the responsibility for long-term care and nursing and residential home care. I think the grey area in the middle is over care in homes. We should integrate that and have one budget and I would like, as a health person, to take control of that—but then people would say I am a control freak, which is fine; you would not like anybody in my job not to be, really. I would like that bit of integration to take place. I do not know what the others think about that, but I think we would save money as well as drive up quality in that regard.

Sir Michael Deegan: Budgetary integration and again align the accountability for planning with the accountability for delivery. Currently, it is disparate and separate. All that needs to be drawn together.

Sir Andrew Cash: I would say that, at the highest level, having the budgets devolved in the way that it is happening in Manchester and Sheffield—not including health, but in due course possibly including health—is the best way to bring about the wider public sector reform. That is really important. For me, the most important change in my NHS career has been foundation trusts. Why? Because it gave you local responsibility. In a similar sort of way, we now have to get local system responsibility in all this. It is no criticism of central regulation, but, if you stack everything to the middle, you lose the power of doing things for your local people. For me, local responsibility through integrated budgets in the way that Manchester is doing is very good.

Q177 **The Chairman:** Listening to today's evidence, if the Secretary of State were listening to it and if I were to say to him that the NHS and social care are not sustainable in the long term, he could just point me to the evidence you have given—which suggests that although there are difficulties, there are structural changes in place; you are making changes to social care and integration; and things will therefore be sustainable.

Dame Julie Moore: I think they will be better, but not sustainable. I think that the growth is part of our success and we need to recognise that and actually say that how a society cares for its older and sicker people is a mark of that society. We need to make sure that we do that and we actually care for our older and sicker people appropriately. We are making

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things better, but we are not making them perfect. I do not think it is sustainable with the current growth in demand.

The Chairman: So what one recommendation, Dame Julie, do you think we should make?

Dame Julie Moore: I would not like to see any change to the way the NHS is funded but we need a public debate about what the NHS is now coping with—the increasing complexity, the increased demand—and to ask, as a society, what we are willing to pay for. If you actually said to people, “You are paying for an extra 10 years of life”, most people would say, “Well, that sounds reasonable”.

Sir Michael Deegan: My Lord Chairman, I do not think it is the funding model, it is the funding level.

Sir Andrew Cash: There is a strong argument for social care and healthcare to be brought together up to but not including means-tested social care. In parts of the country, this is happening, but we now need to bring these social care staff, where they are provided by a local authority, into the health service.

Lord Mawhinney: It is not the funding model, it is the funding level, Sir Michael said, yet this morning’s news carries the story that, of the £250 million that was set aside for mental health, only £75 million of it was used to address mental health issues and the rest was sucked in by hospitals to cover gaps in other parts. It sounds to me that the funding system is a problem, not just the funding levels.

Sir Michael Deegan: Sorry, my Lord, I am not aware of the particular news report you are talking about, but I would say it is around how you align governance in a locality. For example, in the GM setting, that is how we ensure that mental health budgets, acute budgets and social care budgets are all cohered and managed as one. I think that addresses that issue. It is not one, for me, of the overall funding model.

The Chairman: Thank you very much for your evidence; it has been most useful. If, on reflection, you think that there might be some other material that you would like to send in to back up your arguments, please feel free to do so. We are very grateful to you for today’s session.

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Questions 178 - 184

Tuesday 15 November 2016

Watch the meeting

Members present: Lord Patel (The Chairman); Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner and Lord Willis of Knaresborough.

Witnesses

Examination of witnesses

I: Katherine Murphy, Chief Executive, the Patients Association; Janet Morrison, Chief Executive, Independent Age.

Q178 **The Chairman:** Welcome to both of you. This evidence session is extremely important to us. Although we have heard a lot from different people from the health service and social care, you represent a vast number of people, citizens and patients. Your voice, therefore, on all the issues related to NHS and social care is extremely important. You might be small in number in giving this evidence, but we recognise that you represent a large number. To begin with, please introduce yourselves and, if you represent an organisation, please say so. If you want to make an opening statement feel free to do so and then we will move on to the questions.

Janet Morrison: Thank you for inviting me to speak. My name is Janet Morrison; I am chief executive of Independent Age, which is the national older people's charity. We provide information, advice and social support to older people and their carers. We take about 34,000 calls a year to give advice to people on very complex cases. We also have about three-quarters of a million information interventions that we provide to people alongside providing local social support and befriending schemes.

The majority of the calls that we receive are from people who are in crisis at transition points, trying to navigate between and within health and social care. Many of them are at a sticking point where they are trying to identify and find information and advice. They receive very little support. Many of them may be self-funders and therefore are struggling with that interface between moving from perhaps hospital into home care or a care home, struggling with paying for care and knowing what their rights and

entitlements are. We try to provide them with some explanation and support to enable them to achieve a better result. They are often at a crisis point very late in the day and it would have been better if we could have spoken to them earlier to help them prevent some of the crises that they face.

Katherine Murphy: Thank you very much for inviting the Patients Association to give evidence. My name is Katherine Murphy; I am the chief executive of the Patients Association. The Patients Association is a health and social care charity. We are independent. We have been in existence for 54 years now. We have a national helpline and all the work we do is based on the information and the intelligence that we receive through our national helpline. We receive and we assist around 8,000 people who contact our national helpline on a yearly basis. Based on the intelligence and the information we receive on our national helpline, we undertake research and produce independent reports on what patients, the public and their carers are telling us. We also provide the secretariat to the All-Party Parliamentary Group for Patient Safety and the All-Party Parliamentary Group on Patient and Public Involvement.

Q179 **The Chairman:** Our first question is about the patient perception of how sustainable the NHS is in the long term. This inquiry's focus is in the long term, beyond 2025, 2030. What is the patient perspective about the long-term sustainability of health and social care?

Janet Morrison: We conducted a survey in February where we were asking for people's views about the future of health and social care. We found that four-fifths were concerned about the long-term future of the NHS; 51% said that they thought the NHS had worsened in the past year; and 47% thought that social care had worsened in the past year.

The Chairman: How many people were involved?

Janet Morrison: It was a survey of 2,000 people, a representative sample done by ComRes. It was a small indicator of concerns about the long-term future and the issues arising from an ageing population.

Katherine Murphy: As the Patients Association we undertake research on a very frequent basis. We also hear from patients and the public on a daily basis. The public are very concerned about the long-term sustainability and funding of the NHS and social care. They understand the financial restraints on the NHS. They know that no change is not an option. They understand that over the past number of years there has been a huge demand in the services, especially in primary care. What the patients and the public fail to understand and to comprehend is the constant reorganisation in the NHS. Patients and the public would like access when they need it. They would like to be cared for as much as possible in primary care, closer to home, and to stay out of hospital. We know from the work we do and from hearing from patients and the public on a daily basis that the vast majority of people who are in hospital occupying beds at the moment are elderly people with complex care needs. The vast majority of them probably do not need to be there but the services are not available in the community for these patients to remain in their own homes and have the appropriate care. Patients and the public are concerned about the financial sustainability of the NHS.

They are also concerned about the care and treatment provided in the NHS currently.

The Chairman: Do the public feel that they are involved in any discussions relating to the long-term sustainability of the NHS and social care in all its aspects?

Katherine Murphy: That is an interesting question to ask after all the publication there was yesterday on the sustainability transformation plans. I am sure Janet has the same experience as the Patients Association that the public were not consulted on what services should be provided in their local communities. The public are very willing to become involved. They want to be involved; they want to be consulted and talked to and given the correct information. They would like to be involved in an open, transparent and meaningful way. They understand the reasons why services have to be cut within the NHS. What they fail to understand is why such major plans are being drawn up without any consultation with patients and the public.

Janet Morrison: When the Care Act was introduced in 2014 we were involved in a lot of broadcasting and giving information to people to explain what it meant. There was a huge pent-up demand from people wanting to know what it meant for them—what it meant for them in paying for care, what the future was going to be. MPs in particular say that their postbags are not full of questions about social care. However, the BBC had a care calculator on its website and over 48 hours there were half a million hits, with people trying to work out what it might mean for them. The Care Act has been kicked into the long grass for the time being but it demonstrated real concerns.

We also find that when people call us they are in a little bit of shock because they may not have understood or realised about the means testing that is involved in social care. Dealing with people with dementia and multiple long-term conditions, they suddenly discover that there is a dispute or probably lack of funding in terms of caring for their relatives with dementia. That comes as a real shock in terms of realising they are going to have to pay for it and what the consequences will be.

We also meet with many people who are stuck when there is a dispute between continuing care and social care. The transition between the NHS, which is free at the point of use, and the means-testing element is a real sticking point both in transformation and integration plans because it creates that sticking point. That is why people are stuck in hospital, because that is the free bit. The bit that is rationed or means tested becomes more complex. We generally find that the public seem to be very passionate about the NHS and very passionate about anything that threatens the future of the NHS but are much more ignorant and less passionate about social care. For the older people we deal with, the best place is not hospital, it is avoiding being in hospital and having the social support they need to live at home for as long as possible with the care they need.

Q180 **Bishop of Carlisle:** You said quite rightly that people are passionate about the NHS. We have been talking quite a lot in this Committee about future funding with regard to long-term sustainability. From all the

research and surveys that you have done and the people who speak to you, which forms of funding that we might focus on in the future would be most acceptable to people generally? Would it be direct taxation or hypothecated tax or an insurance scheme? Or would it be some of the other things that have been suggested like paying for certain treatments and so on?

Janet Morrison: We did an ageing population survey through the *Guardian* in the winter of 2014 to 2015. Most of those questions are normally about whether people would pay more tax. The results of that showed that 58% of people said they thought they should pay more tax. That increases for those who are over 65 to 66%. Two-thirds say, "Yes, we should pay more tax." In that survey half the people responding said that there should be more facilitation for people setting up financial plans for their future.

My personal view is that it is very rare that the general public are presented with a range of options about future funding. Mostly they are asked, "Would you pay 1p or 2p more in the pounds in your tax?" It would be very rare for the public to have any understanding about hypothecation. However, perhaps the precept does create a little open door or a principle to think about. It is very rare for people to consider long-term social care schemes such as those in Japan. People are very nervous about anything that involves rationing, reducing eligibility or charging or changes to charges because of fears about the future of the NHS. There is very little presentation of the real choices and options that we have as a society to enable us to have a long-term vision of the kind of care we need and the health we need for the future.

Bishop of Carlisle: How would one develop a conversation of that kind?

Janet Morrison: There have been a lot of calls for a national conversation with the public about the future and what our expectations are. There have also been calls that we have supported for a Care for Tomorrow campaign, which is about setting up an independent commission on the future of health and social care. The reason we have backed that is because nobody would automatically say, "Let's have another commission", but the reality is that there seems to be an inability to have an objective and independent debate about the long-term future of health and social care without it starting to become a party-political football where one side will accuse the other of either wanting to privatise or produce death taxes or whatever else. In the absence of being able to achieve cross-party agreement on that kind of high-level debate, we have been supporting Norman Lamb, Stephen Dorrell and Frank Field on that cause, simply because there needs to be a longer-term settlement and something that independently sets out the real choices that we have in terms of also accepting where we may ourselves have to pay more or support ourselves and our families more, alongside what safety net the state should provide.

Katherine Murphy: The Patients Association would support that with the caveat that any extra funding is ring-fenced for health and social care. Whatever model we look at, we must make sure that funding goes to health and social care. There is a great unmet need to have that open

conversation with the public around choices, as Janet mentioned. I am part of Norman Lamb's group looking at this.

Lord Lipsey: I may be a member of the House of Lords but I am a bit sceptical about this wisdom of crowds and that the people should decide. Perhaps that will carry a bit more weight after the election of Donald Trump last week. To take an example, you rightly cited one poll that showed 57% wanted more spending on health. There is another poll by NatCen which shows that the favoured option of the people is that the NHS needs to live within the limits of the cash it has. I do not blame them for this, but people have completely contradictory sets of emotions within them and they require guidance from people taking political and rational judgments before they can have what they really want at the end of the day, which is the best possible balance of all these different considerations.

Janet Morrison: I am sure that is right. Many people who we talk to are very concerned about the problems of integration in terms of some continuity between different systems and how that works. They believe there are many more efficient ways for services within health and social care to be delivered. It will not be very easy to find consensus among the general public and it will take some high-level analytical tools and thinking to weigh up the options and look at what the future should be. I am not sure we will have a public movement of people charging through the streets calling for hypothecation or other forms of long-term financial planning. However, something that takes it above the scrum of party politics would be very valuable.

Lord Lipsey: I agree with that but, to take an example you are very familiar with, in social care there is a straight conflict between giving people more money to pay for their care so they do not have to be means tested and so on and spending on services so they receive the services they require. This has been wrestled with for many years, since the royal commission on which I sat. Unfortunately, what the public want is both and unfortunately that may not be available to them.

Katherine Murphy: The public need to see where and how the current NHS and social care funding is being spent, for example on front-line services, management and reorganisation.

Lord Scriven: I am in support of bringing people in more if it is in the right area, but broad questions such as a funding system might not be. Interestingly, the King's Fund did a recent attitude survey which showed that 44% of people said the NHS should not provide treatments which were poor value for money. In the previous session we were talking about productivity, which professionals in the NHS seem to be unable to get a grip on. Do you think that this is a way that we could introduce the public and patients into this to help deal with that very specific question and help with productivity?

Katherine Murphy: We certainly hear this on our national helpline on a regular basis. Patients and the public are your greatest asset. Very often patients are in hospital for a period of time. They are lying in their beds and they can see what is happening all around them. They can see where the waste is happening within the NHS and how systems could be more

effective. Patients tell us about turning up for appointments to see somebody and whoever they were supposed to see is on leave or is away and there was nobody else to see them. There is a whole raft of innovation and ideas that patients can contribute to the bigger debate. It would be a terrible waste if we did not involve the public.

Lord Scriven: What do you think would need to be put in place? What would need to be put in place systematically to help us deal with this productivity issue in terms of getting the patient perspective?

Katherine Murphy: As I said, knowledge about how the current funding is spent and what is spent in real terms in front-line care; the services and treatments that are currently being delivered in hospital that would be much better delivered closer to home in the patient's own home provided by the right staff in a safe environment.

Lord Warner: You mentioned dementia. Do any of your surveys show confusion, if I may use the term, about the boundary between health and social care for that particular group? Is that a growing problem?

Janet Morrison: I do not have a survey that will tell you statistically but I have information from the advice calls that we receive. We take about 34,000 calls in a year and to many people it comes as a great surprise when they discover that dementia care is not free and delivered by the NHS. We support many cases to try to challenge the decisions made about continuing care and we are successful in some cases. It comes as a very big shock to people in terms of how they continue to provide the right kind of support. When people look at care homes because they need additional dementia care and support, the costs come as a huge shock and there is a real issue about the affordability and the support they can access to sweat their assets or to pay for it in a more efficient way. Most of the people we deal with will be over 75 and the calls will be from their relatives. Most of them will have a number of long-term conditions but there will be dementia as part of that equation. That is where the real difficulty lies. The public could engage at that point in terms of understanding the challenges of health and social care when looking at the issues of supporting people with dementia.

Q181 **Lord Warner:** A lot of concern has been expressed about the current lack of funding for social care. From your contacts with the patients and the public, what alternative funding models for social care could be considered as a viable alternative to the present arrangements? Where do they all stand now on whether they should be paying more for social care in some way, providing that they should not be caught for catastrophic costs—a Dilnot type cap, for example? Where are the public in that area?

Janet Morrison: The majority of people we deal with will be self-funders. You do not have to be very rich to be a self-funder and have to deal with those issues. It does not cross the minds of the majority of the people we deal with to go anywhere near the local authority and social services. They have no expectation that they are going to have any support, even in terms of information and advice or what the local options are or the provision of care that they can expect.

I was involved with a piece of work with Which? We were asked to read 30 diaries of self-funders who were trying to navigate, supporting their family and getting the social care they needed. The vast majority of those never went anywhere near a local authority, they never went anywhere near social services and, surprisingly to us in the voluntary sector, nowhere near a voluntary organisation. They were largely relying on family connections, solicitors or GPs for suggestions. What struck me most of all about that was that self-funders do not have any expectation of support or that they are going to be given any steer. In terms of what to pay, people are very worried. We hoped that with the potential of the care cap would be more provision of financial tools coming into the marketplace to help people. There are options in terms of deferred payments and equity release, but there is simply not enough understanding or trust among the public about what alternative options there might be to pay for care.

We also deal with a lot of people who are paying top-up fees who are already facing additional charges with the introduction of the living wage. We had a case recently where a family member was paying £31 a week, which has increased to £100. That is happening on a regular basis now so people are feeling it, but they are not feeling it in terms of having made a conscious choice about what tools they could have used to pay for care. We talk to people when they are looking at their care home fees and we ask what their contracts say. They may not have a contract or have any awareness of what it might say about future costs. Many of them will not have taken independent financial advice. There is a real issue about financial literacy and options for paying for care. Most people assume they are going to struggle on on their own.

Lord Warner: People are psychologically in a state where they are willing to pay; it is just that we have a rather inhumane system for helping them run that system. Is that a fair summation?

Janet Morrison: In the cases that we are dealing with, people at a crisis point are making a crisis purchase. If they are dealing with a family member who has been in hospital for five months and has suddenly been told to leave and is discharged, they are trying to find a suitable care home without any assistance from social services in terms of what their choices and options are if they are paying for it for themselves. They are faced with an inevitable choice. It is not an acceptance; it is just that that is what they have to do. At that moment there is no independent advice and support for people to make good choices that are good in terms of the quality of the care that is needed in the right location, close to family and all of those requirements, but also good in terms of independent financial choice and the options that are available to them. Crisis purchases tend not to be good purchases.

Katherine Murphy: I agree with that. There is very little, if any, meaningful information that people will need at a given time in their care journey that is available and useful to them to make a meaningful choice. Janet is right: the choices are made when there is a crisis. Whether it is the right choice or not, it is difficult for patients or their carers because they are faced with a problem that they have to deal with.

Lord Warner: Do you think that activating the 2014 Care Act would solve

most of those problems?

Janet Morrison: The care cap is not a perfect mechanism, but it is a mechanism. What was particularly valuable about it was that by having the option of starting your care account running, self-funders would be brought into the ambit of local authorities to have a social care assessment and assistance in navigating the marketplace. I have huge sympathy with local authorities in terms of their capacity to respond to that duty, given the shortfall in funding that they have to provide for an ever-increasing care load in their area. I understand why local authorities might have fallen over at that prospect, but at least those self-funders would have been brought into having more support than they currently do. Even though only a small proportion of those people might have been helped with avoiding catastrophic costs, at least some would have been encouraged to do so. I would be very pleased if there were a wider debate led by the Department of Health about what the options are about reintroducing the care cap or considering other options that would enable self-funders to have a better deal.

Katherine Murphy: I totally agree. It is a very complex system for people to have to navigate and there is very little available to help them to make these decisions at a time of crisis.

Lord Mawhinney: I declare an interest in that my mother went through a period with advanced Alzheimer's. She went into a home and died three years ago. There was no information available to me at all. I had a residual memory as a Member of Parliament dealing with constituents' cases but there was nothing. I listened carefully when you said that there should be a public debate led by the Department of Health. Why should it be led by the Department of Health, given what we are facing up to this morning? Why should it not be led by you two?

Katherine Murphy: I am inclined to agree with you because it is up to organisations like Janet's Independent Age and the Patients Association to lead these kinds of debates. Our interest is in the well-being of patients and the public having access to care and treatment and social care when they need it. However, we are independent charities and these are huge pieces of work. I am sure we would both be happy to lead on it.

Janet Morrison: When I was talking about the Department of Health, it was really about the care cap. My concern is that, having been kicked into the long grass, it may never re-emerge. While it may not have been the perfect solution, it was some kind of way towards being a solution. It was only that limited part that I was talking about.

Lord Mawhinney: Do you not understand that the people who kicked it into the long grass are very unlikely to be in there with torches trying to find it and bring it out on to the playing field?

Janet Morrison: I do.

Lord Mawhinney: I was actually making a serious point.

Janet Morrison: I understand, yes.

Lord Mawhinney: Given the links that you have with other charitable health-oriented organisations, you two would not necessarily be on your

own. If you are half as good as we are told you are, you could be putting together something of which you become the focal point which would force other people into a public debate. What is wrong with my argument?

Katherine Murphy: Absolutely nothing. It is certainly something that the Patients Association have considered. We had a conversation with Independent Age about setting up a commission to look at the future funding of health and social care.

Janet Morrison: We worked in alliance with over 70 organisations as part of the Care and Support Alliance to bring about the Care Act. Many of us helped with the drafting of the guidance and supported it. It is a very good piece of legislation and the principles of it are extremely sound. The principles about prevention, integration and person-centred care are all incredibly important. We are continuing to work together with the Patients Association and with others to try to promote that debate. At some point, that would need to be backed by political will to look at the bigger questions about long-term funding and sustainability. If you would like to give us a job to do, we are more than happy to try to take that up and engage with the people we are dealing with who are expressing real concern about the quality of life that we expect for older people in this country.

Q182 **Lord Willis of Knaresborough:** I am very supportive of the national conversation but we have struggled as a Committee with a huge volume of evidence, and we have time and professional advice. Doing this on a national scale is a task which needs some careful thinking about. There must be priorities that you have whereby you can say that, unless we actually deal with a particular priority rather than the lot, the whole system is going to collapse. What do each of you think is the key priority which this Committee should be recommending to Government to say that, above all, it has to be sorted out?

Katherine Murphy: From the Patients Association's point of view, it is around access, so access to services, access to services closer to home, keeping people well and out of hospital, cared for in their own homes, cared for by the right staff with the right skills and the right expertise, care provided by compassionate individuals. End-of-life care is very important as is prevention and public health.

Lord Willis of Knaresborough: You have gone through 11 points.

Katherine Murphy: I am sorry. Access would be our one thing.

Janet Morrison: Do I have to have one?

Lord Willis of Knaresborough: The area that is of greatest priority.

Janet Morrison: The area of greatest priority is integrated preventive services delivered through the community.

Lord Willis of Knaresborough: Who would lead that?

Janet Morrison: I obviously defer to the great experience around this table but I am very anxious about things that are led only by the NHS. Social care and the philosophy of person-centred care—saying that the person who is receiving that care is the best expert on what they need in

terms of the outcomes for their life—are incredibly important. Anything that happens should have social services and local authorities deeply involved because they are also very close to understanding community needs and supporting that marketplace. If things are only NHS led, they must include social care and there must be a very strong voice for local communities in shaping plans.

Katherine Murphy: If we continue to work in silos, as we currently do, we will never move and we will never provide the service that is needed.

The Chairman: Are the current Government's plans addressing any of these issues?

Janet Morrison: There are many good initiatives—for example, the Better Care Fund and the sustainability and transformation plans. If they are embedded in communities and engage with local authorities and with local communities, those are great moves forward. I am also a big fan of some of the schemes that Bruce Keogh has brought in in terms of hospital avoidance, frailty, "front doors" within hospitals to bring the right skills and not dealing with the medical model but enabling people to return to their homes. The initiatives must be integrated ones that cross over between health and social care. There is much more that needs to be done on the bigger question of what future we look at. In terms of understanding what the public's expectation should be, we all need to understand that there are more things that we can do ourselves in terms of preventive efforts and, those that can, looking after themselves and their families. We need to make preparations earlier in our lives for the kind of older age that we want.

Lord Warner: How would your organisations stop the big barons of the acute hospitals squirrelling away all the money? Answers on one sheet of paper.

The Chairman: On one line.

Katherine Murphy: It is more about the NHS accepting that they cannot and should not work in silos and they cannot and should not work without engaging and integrating social care. Social care needs to be seen as a key priority, not just an add-on. For us to be able to provide services going forward, we need to identify that the greatest need is with older people, many with complex conditions. They need care. All the funding does not need to go into the hospitals. Care should be provided. We should look at reintroducing the Lord Darzi models of care, keeping people out of hospital.

Janet Morrison: The key thing also is making sure that hospitals are absolutely rooted in responsiveness to community and to local need and that the medical model has limited application when you are talking about the kinds of clients that I work with, older people. In reality the responsiveness to community need and to community voice and using this experience is vital. We need to recognise that the best thing we can do for most people is to keep them away from hospital, keep them in their own homes and enable them to receive the community support that they need.

between the NHS and social care. At the moment we hear that much of it is being led by the chief executives of NHS trusts. Their motives may be impeccable. I do not know whether it is true or not, but they say that they understand the needs of the community for which they provide hospital services. Where do the patients and the public come into that? How can we promote the involvement of the patients in that area?

Katherine Murphy: There needs to be openness and transparency with the local communities. You have to demonstrate to them exactly how the funding that is going into their community is being spent. You need to engage with them, identify where the needs are and know what your community make-up is. You should know who is living in your community and look at the services. A lot of people do not want to go to hospital. We should be looking at that. Why is it always the failsafe to send people to hospital when it would be much better if we were caring for that person in their own home, in their own community?

Lord Turnberg: This is entirely right. In the system which we are evolving to provide this integrated care, how can the patient, the public and the social services people take a lead in all of this?

Janet Morrison: The sustainability and transformation plans offer a real opportunity if done correctly.

Lord Turnberg: Are you involved in those?

Janet Morrison: Not directly.

Katherine Murphy: NHS England came to us very late in the day, after the plans were in the public domain.

Janet Morrison: They could be a real opportunity to show how to embed plans for future greater sustainability and improvement.

Lord Turnberg: Are you talking to them?

Katherine Murphy: The Patients Association is talking to some of them and we are talking to NHS England. It is a missed opportunity if they do not involve and engage their local communities. There is a real opportunity to get things right. Unfortunately, by publishing and leaking the plans and not engaging with their local communities, some of that trust has now been eroded. It is about building that trust and being honest with people.

Lord Turnberg: We are trying to look at 2030, or even 40 years hence, and what we are talking about is how to make it better for now. Are any of your organisations involved in thinking about what will happen when we cure dementia, which is possible in the next 10 to 20 years? Are you thinking about longer-term use of technology? How are you involved in taking in the advances we will likely see in the way people are cared for and how disease is prevented?

Katherine Murphy: Technology has a huge part to play in the care that is being delivered now and, more subtly, in care in the future. We need to invest more in technology and demonstrate the huge benefits there are to technology. Unfortunately, technology within the NHS and social care has not always gone smoothly, so again it is about using the advantages we have and making best use of available technology.

Janet Morrison: The opportunities of technology in terms of enabling people to access consultations with consultants or with GPs or with whomever at a distance are hugely advantageous, as are the kinds of telecare that enable people to be kept an eye on. However, it is not an alternative to meaningful face-to-face support and social care. We need a vision where both can work in tandem to allow telecare or other forms of technology to release the energies to provide real support rather than dealing with the monitoring or medication side of it. I was very fortunate to go to Japan, where I was slightly alarmed by the use of robots. The Japanese said that this was because they are particularly fond of robots but there are quite a lot of things being used in care homes that may be more efficient than hoists. It did slightly alarm me, however. At the same time we need to be thinking about all the opportunities, but not so that we do not visit and we do not support older people. We need to have better value out of the face-to-face contact we can provide.

Lord Turnberg: FaceTime does it.

Janet Morrison: Yes, and Skype is fantastic.

Q184 **The Chairman:** What one recommendation do you think this Committee could make that would be effective in the long-term sustainability of the NHS and social care that needs to be addressed?

Katherine Murphy: Integration of both.

The Chairman: What does that mean?

Katherine Murphy: Health and social care working together in the best interests of the patient, for the best outcome and experience for the patient.

The Chairman: If we make that as one recommendation from people like you who represent the public and therefore is very important, is that the key recommendation that would change the whole thing?

Katherine Murphy: It would go a long way to changing some of the huge unmet needs that patients are experiencing currently.

The Chairman: How would this be brought about and by whom?

Katherine Murphy: By health and social care, the local authority, working much closer together.

Janet Morrison: I hate to use a mechanism, but I would argue for a commission on the future of long-term funding of health and social care. My second suggestion is that I would like it to be called social care and health and not the other way around. I am sounding like a globetrotter, but by invitation I went to visit care homes in Finland. Their department is the Department of Social Care and Health. That is an important message about what is important.

Lord Lipsey: There have been four commissions on social care in recent times, the royal commission, Wanless, Barker and Dilnot. We still have the problem exactly as it was in 1999 when the royal commission sat. What is your commission going to do when all of us have failed so hopelessly?

Janet Morrison: I have huge sympathy because all of that work has been done, with the expertise around this table putting the commitment and drive into finding those solutions. The only thing I can say is that in conversations that I was involved with probably four or five years ago we seemed to be closer to cross-party agreement on the need for a long-term solution than we are now. That makes me extremely anxious. Anything that could drive cross-party agreement that it is not a political football—it is the future for us and our families that matters—is important. It would be a mechanism to try to drive cross-party agreement that it needs to go above party politics into a bigger and longer-term solution that is honest about our own contribution as well as the state's contribution to our health and well-being. That is the absence of having any other solutions that come to mind.

Lord Lipsey: I share your difficulty. There was cross-party agreement. Cross-party agreement was watered-down Dilnot; it was not perfect and more funding was needed. Then one Friday afternoon when Parliament was about to rise, the Department of Health announced that it was kicking Dilnot forever into the long grass. It is no good having cross-party agreement if one party or the other is prepared to ditch it at their first convenience.

The Chairman: Do you think an independent commission involving public and patients with cross-party agreement might have a better success?

Janet Morrison: One of the things that we can most usefully do in our experience with Independent Age, the Patients Association and many others is illuminate the real stories of people's journeys through trying to have the well-being and quality of life they want in later life whatever medical conditions or issues of disability they may be carrying. That is how we can illuminate that and try to put pressure on those in power to understand that this is not happening to someone else, it is going to happen to all of us, however well prepared we are and however much we have saved or tried to keep ourselves healthy through our lives. We cannot continue to leave people falling into these huge crises with this lack of support. I sympathise with Lord Mawhinney and what he said. Trying to deal with my own parents' needs for social care when I am supposedly an expert and trying to get an assessment or contact a human being who would do an assessment was impossible. We must illuminate the real journeys and the real stories of people. Dementia care and things like that are a real illuminator of what the issues are.

Lord Warner: Would you accept as second best a properly funded and properly introduced 2014 Care Act as a practical way of getting near to what you want?

Janet Morrison: I was involved in discussions with the Care and Support Alliance about what does "good" look like and my conclusion was that it is the Care Act, but properly funded and supported. It is a very good piece of legislation that unifies myriad requirements but sets out very clear principles. If it were properly funded, it would go a long way to giving us the person-centred care that we need in this country.

Katherine Murphy: What is important is the person-centred care, but it needs to be funded appropriately.

The Chairman: Thank you both very much. The written evidence from both of you was excellent; thank you for that, too. If you have any further material to send us, particularly following today's questions, please feel free to do so. You will see the transcript. You cannot change it but, if anything is not accurate, please let us know.

Professor Maureen Baker, NHS Tower Hamlets CCF and Dr Clare Gerada – Oral evidence (QQ 185-190)

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Evidence Session No. 19 Heard in Public Questions 185 – 190

Tuesday 15 November 2016

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Members present: Lord Patel (The Chairman); Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner and Lord Willis of Knaresborough.

Examination of witnesses

I: Professor Maureen Baker, Chair, Royal College of General Practitioners; Sir Sam Everington, Chair, NHS Tower Hamlets CCG, and Dr Clare Gerada, General Practitioner and former Chair, Royal College of General Practitioners.

Q185 **The Chairman:** Good morning to our witnesses. Thank you for coming today. It gives us an opportunity to widely explore, I hope, the future of primary and community care, as you see it, and how it could be a system of delivery of healthcare and social care in the future. I hope to hear from the three of you some out-of-box thinking. First, I declare I am an honorary fellow of the Royal College of General Practitioners but not any part of its management, as you well know. Maureen, you and I have been associated for a long time because I taught you at one time.

Professor Maureen Baker: You did, sir. Very well, I may say.

The Chairman: I have heard that many times, so it does not come as a surprise.

Sir Sam Everington: Lord Mawhinney taught me medical physics at the Royal Free years ago.

The Chairman: Before we start, if you would not mind introducing yourselves—from your side, Clare, first—and if you have any opening statement to make feel free to do so. We realise, Maureen, you are president of the royal college for only four more days, but we are seeing your new president later.

Dr Clare Gerada: Thank you very much. I will not make an opening statement—I am interested to hear the questions you ask—but I will introduce myself. I do not think anybody round this table has taught me, though I have been in awe of many of you over the years. I used to be in Maureen's role but Maureen took over from me three years ago. I am

currently a general practitioner and have been for the last 30 years. My organisation, the Hurley Group, runs a very large consortium of GPs across London. We have about 10 CCGs and we hope we are the forefront of innovation in using technology, such as e-health, which I was hearing about before. Other than that, I run a service for doctors and dentists with mental health and addiction problems, so as well as being a normal GP I suppose I am at the front end of seeing the current state of the people who work within our service and are delivering care 1.2 million times a day to the patients of England. I do not see all of them, but I see vast numbers of them.

Sir Sam Everington: I am Sam Everington. I started life as a barrister and then trained at the Royal Free as a doctor and started my life as a GP. I have been a GP in Tower Hamlets, at the Bromley by Bow Centre, which Lord Mawhinney was key in getting started originally. I am also chair of Tower Hamlets CCG and clinical lead for our STP in north-east London. I am a director of Community Health Partnerships—which you might know as NHS LIFT—and have been on Sir Robert Naylor’s review of estates that is going on at the moment and is about to report. Most of all, two days a week I work as a clinical GP in the East End of London.

Professor Maureen Baker: I am Maureen Baker and I am the current chair of the Royal College of General Practitioners, as you say stepping down on Friday evening. I have been a GP for more than 30 years in the city of Lincoln and in Lincolnshire. If I may, I would like to make a few points by way of introduction.

You are, I hope, aware of the publication of the *GP Forward View* from NHS England and Health Education England. This was published in April. In his foreword, Simon Stevens wrote that there is arguably no more important job in modern Britain than that of the family doctor, quoting a recent *BMJ* headline stating that if general practice fails the whole NHS fails. GPs act as gatekeepers to the wider NHS, accounting for about 90% of patient contact with the healthcare system. If the capacity of GPs to see patients is reduced by only a small amount then services downstream, particularly A&E units, greatly struggle to cope with the resultant pressures.

It is very important for us to state that we see the importance in the centrality of general practice becoming greater as the population grows and ages, and as the incidence of complex multiple health conditions increases. Person-centred holistic care delivered close to home is the model of general practice in wider primary care that will provide a sustainable NHS in the future. My college has produced a position statement responding to the needs of patients with multimorbidity which I would very happy to leave with the secretariat. We believe this is the first position statement on multimorbidity, certainly in the UK and, as far as we know, globally.

Going back to the *GP Forward View*, it recognises the need to move to general practice being able to provide more care to patients in and close to home with GPs deploying their skills as expert medical generalists, leading multidisciplinary teams treating a variety of conditions within the community setting. We feel it is very important to say that the *GP Forward View*, which pledges a £2.4 billion increase in yearly investment

in general practice by 2020-21, we see as absolutely critical. We believe it is the right plan for general practice and that we all need to work to make sure those pledges are delivered. That is my introductory statement.

The Chairman: Thank you very much. But, as a Committee, we are looking much further on, as to what will be sustainable beyond 2025 to 2030. The questioning relates to what we need to make health and social care sustainable in 2025 and beyond. In that respect, if I ask you to particularly focus in on general practice, what do we need to make primary care and community care sustainable 2030 and beyond? How are we going to achieve that? What are the barriers to achieving that? We heard that the model of primary care and community care, which everybody agrees needs to be a strong part of the delivery of healthcare, and therefore needs to be strengthened, needs to change. Sam, I think you are on record as saying that primary care ought to change to be able to deliver more care and less management and bureaucracy. How are we to achieve this in the long term?

Dr Clare Gerada: I have brought a little gift. It is not for you; I am going to take it back. I came on my bike today, so this is a real treat. These are the documents that I have been involved with or was privy to writing about the future of my profession of general practice. Some of these come from the Royal College of GPs, some come from the King's Fund, some come from my role when I was head of primary care for London and some come from other places, including this place. People have looked at this problem over the last 30 years, and I think you need to turn the whole thing upside down. Unfortunately, we look at models and it is a bit like looking at Lego models; people design a Lego model and then dismantle it and redesign it. What you have to do is say, "What are the needs of the people we are trying to deliver care to?" That is what we did when I was heading up NHS London. We asked Londoners—I thought Lord Darzi would be here because he was part of that process—what they wanted and needed, and we broke that down into they want access and proactive care. In other words, they wanted to stay healthy for as long as possible, and then die with dignity in a place of their choosing. They wanted care co-ordination.

Once you start to put those in and to set standards against those, the model falls out of it and so, too, do the enablers and the disablers. For example, the enablers: e-health. We need to embrace technology. At the moment, less than 2% of GPs use technology for their patients other than the telephone. We heard about Skype. Skype is not the way forward; it takes just as long to consult with a patient using Skype. We have to use technology smartly to stop people coming into the home. We also talked about the other end, the elders. We talk about our ageing population: what do our elders need? They are lonely, so we need an army of people to provide support around them in a health and social care environment.

You are going to have to deliberate over this, but you need to turn it upside down. If you talk about models, the model for rural Cumbria or the far west of Cornwall will be a completely different model of service delivery from where I work and where Sam works, in Lambeth and Tower Hamlets. Then things will start to sort out. The enablers are money, unfortunately, stability, unfortunately, and, as we have heard, issues such

as decent premises to consult from. We have ageing premises, as I am sure Sam will tell you. That is what I would urge you to do.

Sir Sam Everington: I forgot to mention that I am an adviser to the 50 new models of care nationally for NHS England. Within the new models are fantastic examples of what primary care will look like in 2030, so the issue you have to tackle is how you deal with the variability in what is going on across the country in primary care. What are the sort of things we are seeing in the new models of care? Tower Hamlets is one of the vanguards, and we can now turn around a renal referral within a few days. That means that as a GP I will e-refer to the consultant renal physician, who can look remotely in my notes in the general practice and in the hospital notes, and then come back with written advice. It is fantastic for patients and fantastic for GPs; it means I get my question answered in real time, not three months down the line when the patient will have gone to a raft of other outpatient clinics, where it becomes increasingly complicated.

What we see in this—I will raise it later—is a massive transformation of the role of the consultant. We have now a forward view for GPs; we need the same for consultants and nurses. What is their future role? Tower Hamlets, one of the most deprived areas of the country, has the best blood pressure and cholesterol control in the country, with early evidence of a reduction in strokes, heart attacks and complications of diabetes. There is a story behind how we achieved that, part of which is complete transparency of data. You can see, in Tower Hamlets, the outcomes on a massive range of measures for your general practice compared to anyone else. That information drives up quality and delivers quality improvement.

The second thing is we contract with groups of GPs, which is 30% dependent on outcome. If my neighbouring GP, with whom I have no legal relationship, does not deliver, I do not get the 30%. Guess what: they all deliver because they are all working together. That is the new way; working together is critical.

Thirdly, we have protected learning time as teams. The idea that it is just the doctor or the nurse for the future is not appropriate, and I will come on later to challenge therefore the medical school training in this country, because it is about teamwork. We are about to involve the Army, in early December, to look at how we transform outpatients. We want to get rid of choose and book; we want choose and consult. We reckon we can empty outpatients by 50% by streamlining and bringing back the old relationship we used to have between the GPs and consultants, along the renal lines. Guess what: I send a referral with my mobile number; that means the consultant can ring me and say, "Sam, that's not a good referral; you should have done this", or they can email me or they can email the patient.

The Chairman: That is good, but if we cannot clone you 30,000 times, how do we have a system in place to achieve this?

Sir Sam Everington: You can, is the answer. You do it through a combination of contracts with the GPs. That is the first thing. I have hinted at how you do that. You need to get NHS England—and it is in the process—to massively transform "choose and book". The idea of booking

somebody in outpatients is as archaic in the modern world as going down to your bank to pick up money or to do some transactions. The answer is you can.

On top of that, you can make the transparency of data available across the country. You can put the emphasis on quality improvement, rather than regulation. Then there are three very quick points; the first is social prescribing everywhere, which is what the Five Year Forward Plan says. It is about enabling and empowering patients to manage their own care. We now have 500 groups around the country doing that in a network. We have somebody appointed as ambassador to social enterprise, Dr Mike Dixon, in NHS England. It is absolutely about changing the concept. When we were at medical school it was all about, "What's the matter with a patient?". The modern paradigm is "What matters to patients?". Once you start addressing that you start addressing the 70%, according to Professor Marmot, of health and well-being that has nothing to do with the NHS. We can now connect our practice in Tower Hamlets through a referral form to the social prescribing team which can connect them, in turn, to 1,500 voluntary sector organisations in Tower Hamlets. Imagine what that does to their health and imagine what that does to reduce pressure on the NHS.

Professor Maureen Baker: I absolutely take your point about thinking ahead to 2025 to 2030, but I think having expert generalists in the community—GPs—is essential to delivering the services that will be needed then. We have to make sure that general practice survives to transform and grow to meet the needs as we are moving on.

I will say just a little more about multimorbidity. It is such a key challenge. People are living longer, thank goodness. Is that not great? I would certainly want to live to be old, and I am sure you all want to live to be old and indeed very old.

The Chairman: Some of us look forward to it.

Professor Maureen Baker: It is great that this is the case but it does mean that people will be living longer with multiple ongoing conditions. We do not know very well how to deal with that. There is very little evidence that underpins the clinically effective and cost-effective management of multimorbidity. I think you have to put this squarely: how will that be dealt with to have a sustainable NHS in 10 or 15 years' time?

A little more about tech: in healthcare we have been slow to harness the potential of tech. It is not the panacea, it has to be adopted and implemented appropriately, but we have to look, in all aspects of our lives, at how the technology is becoming mobile and miniature and at the proliferation of apps. In particular, if we are to think about self-care and supporting people to look after themselves and their families as best they can, we have to think about how we can best support people with the appropriate tools.

I also agree that there is huge potential in real-time data. Again, there is lots of data floating around the NHS; we do not harness it and use it in real time in ways that can really make a difference to care and quality.

The Chairman: I know you all have a lot to say, but we do not have all

the time to listen. What we are going to do, because we have a lot of questions, is to try, on our part and on your part, to see if we can keep it succinct but get the message across. First Lord Warner, then Lord McColl and then Lord Willis. Then I need to move on to the next question.

Lord Warner: How do we take the two propositions from Clare and Sam—that is, Darzi and the kind of model that you have evolved in east London, Sam? How do we go to scale on that? How do we go across the country? I would settle for the big cities, for starters. What do we say, as a Committee, to the Government to go to scale for those models?

Dr Clare Gerada: You have the experts here that have worked on this. You need to look at some of the key areas in order to go to scale. Premises, which Lord Darzi was looking at, so we need premises fit for purpose; we need the larger premises where we can start co-locating services and diagnostic, and the smaller—

The Chairman: You are saying, “We’ve got a model, just get on with it”?

Dr Clare Gerada: Not necessarily. If you are talking about London, it is very different from rural Cumbria, but there are models. They may need to be agreed in principle but there are models which you can get on with. There are some things that still need lubricating. There is a lot about e-health, but we have very, very little of it. Again, with my slight conflict of interest with my practice that has developed e-health, which is getting patients to be able to consult online, we now have over 2 million patients who can do this. You need that, and you need to focus on premises. We cannot do anything if we do not have somewhere to consult.

Lord Kakkar: I wanted to follow up on something Sam said. You have described the success of your vanguard in Tower Hamlets. How much consultation has there been, and how successfully has the discussion taken place, with regard to other STPs and incorporating that kind of good practice into the models that are now starting to be published? We heard earlier from the Shelford group that they would, if I understood them correctly, like to be very much more in control of how local health economies develop with regard to capitation and the development of more accountable care structures. How would that fit with the transformation in primary care that you have described as a bridge to sustainability in 2030?

Sir Sam Everington: STPs are still very early. Everybody is rushing to get everything sorted, and I do not think necessarily the depth of attention is being put into this. We have in our area, because we had a process that was looking at all this before. It has, dare I say, been a little distracting because it is a restructuring of sorts for the last six months, so it has delayed a significant amount of transformation. In terms of accountable care organisation that is critical, but it is about changing people’s sense of their role. There are five things you can do that I would have answered—one, as I have answered already, is the contract. Secondly you need to change the consultants so they become responsible. I am not talking about a consultant contract; I am talking about changing their job to something that is responsible for the population and for the whole pathway, from beginning to end, say, of diabetes. If you want me to take it one step further, I would put them in charge of the hospitals.

Consultants and GPs spend the money on what we do. It seems anathema to have a situation where in primary care we are in charge and we are responsible for managing virtually everything; you need the parallel in hospitals. If you do not do that, I do not think you will sustain the NHS.

Data transparency, which Maureen has talked about, is absolutely critical to all. Clinicians are intensely competitive. If you see that you are at the bottom of something, trust me—it is real-time data—you are going to want to do something about it straightaway. The stethoscope was our tool when we trained; it is not any more, it is the iPad. I put wi-fi in every surgery in Tower Hamlets. The Hurley Group pioneered this amazing webGP. Finally, you need to accelerate social prescribing. Manchester loves it; it needs to be the norm across the country.

Lord McColl of Dulwich: As the main problem within the NHS is the huge obesity epidemic, and we admire very much what you are doing, Sam, how are you coping with that in your practice?

The Chairman: A quick answer. How do we spell that out?

Sir Sam Everington: The classic example of how it is dealt with is in a school in Stirling where all the kids and the teachers go on a mile run every day. In Tower Hamlets we want to apply the dashboards we apply to every general practice to every school. Every head teacher will know how healthy their children are. Trust me; they will drive up health and well-being, which is the education of the children, if they know that. Also, why should that not be given to parents? If you are a parent like me, of five children, what matters most is not the GCSEs or the A*s, or whatever, but whether my child is going to be happy and healthy in this school. Schools need to play a part.

Q186 **Lord Turnberg:** I am afraid we are going to talk about funding and how we fund the NHS and the social care system. There have been a number of suggested models for funding. Do you have any plans for us?

Dr Clare Gerada: I do. I think we should re-look at the national insurance model. You pay national insurance only when you are working and it tapers as you earn more, so it is not a progressive tax, and you do not pay it when you have retired; despite there being a fair whack of wealthy elders who pay nothing. You should look at a hypothecated tax. I know that the IPPR recently published a look at this and looked at the pros and cons of it. I think we need a hypothecated health and social care tax so that the public are aware of what we are going for. The thinking has started and, clearly, a lot of thinking has to be done, but there are two starters.

The Chairman: Sam, do you have a different view?

Sir Sam Everington: All the things you have suggested. If you take Tower Hamlets, there is an 11-year difference in life expectancy between rich and poor, and 20 years' loss of life quality. That means, in Tower Hamlets, at the age of 55 you are 75. The changes are not going to come from genomes, cancer cures or anything like that; it is absolutely about lifestyle, which is absolutely about the individual. My challenge is to say that it should be as normal for you to go on holiday as it would be to

invest your money in your health and well-being. There is a serious issue about how we, on the whole, have discouraged within the system people investing their time, resources, community and their incomes in their own health and well-being. You can change that. Winter crises are not inevitable.

One of the things we learned from the junior doctors' hours strike was that all the hospitals worked brilliantly in acute care. Yes, there are great delays in outpatients—there is a lesson there—but the other lesson is mass flu vaccination. We go for herd immunity on everything else; why would you not go for flu? Any good business in the City vaccinates all its staff. We do that for all our staff. Why do we not go for mass vaccination? Why should that not be part of what Public Health England and the Government push for?

The Chairman: The question is about future funding.

Sir Sam Everington: The way to do that is to enable GPs, for example, to charge £10 to vaccinate those patients who are non-eligible in the NHS for a flu vaccination.

The Chairman: Who takes the money?

Sir Sam Everington: That would go to a general practice. At the moment, a pharmacist can do it but a GP cannot. The GPs can show if you get the incentives right you can get immunisation rates of 80-plus.

Lord Turnberg: This is a fee for a service.

Sir Sam Everington: A fee for a service that is not available on the NHS.

The Chairman: We are getting into a different discussion here about why it should not be available on the NHS anyway. Maureen, do you have a comment about overall funding?

Professor Maureen Baker: In terms of hypothecation, there is not much point aiming for hypothecated budgets solely for the NHS. If you are going to do that it should be for health and social care together. We have no formal position on this except that in the previous Labour Administration, when it was suggested that national insurance be increased to fund the NHS, we supported that and my recollection is that there was strong public support at the time for such a move. The funding settlement as currently set out is insufficient. I know that is current and we have to think about the future, but we have to have a public concord—society-wide agreement—about whether we are willing to give NHS and social care the money that is needed, especially to deal with the population as we get older.

Q187 **Lord Warner:** Could we move on to the effectiveness or possible out-of-datedness of the present model of primary care? How fit for purpose is the GMS contract? How fit for purpose is the small businessman model of providing primary care? Sam does not sound like a small businessman. Particularly the college, can you tell us how this model possibly needs to change over the next 10 to 15 years to deliver what everybody wants delivered, which is more care and prevention outside hospitals?

Professor Maureen Baker: There are certainly aspects of the small business model that we would suggest work well or could work well, and certainly could work well in the future. The ability at a relatively small, local structure to make your own decisions about how you will invest, the staff you will have and how you react to particular challenges, I would not like to see lost. It was my college, and in fact me, who wrote the document about what we now called federations. The principle of GPs working collaboratively with each other while still having a base in the community they serve is something we set out in the first place and is now becoming the model widely. Currently we believe that about 60% of GPs are working in a federated model. There is something about collaboration: there is collaboration with other practices or there is collaboration within big practices and new models of care—it does not matter—and there is collaboration with the wider health economy. As we move forward, to work most effectively and to provide the type of integrated, joined-up care that patients need, we need to look at how GPs can work locally, rooted in their communities but linked up with each other and with other services. We see the building on the federated model and moving into the current new models of care which have grown from that, and support these developments.

Lord Warner: How does the central contract either incentivise that or get in the way? I am someone who spent some of the best years of his life negotiating with many of your members about this. I have a sense that somewhere in this mix something is not right about the incentives for getting the primary care system we want.

Professor Maureen Baker: The current contract we are working to is now 12 years old and there are ongoing discussions about how you can support GPs to work in other structures. Having said that, and I hesitate to speak for colleagues in the GPC, they would say, “Actually, we’ve got to the stage where 60% or more of GPs are working in federations under the current contract”, so it has not helped it but it has not got in the way either. It is good practice periodically to look at how we want to run our system. How do we want people to work and what are the contractual models that support that? We are at that stage currently and it is perfectly reasonable to look at how we modernise.

The Chairman: Briefly, Sam, is the current independent contractor status still appropriate?

Sir Sam Everington: There are 36 practices in Tower Hamlets, eight confederations, one social enterprise of all 36 practices and a single-handed practice managing within that, and it is very popular with the patients. The answer is confederations. The second thing is definitely a local contract. Tower Hamlets has a £9 million local contract; the equivalent of 25% of what a GP’s national contract would be. If you are to shift that care out of hospital with, as Clare rightly says, different solutions around the country, you have to come up with locally sensitive contracts to make that happen. It will be very different, say, over on the west coast of Scotland from an inner city area. I do not believe you can design that change purely on the basis of a national contract. The key to a national contract is to give the sustainability of primary care while you create the shift. We are talking, in our STP, of potentially increasing the

offer of primary care—I do not mean just GPs—by 33% in the next five years, on the back of the new models of care. It is what patients want. One of our vanguards, by the way, has reduced terminal illness death in hospital from 48% to 14%. These are the sorts of fantastic successes you will get with different models of care. It is what patients say to us all the time. If you ask them where they want to die, the vast majority want to die at home surrounded by their loved ones, yet we are failing to give them that.

Dr Clare Gerada: Can I pick up on that a tiny bit? I struggled with this independent contractor status when I was chair of council. In more or less the last week of my chairmanship I said I thought the independent contractor status was not fit for purpose. I felt we needed to unpick it, and GPs needed to still be in charge of their organisations, but that could be done in a different way. The different way is exactly as Sam is describing, and ours is to a certain extent, to have an overarching management structure with salaried doctors within it. I think there are moves afoot. Essentially, right across the country, especially in London, we do not have the independent contractor status you probably think about. Many doctors in London are now salaried.

You have to wonder what you wish for because if you get rid of the independent contractor status you have the leases on the buildings to deal with and you have the whole complexity. You can end up with the best model, which is to retain that but still get federations or confederations, or groups of practices, working within a managed structure.

Lord Mawhinney: Chair, I had better start by declaring an interest. The Royal Free can look after itself but during my time as Health Minister I chose to devote some of my time and effort to Tower Hamlets. If colleagues have not been to Bromley and Bow, they should go. It is the most amazing social enterprise scheme beyond your fantasy—not just in health but right across the board. As Sam hinted, I had to instruct the local Tower Hamlets NHS in writing to assist the people of Bromley-by-Bow. Whether I had the legal power or not, I have no idea, but I had the real-time power. It was not a one-off; I spent a lot of time with GPs' surgeries, from one person to multiple people, talking about how we could do that. On that basis I raise my question. We all know that one of the things patients most like about GPs is they have their own GP, and maybe he or she has been the family GP for generations. What you do and, probably even worse, what STPs are going to do is wreck that concept probably for ever. How have you dealt with the fact that you cannot supply the "my GP" concept?

Sir Sam Everington: In two ways. If you look at the wider teams, I want to tell you about Christine, who is our phlebotomist. She has no formal education whatsoever. She started as what we call a patient assistant—we do not call them receptionists any more, which is quite a key change—and now she is a phlebotomist. She is a real East Ender, too. She is fantastic at taking blood, relaxing people, giving a great conversation—she knows them all. If Christine rings through to me and says, "You need to see this patient this morning", she is right. She has made some

amazing diagnoses, and that is without any skill. The answer is you can create that relationship within the team.

The other thing is where it matters most. I give my mobile phone number to every one of my terminally ill patients. You have to say, "Where is the continuity really important?" The answer is probably in something like 30% of our population: chronic disease, complex care, the terminally ill, the housebound. That is where it is really important. Our youngsters, our kids, are very different; they are a different generation. They are used to instant. We have four hubs in Tower Hamlets where we provide that service. They have a problem, have been on the internet and learned a lot of things and they want an answer straightaway. Continuity of care is far less important.

We think the answer is what we are doing. We have team meetings every month where we proactively manage 7% of the patients, and it is going up to 30%, where somebody will take a key lead. Our nurse practitioner takes the lead with all the housebound, and it is absolutely fabulous because they know they can ring her at any time, and she will be known by them completely. You are asking for continuity where it really counts, and we are delivering it where it really counts.

Professor Maureen Baker: We have looked specifically at this in the college. We asked the question: is it possible to provide continuity of care in modern, emerging general practice, not in how we used to have it? The answer is it is possible for those patients who need and want it, and there are ways in which you can do that. Again, we have a document on that we are very happy to share with you.

Q188 **Baroness Redfern:** What could be done to address issues of recruitment and retention for long-term capacity of the general practice workforce? Ultimately, who is responsible for addressing those?

Professor Maureen Baker: Shall I start, if that is all right? This has been a running theme throughout my time as chair. If we want to meet the needs of patients by providing them with GPs—expert generalists—we have to recruit them. At the moment, it is a hard job, and people see that and it puts them off, but we think things will change. We are doing a lot of work to make the job better and more attractive. Again, there is something about inspiring young people at school, medical students and junior doctors about why general practice and being an expert generalist is a great career in medicine. We know that the prevailing culture in medical school and in wider areas of the NHS is anti-general practice. We know that there is a lot of disparaging and bad-mouthing. It is called banter but it is not; it is insidious and wrong, frankly. We are now addressing that. We are writing and talking about it; we are having discussions with medical schools, with medical schools' councils, with other colleges and with colleagues to start saying it is in our collective interest to make sure we have a balanced workforce with the GPs and the specialists that we need. We need to tackle attitudes of denigration, running-down and bad-mouthing colleagues and ways of working. When you are a medical student and you spend five years in a bubble, and in that bubble you have constant exposure to scathing and denigratory attitudes, that really counts and it does put people off. We have lots of

evidence of medical students and young doctors saying things like, “I’m scared to say to such-and-such consultant that I want to be a GP; I will be mocked and humiliated.” If you have people exposed to that, it sets them up to have to climb mountains in some ways to become GPs. We have to tackle that and get an accurate picture.

The Chairman: Maureen, can you think out of the box a bit and say how we are going to achieve this by 2030? I have no problem with what you say: we need more in medical workforce training to think about general practice when general practice is half the workforce. Some medical schools are addressing the issue about setting targets that 50% of the medical school intake—your previous medical school is doing exactly that—will go into general practice. How do we achieve this? I know what you say, and I read your blog, but how in 2030 is the question we have to understand.

Professor Maureen Baker: We have to start now; our doctors in 2025 to 2030 are at school now. There is something about the way we engage with schools and with medical students in their early years, to see what their ideas are, and to paint the picture of what it will be like to be a GP working in these new models of care, working in the wider stream and meeting the challenges we will face in this time. We have to start now; we have to keep thinking about it and, again, keep making sure that it is an attractive job that people want to do.

Dr Clare Gerada: Maureen has been instrumental over the last three years in addressing the workforce issues of our profession. She has written an awful lot and I urge you to read it. There are also things we need to look at; we need to look at how we have boxed in doctors at a very early age to choose a career. Many of you round this table who are doctors will not have chosen your specialty till quite a bit further along; we are now boxing them in through the run-through training to have to realise that from the ages of 22 to 70 they are going to be a cardiothoracic surgeon or a neurologist or a GP. We need to make it much more flexible. I do not think we should dumb down our profession but we should have much more flexibility. If you do two, three or four years in one profession, that should be lopped off and you should not have to start from the beginning, which is what we are doing at the moment. We also need to make sure that we have what was thought through but never happened, which is broad-based training—much broader training in all the specialties together, including general practice, which you can then leapfrog through into general practice, or whatever.

I worry about attracting medical students because I think general practice and, to a certain extent, psychiatry, are jobs you do when you are more mature. They are jobs you do when you do not have to demonstrate your technical skills; you do not have to put your metaphorical white coat on and go boasting and put your stethoscope around your neck, because the tools of our trade and our thinking are in here. We have to make it more flexible, we have to look at how we train doctors and how we are boxing them in at a young age.

Finally, we have to tell people the real secret: general practice is the best profession in the world. It is one that has sustained me for 35 years. It is

the best. We have to tell other specialties, “You have missed a treat by not doing my job”.

Sir Sam Everington: Some of you will know the research Professor Esmail and I published over the years, which looked at race and sex discrimination in the NHS from cradle to grave. We are about to publish similar research which relates to the parity of esteem of general practice versus “partialists”. I use that word on purpose because one of the things we have seen in the last few years, which we have to reverse, is the partialisation of the roles of specialists. The ageing population, the new models of care and all the evidence shows we have to incentivise everyone to be a generalist. Even if you see an orthopaedic surgeon, they need to be looking at you as a whole person, not just at your knee. You want some solutions. There is a difference in output from medical schools of people who end up as GPs that varies between 7% and 30%. That is, with our previous knowledge of discrimination, way beyond anything that is statistically significant. What would I suggest you do? Incentivise and change the financial incentive. If a medical school is not delivering the type of training, the multidisciplinary team approach or the generalists—whether in hospital or primary care—it gets less money. Trust me, you get their attention that way.

As I say, the second part of it is we have estimated within our STP that we are going to have half the number of GPs in five years’ time. That is not something we choose to do; that is the reality of our analysis of how many GPs there will be around. That is the change that Clare talked about. Some 65% of ours are salaried. They are averaging 35 hours a week because they are so exhausted by it. We know we are not going to have the GPs. What have we done? Our CCG has invested in Barts setting up a physician associate course. We have pharmacists in the practice; we have the phlebotomist doing these things, healthcare assistants—

The Chairman: Those are wonderful things you are doing, but we are more interested in national things for 2030.

Sir Sam Everington: Your solution is the incentive for medical schools and accountability of the HEE budget to the STP.

Dr Clare Gerada: And cap the number of specialists. We have seen—you will have to check the figure—a 200% increase in specialists. If you capped the number of specialists, where are they going to go? They will come into general practice. At the moment, we have an epidemic, as Sam said, of partialists.

The Chairman: I listen to you, but I hear also that some medical schools are now stating a target that 50% of their output will do general practice. I have not heard all medical schools doing it, and I take your point, Sam, that we need some kind of incentive for them to do it, but I see Lord Ribeiro, as a specialist generalist—

Dr Clare Gerada: I worry about that.

Lord Ribeiro: I have a problem here because there was a clear decision some time ago that we should be moving at least 50% of the medical workforce into general practice. That was a clear policy decision. However, I also hear this very clear statement that 65% of your

workforce are now salaried, some doing 35 hours, and we have a mix of more women going into general practice and work-sharing, time-sharing and so forth. I do not see how this model, which is based on general practice holding the money and being a private organisation in many ways, is going to be sustainable in 2030 when the majority of the workforce will be salaried and want to work in the same way as those in hospital practice.

Dr Clare Gerada: I am the honorary secretary of the Medical Women's Federation as well as everything else. First, we are not private; we must not use that term. We are NHS through and through. We are not as if we were a private organisation. We cannot sell shares, we cannot advertise, the vast majority of our income comes from the NHS, blah-blah-blah. Independent contractor and private are two different things.

With the women issue, it is a fact of life that women have babies and women are carers, but we are trying to tackle this. It may be that you take time out but you have to find your way back in in a flexible way. Nevertheless, with the feminisation of the profession we have to bite that bullet and accept it. We have to find new models of working and we have to extend the hours. The reason we have a shortage now is because we have extended the hours and extended the places, so the same number of people are working over a longer period. There are ways of doing it. I had a debate on Saturday about whether we should have quotas for men into medical school. We are looking very seriously at what is happening to the profession and how we do it. We are where we are, we have women, and well done.

The Chairman: Legally, I am not sure—

Dr Clare Gerada: We cannot do it legally; no, we cannot.

Lord Ribeiro: Chairman, I did not say what my interest was, which I should have stated: I am a retired general surgeon.

Lord Willis of Knaresborough: We asked a question about the workforce, and all we have talked about are GPs. In reality you cannot provide a workforce of the future unless you radically look at what we are expecting from GPs and the college gets its act together to say that a lot of the work currently done by GPs, quite frankly, could be done by others just as successfully. You have not mentioned any of that. It is protectionism.

Professor Maureen Baker: I completely refute that. The college has done huge amounts of work, particularly over the last few years, looking at the skills needed for modern general practice and general practice as we develop. We are the ones who have led the charge about nursing skills in general practice and the community; we have pointed out how disgraceful the huge drop in district nurses has been. We need high-level nursing skills in the community and we have denuded that workforce. We have led the charge on that. Likewise, we initiated and sold, as it were, to NHS England the concept of practice-based pharmacies, and that has really taken off in the last few years. We are also talking about introducing a model for medical assistance. I am sorry about the name—it is too like physician assistants—physician associates, but this is a model used in the US where you have colleagues who support the doctor in

doing a lot of admin, form filling and basic clinical tasks. They are not the same as physician assistants.

We have been promoting the use of all these models, we have been selling this into, if you like, to the Department of Health and NHS England, we have been writing papers about it and we contributed to the Roland commission. We have been leading the push to expand and enhance the skills of the workforce in primary care, and we are not protectionist. We are saying we need this range of skills, we need GPs—we need as many GPs as we can get—and we need other colleagues to work so that they have the right workforce with the skills that 21st century patients need in the community. We are not protectionist—far from it.

Lord Warner: You have said you want 10,000 more GPs by 2020; Sam has said they will not get them in London so we are going to change the skills mix. I am not sure what message the Committee is supposed to take away from this. Is there really a shortage or is there poor organisation?

Professor Maureen Baker: Yes, there is a shortage of GPs. Some 10,000 GPs across the UK is one per practice. That is not an explosion in the number of GPs. When you look at why people are working part-time and why the job is so difficult, it is a hugely intense, pressurised job. Having more GPs with the skills is absolutely an aspiration, but it is not just about GPs, which is where I come back to what I was saying about nurses and others. I am sorry; I cannot listen to three people at the one time. It is not a mixed message. The difficulties of recruitment need to be addressed and we need to think about how we make the job sufficiently attractive. We need to think about how we increase our recruits; we need to think about how we get people committing to staying in general practice to the end of their careers.

The Chairman: The message you are trying to give is if we are looking at 2030 and a future model beyond that, yes, I understand that we need to start thinking now and training people for that now, but if you are looking at a model of primary care and community care for 2030, then we need a model that describes the workforce needs not just of doctors but nurses who work there, the physiotherapists who work there—

Professor Maureen Baker: Absolutely. That is what the Roland commission has done.

The Chairman: All we need is a consensus that that is the model we should have.

Professor Maureen Baker: That is what the Roland commission has done, and we supported the Roland commission. We fed into that and then we supported the findings. We have been working ever since to expand the roles we have put into the general practice setting and the primary care setting; increasingly we want patients to access the skills they need in the community or at home.

The Chairman: We need the workforce. I am going to move on. Lord Lipsey.

Professor Maureen Baker, NHS Tower Hamlets CCF and Dr Clare Gerada – Oral evidence (QQ 185-190)

Q189 **Lord Lipsey:** The Government keep telling us that recent reforms have swept away bureaucracy from GP practices, but when I meet a GP they do not, on the whole, say, "Life is so wonderful since the bureaucracy has been swept away". Has it increased and what can be done to diminish it?

Dr Clare Gerada: Do you mean the latest reforms, as in the Lansley Act?

Lord Lipsey: The Lansley Act and subsequent CQC claims to have changed all its methods so it is now a perfect figure.

Dr Clare Gerada: We live in a bureaucratic jungle. It is terrible. Every single day is full of box-ticking and reporting. Even I do not now know what I am meant to do. I discovered the other day that I have not done my heavy lifting training, which will make me non-CQC-compliant. I have to go and do it. It is dreadful in there. It certainly has not released us from the bureaucratic nightmare.

Professor Maureen Baker: Bureaucracy has increased and the King's Fund report in May of this year specifically drew attention to that. It has increased, not decreased.

Sir Sam Everington: I want to give some solutions to multiple regulators and a system where you cannot get an answer from somebody. That is the problem. Even if you have a fabulous idea, you go round a whole raft of regulators and performance managers to get a solution. HEE is the classic example. By the way, come and meet our practice nurse, who is a full profit-sharing partner of the practice, or some of our social prescribing team, and you will have a sense of a completely wider team, which includes patients, by the way.

The Chairman: Stick to the original point.

Sir Sam Everington: HEE needs to change. The second thing is estates. Just to give you an example, we had to get one of your fellow Lords to intervene in an issue about tens of thousands of pounds only to have a meeting on an estates issue in Tower Hamlets. Basically, because there are so many people involved in making the decision, you cannot get anything done. The final thing I would say is that the consequence of this regulation—and, I think, a loss of compact with patients because it has a very strong focus on rights rather than responsibilities—is that if you are a GP and you walk across the border to Scotland, you will pay a third of the cost of indemnity charges. Look at the consequences of what regulation has done in changing what I would argue is the compact that our society has with the NHS.

Q190 **The Chairman:** We come to the last question. I have a feeling I know what you are going to say but I will ask it anyway. If there was one recommendation that you would like to see this committee make on the long-term sustainability of the NHS and social care, not just focusing on general practice, what would that be? Clare.

Dr Clare Gerada: Fair funding for health and social care. Once you have done that, we can start looking at creating the accountable care organisations with a sensible geographical size, co-located with local authorities. There has to be fair funding; we are drowning at the moment.

Sir Sam Everington: A forward view for consultants, nurses and all the other stuff that you talk about. A vision about what these people will be in the future. Secondly, social prescribing should be the norm in any practice around the country. After all, we see 90% of patients in a year. Tesco would die for that as a footfall. Do not worry too much about the weight in the NHS; look at it as an opportunity. Finally, a chief medical officer for the Department for Education. For the five to 18 year-old it is all about school. Health and well-being should be a compulsory part of the curriculum, ahead of maths and English, because it is the thing that is delaying, most of all, the educational achievements of kids in my area.

Professor Maureen Baker: I would repeat those points, and I would expand a little on Clare's. On fair funding and transparency of funding, it has become clear to us over the past few years, when we have been looking at funding streams, that to meet the ever-increasing demands of the acute sector, different areas that are outwith the acute sector suffer. We have heard recently about money intended for child and adolescent mental health services not going where it is meant to. We have seen this, year after year, in the funding of general practice and primary care; money is held back to address acute trust deficits. I know that is a "now" issue but if we keep going on like this we will not be able to grow our NHS as we need to. Just to finish on the same area and come back to real-time data, if we are able to see our funding streams—where they going and how they are being used, et cetera—that is a hugely powerful weapon. It is transparent, and it gives power to people.

The Chairman: Thank you all very much. If you have any other evidence you want to send in following our questions, please do so. We have quite a volume so it has to be pertinent. Thank you for today. This was the 19th session and you have succeeded in exciting the Committee more than the last 18 sessions. Maureen, I did not put you off going into general practice as a specialist. Thank you very much.

Academy of Royal Medical Colleges, Royal College of Surgeons and Royal College of Physicians – Oral evidence (QQ 191-206)

Evidence Session No. 20

Heard in Public

Questions 191 - 206

Tuesday 22 November 2016

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

Professor Dame Sue Bailey DBE, Chair, Academy of Medical Royal Colleges; Ian Eardley, Vice President, Royal College of Surgeons; and Professor Jane Dacre, President, Royal College of Physicians.

Q191 **The Chairman:** Good morning and welcome. Thank you very much for coming today to assist us. I need to tell you some of the rules. We are being broadcast live and if you have private conversations they may be picked up. That applies also to the Committee members. During the inquiry, if issues come up about which you feel you would like to send more evidence, please feel free to do so after the session. You will be sent a transcript of the session; you are not allowed to change it but if there are gross inaccuracies please let us know. Would you please introduce yourselves and if you want to make an opening statement, please do so. Before we start, I declare that I am a fellow of several medical royal colleges—as you all know.

Professor Dame Sue Bailey: Good morning, everybody. I am Sue Bailey. I am privileged to be chair of the Academy of Medical Royal Colleges, which is a UK-wide organisation with 220,000 doctors. I was previously president of the Royal College of Psychiatrists. In my day job, with my concern about child mental health, I chair the Children and Young People's Mental Health Coalition.

As a headline statement I would say that in the short term we need urgently to ask that social care is properly funded, because healthcare is co-dependent on social care. We would be able to deliver better if the pressure was off social care. We need to be bold in helping the current workforce to adapt and the future workforce to work differently. We need to move from an illness to a wellness model. We need to start a national conversation with the public about what an open all hours service is for, what they can expect and how they can play their part in it. These are

interesting times, with opportunities, but we need to attack with optimism rather than pessimism.

Ian Eardley: Good morning. I am Ian Eardley. I am a practising urological surgeon from St James's University Hospital, Leeds. I am also vice president of the Royal College of Surgeons. The Royal College of Surgeons represents around 20,000 surgeons and dentists in the UK and beyond. I have a background in surgical training; I was the chairman of our own specialty accreditation committee and have chaired the committee that oversees the whole of surgical training in the UK and Ireland. I am currently vice president of the college, with particular responsibility for workforce, for training and for the non-medical workforce as a means of support for surgical care. I would be very happy to expand on any of those issues.

Professor Jane Dacre: I am Jane Dacre. I am a physician rheumatologist working in north London. I have a long background in medical education, having been the director of UCL Medical School for many years. I am the president of the Royal College of Physicians.

My interest in this perhaps stems from my interest in education in the workforce. I have deep concerns about the morale of the workforce and the stress that is being put on the workforce by the gap that there appears to be between the aspirations of our wonderful health service and our ability to deliver that service.

Q192 **The Chairman:** Thank you. We have heard a lot of evidence about different funding models for health and social care, but what we do not have is a cohesive argument that everybody accepts. You represent through the royal colleges a large workforce in the health service and social care. Do you have any views about future sustainability as far as funding is concerned for health and social care? In all of our questions we are looking long term, 2025 and beyond, and not at current problems.

Professor Dame Sue Bailey: First of all, there needs to be clarity in the identification of the funding and spend. There is lack of clarity at the moment. That is in the short term. Going forward, the academy supports the position that healthcare should be free at the point of use. There needs to be further investment and we need to argue the case for that when we have delivered productivity efficiency and we have a healthy workforce. Then it is for the public to have that conversation about how it might be funded; it is a democratic process.

The Chairman: Are there particular models that you would support?

Professor Jane Dacre: What is not in doubt is that the health service appears to those in the front line to be underfunded. When comparisons are made with other health economies there is much discussion about how we are relatively underfunded in terms of the amount of GDP that is spent on health. That is the first thing.

The second thing is that social care is in a worse position than healthcare. Even though I am sitting at the top of a medical royal college, I say that any funding model has to put social care first because of the difficulties that social care is experiencing and the effects on transfers of care around and out of our medical practice, either in primary care or in hospitals.

In terms of what could happen, I do not see, as head of a medical royal college, that it is my role to suggest how that should happen. That is a conversation that the Government of the day need to have with the electorate. Increasing taxes or cutting what we do or changing the way that the tax model happens are all ways to increase the funding for the health service. That is not the job of a medical royal college; that is the job of the Government of the day.

Ian Eardley: We agree broadly with what has been said, but with one or two caveats. I went to the launch of my own STP last week and in the discussions about social care and healthcare I was struck that the social care people clearly saw the healthcare budget as an opportunity to bail out their problems. This is within the context of an NHS which is in many ways cash strapped. There are funding issues. We have a triangle of increasing demand, not quite enough money and workforce problems. I am sure we will talk later this morning about ways in which we could perhaps do things differently in order to make the service more efficient in the medium to long term. It is very difficult to see past a wider debate with the population and with the service about whether the whole of healthcare should remain free at the point of delivery. We believe that that is the right thing to do, but it is challenging to achieve, given the economic constraints we have.

The Chairman: Do you think there should be other models where there are co-payments?

Ian Eardley: We do not support co-payments. That is not what we view—but it is one of the options that people have to look at to achieve greater funding. If you look at it in ballpark terms, our funding of the NHS as a proportion of GDP is well below the European average. We would be supportive over a period of time, as the economic circumstances of the country allow, of an increase in healthcare spending to that sort of level.

The Chairman: I think that comment will interest Lord Warner—but we will hear from Lord Willis first.

Q193 **Lord Willis of Knaresborough:** I would like to take up and challenge Professor Dacre's comment that it did not seem to be anything to do with the royal colleges. If, as a royal college, you feel that you cannot improve healthcare in an abstract way without looking at health economics, I would challenge you and say that perhaps that is something you should look at. Working in different ways to deliver a quality of service should be led by the royal colleges; they should not simply trail along behind.

Professor Jane Dacre: I think perhaps there has been a misunderstanding. Changes in models of care, transforming the way that care should happen, driving for efficiencies in the health service are absolutely the role of the medical royal colleges. But we are doing all of that. We are committed to doing all of that but there remains what we see as a funding gap. So there is still a need for more investment in the system in which we work. Where that money comes from is something for political debate.

Lord Warner: If you look at the evidence we have been given and compare healthcare systems on a comparable basis, as OECD has done,

we are not that much below the OECD average on what we spend on health and social care. Pleading poverty is not a very convincing argument from the evidence we have. If we cannot get you to look at the quantum, how about the way the money is distributed? You must have views on that. Is the system distributing money correctly with its very strong emphasis on the acute hospital?

Professor Jane Dacre: It has been recognised for some time that it would be better to distribute more funding into public health and primary care. I say that as the head of a medical royal college. However, I do not think that the role for acute hospitals will necessarily diminish or go away. Whilst there should be more equitable distribution of resource, the reason there are problems with this is that, looking at the view from the coalface, from our fellows and members, there is not enough resource to do the things that we aspire to do.

The Chairman: If the model of redistribution is to give more money to primary care, do you think the current model of primary and community care needs to change or remain the same?

Professor Jane Dacre: The College of General Practitioners is not here.

The Chairman: They have been questioned but they need not be here. We would like to hear your view.

Professor Jane Dacre: My view is that we all need to change in the way that we deliver care.

The Chairman: We are particularly interested in whether the current model of primary care needs to change if more money is going to go to primary and community care for them, presumably, to provide more healthcare.

Professor Jane Dacre: The two models that were presented in the Five Year Forward View, PACS and MCPs, need to be given a chance to see whether they are going to work effectively. Those are changes in the way that primary care is delivered that we have not given enough time to evaluate.

The Chairman: You are being guarded, Jane, but there we are.

Q194 **Baroness Redfern:** Ian, you mentioned that you had talks regarding your STP. You quoted that healthcare was there to "bail them out of their problems".

Ian Eardley: That was the tone of the discussion. The social care services in my part of the country, which is Leeds and West Yorkshire, have had their funding cut substantially in the past few years as a consequence of economic problems. I perceived from their tone that they saw a merging of the healthcare budget with the social care budget as an opportunity for them.

Baroness Redfern: Do you?

Ian Eardley: It is a challenge. I am a surgeon and when I go in to do an operating list at 8 am I have an operating list to start. It rarely starts on time because the hospital is too full of patients. Each morning we have 70 more patients in the hospital than there are beds. At the same time we

have 90 patients in the hospital who need to be in social care beds but who cannot get into social care beds. That is making me inefficient. So improving spending in social care would improve my efficiency and would improve the efficiency of elective surgery. So while the principle of merging the budgets and having a more streamlined, joined-up approach to the spend makes enormous sense to me, I worry that simply transferring money from the healthcare budget to the social care budget on its own might not necessarily solve all the problems.

Baroness Redfern: So at this moment you would not want to see a change at all in the allocation of the budget?

Ian Eardley: I would like to see joined-up thinking.

Baroness Redfern: Thinking and putting into practice are different.

Ian Eardley: I would like to see the practice that goes with it, yes.

Q195 **Lord Bradley:** You have commented on the integration of health and social care. Do you see the integration of mental and physical health and a move to per capita funding in the long term as part of an efficiency and sustainability agenda?

Ian Eardley: I cannot claim to be much of an expert on mental health.

Professor Dame Sue Bailey: Yes, absolutely. There are two sides to this coin and the coin needs to get back together. Mental health funding has been chronically lagging behind and our patients suffer because of that. The other side of the coin is that the skills of mental health have a great deal to offer physical health services, given that 26% of patients in gastroenterology outpatient clinics are people who have psychological difficulties. That does not make them any the less ill; they just need a different sort of intervention. It is about time that we got back together properly, particularly when we start looking at prevention in the younger age range. We need to be brave enough. I am not here as the president of the Royal College of Psychiatrists but the concern on behalf of mental health is that we will have things taken away from us.

Part of the answer to A&E is to have more mental health teams helping that swarm of people who come to A&E who need psychological support and who can give proper help to those who are frail and elderly so that they can get through the system or do not have to come to A&E in the first place. Much of that is about how we integrate and look at the workforce. I welcome the nursing and social care associates who can deliver good, integrated care so that people can stay safely in their own homes and have meaning, sense, control and purpose in their lives. We should completely rebadge and shape how we look at healthcare.

Q196 **Lord Turnberg:** I express my interest as a fellow of Professor Dacre's college and a past president. I am also a fellow of the College of Surgeons, but no one has asked me to operate. My question relates to workforce and workforce planning. We know that the workforce is under tremendous pressure. We are trying to lift our heads above the parapet and think about the future. What sort of assessment of workforce planning are you making? Are we getting it right? How far into the future can you predict the future workforce's needs, remembering that we do

have the smallest number of doctors per head of population of any OECD country—pace Lord Warner?

Professor Jane Dacre: I have always had a problem with the accuracy of workforce planning. Throughout my career I have never heard anybody say how marvellous workforce planning is at getting the answer right. It is an impossible thing to do. The reason for that is that the demographics of the workforce change. Next year for the first time there will be a majority of women in the workforce. Women want to work part-time but we do not know how often or when or which specialities those women will be in.

The other thing that changes is medicine itself. Twenty-five years ago, if you had an ulcer you had an operation. But today you have some antibiotics and do not need to go into hospital. Patterns of where care is delivered change. The trend is now for more care to be delivered in the community.

The complexity of workforce planning to me means that it becomes an increasingly inexact science. There may be a better way of looking at it, which is to say that if you employ the workforce that you have efficiently and flexibly, you should be able to move your healthcare workers around to where the service needs them. One of the difficulties we have is that we are locked into very long training programmes to highly specialist levels, which means that when you no longer need, for example, as many cardiothoracic surgeons—I am pulling that out of a hat—because a cardiologist can poke a stent through the hole, what do you do with all your cardiothoracic surgeons?

We need to increase training so that we have people who have a more flexible skill mix so that when the workforce needs change those people can change the work that they do. For that to work, we need a small oversupply of medical practitioners, because there is attrition. There is attrition because of pension, there is attrition because of family responsibilities, there is attrition because of all sorts of things including, currently, trying to work in Australia. If you have an undersupply you end up with a less flexible workforce because they can go and work wherever they like. So there are some fundamental principles that need to be changed in developing an effective and efficient workforce, which is about us being less focused on spending a long time to get that highly tuned specialist who is able to do only one thing at the end of the day.

Lord Turnberg: Are you changing your training programmes with that in mind?

Professor Jane Dacre: Yes, we are. The Shape of Training review has been quite controversial, but within physicianally practice we are working with our specialty societies to ensure that all physicianally trainees who come through have the capability to do more general medicine and so are trained to a higher level in less specialist activities. Not everybody agrees that that is the way forward, particularly people from some highly specialised areas. But what we would like to see is more people with a broader range of clinical capability.

The Chairman: It is suggested that currently the training programmes in medicine are far too long, including for undergraduates. There are unnecessary steps and people who want to specialise, even if it is in

general medicine, should be able to do so earlier on and shorten the programme. Would you comment on that?

Secondly, in answer to Lord Turnberg, you said you have new programmes starting. Do you have a timeline for that? When do these people start taking up their post? Jane, you also said that you need oversupply. What does oversupply mean? Does that mean they will be paid but have no job?

Professor Jane Dacre: No, it means that you have enough jobs to do the work. Maybe you need to take account of those people who, by attrition, are going to leave the system. Our workforce unit has worked out that you need to train 1.3 men and 1.5 women to achieve a fully committed workforce because of attrition for various reasons. That is what I mean by oversupply. Those people will not be unemployed; they will have walked away.

The Chairman: So if you train forward, you only need 1.3?

Professor Jane Dacre: Yes, 1.3.

Q197 **Lord Turnberg:** What is the impact of Brexit on all this? Have you calculated that?

Professor Jane Dacre: Up to 20% of our workforce are currently from the EU. We have not done the numbers with Brexit because it is still up in the air. Suffice to say, it is not good.

Ian Eardley: We are in a similar position. Some 40% of surgeons on the specialist register in this country trained overseas. Of those, half trained in Europe and the other half trained outside Europe. In recent years the number of people coming from outside Europe has been diminishing while the number coming from within Europe has been increasing. If that tap were to be turned off there is potentially a significant problem, certainly for surgery.

Q198 **Lord Kakkar:** I declare my interest as a fellow of the Royal College of Surgeons and a fellow of the Royal College of Physicians. I was a member of the Shape of Training review that has been mentioned. Professor Dacre, in terms of the structural organisation of developing a workforce, do you think that there are problems in the relationships between different organisations that have a locus in terms of developing the workforce? Could the relationships between those organisations be better co-ordinated to ensure that there is more flexibility, both in the creation of a generalist workforce and the development of the small number of highly specialist clinicians that are required?

Professor Jane Dacre: The short answer is yes.

Lord Kakkar: How would you go about addressing it?

Professor Jane Dacre: The first step towards addressing it is to recognise and identify that there has been a problem hitherto. The royal colleges and the arm's-length bodies within the NHS have, to a certain extent, been at loggerheads. We need to find a way to take the profession with the government initiatives—and that has not always worked very well. Our problem internally with the shortening of training requirements

in the Shape of Training review has been about taking our fellows and members with us. There is a difference between coming up with an idea and saying it is all going to be great if we do it like this, and getting the people who are working as they currently are in the health service who we need, respect and value, to come closer to where that shining idea is. That piece of the management of change has been problematic.

Q199 **Baroness Blackstone:** I declare an interest as the chair of Great Ormond Street Hospital Foundation Trust Board and I am a member of the board of UCL Partners. On the question of length of training and greater flexibility, have the royal colleges done anything to put pressure on medical schools to provide four-year programmes for science graduates? I believe that there is a huge shortage of places on four-year programmes for them and it seems a waste of public money to insist that they start back at the beginning on a five-year programme.

Professor Jane Dacre: Yes, we have had those conversations. This area is fraught with regulation. There are regulations from the EU about the length of time that you need to spend on a programme in order to be trained as a doctor. There are also regulations within the universities about bringing undergraduates in for one course and wanting to transfer them over to another course for which they were not originally interviewed. The principle is there but it is fraught with difficult detail which often slows down progress.

Baroness Blackstone: I will put a bit of pressure on you. There are 14 medical schools that do have four-year programmes for graduates and have got round the EU regulations. Why can the rest not do so?

Professor Dame Sue Bailey: I would like to support you. We should challenge the regulations. We should have a different rethink when we take medical students in, whether they have already done science degrees, and be honest and open with them about the nature of the work they are going to do across their careers. We do not have that open, honest conversation. We ask for the brightest and the best but we should explain to them realistically the sorts of roles they will be taking. That does mean some radical changes in the way that medical schools run and think and the way we support them from beginning to end.

The Chairman: What Baroness Blackstone said is correct. There are 14 medical schools, mine being one of them, that do these courses over a shorter period. That also applies to postgraduate training. Both Lord Turnberg and I fought the battles over regulation some years ago. You can shorten the courses—but that is by the way.

Q200 **Bishop of Carlisle:** I would like to go back to the question of attrition. You said there are all sorts of reasons why attrition happens and it is difficult to retain people, so more people should be trained to cope with the numbers. What could be done to prevent some of that attrition? Are there measures that could be taken to keep people in this country rather than them going abroad?

Professor Jane Dacre: Absolutely. We are all focusing on that. Since the industrial action there is a huge problem with trainee morale. The brightest and the best having got into medicine as a profession are finding

it is not as fulfilling a profession as they had hoped. The evidence is accruing that they are either trying to work elsewhere, they are going into other professions or they are giving up altogether. There is a big problem at the moment among trainee doctors which is beginning to filter down into medical students that maybe going into medicine is not as great a job as it should be. In the College of Physicians we have a programme of activities that are designed to investigate and improve the morale of our trainees. We are repeatedly trying to remind people why they wanted to be a doctor in the first place and to remind them that that magic is still there somewhere.

Bishop of Carlisle: In your view is the problem more to do with the pressures on people rather than levels of pay and that kind of thing?

Professor Jane Dacre: Yes.

Professor Dame Sue Bailey: We seem not to be able to deliver an enabling environment for a healthy workforce and yet we know what we need to do. We do not pay enough attention to generational difference. With respect, I guess most of us are baby boomers in this room. It is a different expectation. Doctors and other professions want to have portfolio careers. We need to understand that and go with them. This is not just about doctors, it is about the porter in the hospital, it is about the receptionist in a general practitioner's, it is across the whole of the workforce. This is the one thing we need to grasp. There are ways of doing that which are not complicated. I am working with Cary Cooper at Manchester University on this very thing at the moment. We can deliver this but it will take some time, some thought and some determination. Providers and employers have to be on board with this. This is the key thing we could do.

Q201 **Baroness Blackstone:** I know you think that workforce planning is very difficult because of all the uncertainties of demographic change and so on, but would you be able to say whether you think the current skills mix is right and whether that skills mix is going to be appropriate for the next 10 to 15 years?

Professor Dame Sue Bailey: No, it is not. We need more generalists and we need to think more carefully about what doctors do and whether other parts of the health workforce could do some of that work. As science progresses we are going to need upskilling super-specialists in certain areas. This needs looking at right across the board—for example, physician associates or anaesthetists having more perioperative skills. This is at the core of how we do it. Doctors are not going to be unemployed.

The Chairman: Are the colleges addressing this issue?

Professor Dame Sue Bailey: Yes.

The Chairman: How?

Ian Eardley: I would agree completely with what Dame Sue has just said. There are two challenges. The first challenge is at the diagnostic and entry level, where we probably have too few people. Going to the high-level intervention level, for example specialised surgery, in some areas we

do not have enough specialists. So we have to change the shape of our workforce. It is not just about doctors; it is about the non-medical workforce which can support and in some cases replace doctors.

We are currently doing a pilot programme of training with Health Education England which will begin in about 18 months' time that seeks to integrate a non-medical workforce within surgical training, thereby supporting the young surgeons and helping them to spend more time training and less time doing the unhelpful service stuff that in many ways is demoralising them. I would agree with the point about morale at the moment. The problem is that we train doctors to be doctors and in the first two or three years of clinical practice they are not acting as doctors, they are glorified administrators.

Baroness Blackstone: Could you give us some illustrations of where the medical workforce could be replaced by less highly trained and less expensive people in a variety of different ways?

Ian Eardley: I will give you two or three: how long have you got? We did a survey of foundation core trainees in surgery in three deaneries in this country, with 990 responses. We asked them what they did on their shift. They spent three to four hours doing administrative paperwork relating to discharge. It is not difficult to see that administrative support at a relatively low banding could support that. There are many examples around the country where physician associates, surgical care practitioners and advanced care practitioners are supporting and replacing junior doctors overnight to support care for overnight stay. If you go down to St George's at the moment, physician associates are doing that; they have advanced care practitioners that support the ENT and oral maxillofacial facial surgery service overnight. There are many aspects within surgery where a non-medical workforce could support and replace junior doctors.

Baroness Blackstone: Why is this not happening?

Ian Eardley: First, there is a workforce issue. There are not enough of them at the moment. To be fair to Health Education England, it has put a lot of money into training and increasing the number of physician associates. There is a regulatory issue with physician associates; they are not regulated and therefore cannot prescribe. They cannot prescribe radiation, for example. So there are challenges along the way, but it is quite interesting. We have done a report, which you are very welcome to have, which looks at areas of good practice of this sort up and down the country where people have been using a non-medical workforce to support surgical services.

Professor Dame Sue Bailey: There is a further problem. You train advanced practitioners but when they go back to their provider organisation they are not always utilised for what they have been trained to do because they are pulled off into other things.

Lord Warner: Why are the royal colleges not driving an agenda of parapsychiatrists, parasurgeons and parapsychiatrists? If there is such a shortage of these professions, is it not in your interest, given that you all work in teams now, to grab this agenda and overcome the regulatory problems?

Professor Jane Dacre: The answer is that we are. We have set up the Faculty of Physician Associates. They have had their first CPD day. We welcomed them into our college and are looking forward to working with them towards the future. Physician associates are the only truly new group in the workforce that are not robbing Peter to pay Paul. We are welcoming them and supporting them. They have a member on our council. We support their council, we help them to run their exam and we are running their CPD programmes to do exactly as you suggest.

Ian Eardley: I would accept that the surgeons were a little bit late to the table but certainly for the past two years we have been committed to that and, indeed, I am going straight from this meeting to meet Health Education England to sit on a group whereby we are pushing for regulation of this different healthcare group to support services.

Professor Jane Dacre: There are not quite enough of them yet. They are exponentially increasing in number because they have to have three years of training before they go out into the service. So over the next two or three years their numbers will exponentially increase. We hope that that will be hugely helpful to the service.

Q202 **Lord McColl of Dulwich:** How far is burdensome regulation impairing healthcare? Many of my general practitioner friends are demoralised by the CQC inspections by people who do not know much about the subject. Why can local medical committees not do the same job?

Ian Eardley: We are supportive of the CQC, which was developed as a response to quite a significant healthcare issue in Mid-Staffs. As a means of regulating for quality we think it is fundamentally a good thing. Clearly it has to be value for money and there is more work that could be usefully done there. The difficulty for a medical committee to do it is the issue of externality; there needs to be an externality to any quality assurance process. As a principle and as a model we are supportive of it.

Lord McColl of Dulwich: I was thinking more about general practitioners. I know it was useful in the hospital service but it is in general practice that it is destroying morale.

Ian Eardley: I am not equipped to comment on primary care.

Professor Jane Dacre: There is an issue of proportionality. There is no doubt that we, as a group of professionals, need to continue to polish all our apples and raise standards. There is no doubt that regulation is a very good way of doing that. But regulation becomes a problem when it is overly burdensome. In my trust we had training sessions to teach us how to handle the CQC when they came to visit. The sorts of investments that you need to put in to do well in your external regulation cannot do anything but remove focus from care of patients in the front line. It is a case of proportionality.

The Chairman: Does that not demonstrate the question that Lord McColl is posing—that there is a lot of bureaucracy for not very much benefit? You say externality is important but it is not focusing on outcome quality measures. It is counting empty ashtrays or whatever.

Professor Jane Dacre: We measure what we can rather than what we should.

Lord Willis of Knaresborough: Why do we not have one single regulator? The problem, as it seems to me, is that we are constantly duplicating, perhaps at the margins, the number of inspections. Why are you not fighting to have just one regulator? Or is that a silly idea?

Professor Dame Sue Bailey: I totally agree. There are nine regulators and I do not see why they cannot go down to two. In terms of CQC, we need to move to an inspection of a whole system of care and place-based health. I think that they are moving to that. There are a lot of myths and perceived obstacles in the world and we need to challenge those together.

Lord Kakkar: When you say there should be a single regulator, do you mean that the professional regulator and the systems regulator should all be in one?

Professor Dame Sue Bailey: We need a reduced number of professional regulators. For instance, if we are going to get physician associates up there and recognised, some of the big regulators need to decide who is going to do that. Inspections need to be separate but they need to work together better.

Q203 **Lord Kakkar:** I would like to turn to the question of planning in the health and social care systems. We have the sense that this is always done at a time of crisis and is therefore principally determined on planning for the very short term. Would you agree with the assertion that there is little by way of long-term planning? How does the variability of funding impact on system leaders to be able to plan for the longer term? If the Government and health systems themselves are consistently failing to be able to address long-term issues, who should be charged with ensuring that there is planning for a sustainable health service 20 years hence?

Professor Jane Dacre: The answer is that, yes, there is a problem. We are blighted by short-term planning that goes along with the electoral cycle. The health service is a very big and very expensive organisation that does fantastically well. But it is frequently the victim of short-term political decisions that make it less efficient. Strategies for the health system, such as the Five Year Forward View, are admirable and perfectly deliverable but not over a five-year period. An increase in the length of time and less inference during the process of those reviews would be very welcome to those of us who work in the health system.

Lord Kakkar: Do you think there is sufficient planning with regard to the social care element of the health and social care continuum?

Professor Jane Dacre: I think the same thing; I do not think there is enough. The really big thing is public health, because public health interventions take an awfully long time to have a benefit. At the College of Physicians we first started campaigning about smoking in the 1960s and over the last few years we have just about got some pieces of legislation through that have made a significant difference to the number of people who smoke.

The Chairman: Lord Kakkar was also asking about social care planning.

Professor Jane Dacre: It is the same; I think long-term planning would be preferable.

Lord Kakkar: If we all agree that long-term planning would be sensible, who should be responsible for this long-term planning?

Professor Jane Dacre: I think the chief executive of the NHS has made a very good strategy for the NHS, but it should be rolled out over a longer period. Parallels in social care would be effective.

Lord Kakkar: How would the professions contribute to that? Do you feel that the royal colleges and professional bodies play an active enough role in contributing to long-term planning for health and social care? Do you think they have a role in that?

Professor Dame Sue Bailey: Yes, we absolutely have a role. The academy overall is looking at things such as choosing wisely, sustainability and disease prevention and we need to bed these things in. Over the years we have done that on big public health issues. We need to get behind public health and help that; it is the bridge across social care and healthcare.

Q204 **Lord Turnberg:** We know that the Royal College of Physicians has the Future Hospital plan. Would you like to tell us about that because that is your plan for the future?

Professor Jane Dacre: The Future Hospital plan came out of recognition that hospitals were going over a cliff. When it was written in 2013 they were just going over the cliff and now we feel as if they are in freefall. We felt that the way that the health system was designed is no longer appropriate for the needs of its delivery. There were 40-something recommendations and along with those are some of the things we have been talking about today, including planning within hospitals to increase integration with primary and secondary care, increasing the flow through the hospital to try to improve the length of time that patients spend in hospital, increasing the focus on primary care and also on population health to try to prevent hospitals from becoming full, and talking about the skill mix of the workforce to increase generalism so that people are able to work across boundaries in a way they have not been able to do. We now have eight development sites that are piloting aspects of this. We are particularly interested in the chief registrar programme where we are training up medical registrars in leadership as well as management so that they work in the health service but also have an eye to developing their skills to try to change the system that they work in. That is a summary of what we are doing.

Q205 **Baroness Redfern:** Looking at health and social care in the next 15 to 20 years, what work is being done to progress real data sharing and having the confidence to do that?

Professor Jane Dacre: As people know, there has been a problem with the care.data initiative. However, within our college we are extremely supportive of developing data-sharing systems. We have a health informatics unit and today there is an announcement about a data-

sharing system that is going to be used at the Royal Free Hospital in Hampstead which we very much support. We think that data sharing is essential.

Lord Warner: The Five Year Forward View is only looking at service delivery models and money. Where do you see the workforce fitting into a longer-term planning approach? Who should be doing it?

Professor Jane Dacre: The profession has very clear views about what the problems with the workforce are and reported those to us in our document that we called *Underfunded, Underdoctored, Overstretched*. We have very good data about the morale and the numbers of the workforce. We would very much like to be involved in some longer-term discussions about the workforce and the way the workforce needs to change.

The Chairman: The Committee can help you here but we need some specific answers from you as to how we can help. The question that Lord Warner is asking is, who should be made responsible for the workforce? That does not just apply to the medical workforce, it is the whole health and social care workforce.

Professor Jane Dacre: There is already an organisation that is responsible for the medical and clinical workforce, which is Health Education England. Should that include the social care workforce? I am afraid I do not know.

Lord Warner: From all the evidence we have heard, no one is in charge of this issue. Health Education England does not have a long-term horizon. It is not clear how the workforce is synchronised with the service delivery changes and the funding changes that people want to see. We are asking for help. We want some ideas to come from the professions because if we do not get those ideas the risk is that people will do things to you that you do not particularly want.

Ian Eardley: The nature of your question suggests to me that you know the answer.

Lord Warner: I wish it were so.

Ian Eardley: Health Education England currently does it and expects the main funder to be the people who do the planning. The problem is that they are constrained by the short-termism that was alluded to in the previous question. They are constrained by short-term political expedience. There needs to be a longer-term view and the colleges are very happy to provide advice on that.

The Chairman: Would it be all right for us to say in our evidence that nobody has any idea, nobody is responsible and that includes the colleges?

Ian Eardley: No, We have a view.

The Chairman: That does not mean planning. Lots of people have views.

Professor Jane Dacre: I gave my view earlier when I said that we need a few more than are required for the service and we need to allow them the flexibility to thrive. My workforce plan would be to stop trying to plan the workforce because it does not work; it would be to say that if we had

enough doctors, if we had enough nurses, if we had enough physician associates, if we had enough social workers, if we had enough physiotherapists then we could get on with it and do it really well.

Lord Willis of Knaresborough: Could I try and help here, because that is my role on this Committee? It seems to me that Lord Warner is being extremely unfair. Health Education England, which has the task, also has a mandate to only do it short term. If it were given a longer-term mandate to say that its responsibility is to assist in the planning of the workforce until 2025 or 2030, would that be helpful?

Professor Dame Sue Bailey: I have to declare my conflict in that I am the senior advisor to Health Education England for mental health and learning disability. Having a mandate to look forward through a training cycle for 10 to 15 years would be extraordinary helpful. We have ideas about how to land that, and how the core to this is making everybody you train have more skills and adaptability and flexibility. The colleges would be very happy to work with HEE to deliver on that. This needs to be considered as being across health and social care.

Lord Kakkar: Does that mean that Health Education England should also take on the planning for the social care workforce?

Professor Dame Sue Bailey: I think this has to be seen across the board. I am in difficulty here because I am employed by one part of this organisation—but we are already doing that. I will give you the example of mental health. We are doing the skills training for people working in social care and learning disability. De facto we are already doing it.

The Chairman: But they do not have a statutory responsibility.

Professor Dame Sue Bailey: No.

Professor Jane Dacre: Whether it should be Health Education England or whether it should be a new, wonderful organisation is difficult. The long-term planning of health and social care should be hand in glove. We would agree on that—but who would do it from what we have available currently is difficult to say. Health Education England has trouble with its mandate because it is constrained, and it would need to change.

Lord Lipsey: With all this emphasis on planning it sounds to me as if we are moving to a Gosplan economy in the height of the Soviet Union. Nobody has mentioned what is the primary motivator of the workforce, which is pay and morale. Pay is constrained appallingly by low budgets in social care; hospital trusts cannot pay people what they think they are worth and where they think more pay is needed. Should we not ask for more flexibility on pay as well as asking for a measure of planning?

Professor Jane Dacre: The better answer is with morale and people feeling they are worthwhile and are doing a job that is worthwhile. I spent many hours in dialogue with the junior doctors over the last 12 months. They may have had the dispute over pay, but that was not what was underlying that. That is the real change that is needed.

Q206 **Baroness Blackstone:** What is your key single suggestion for change that this Committee ought to recommend to support the long-term sustainability of the NHS? One sentence each.

Professor Dame Sue Bailey: We have to move from an illness model to a wellness model, get on with prevention, start early in schools and support social care. I live in Devo Manc and we have been given the opportunity to try and deliver on that.

Ian Eardley: I think this relates to the issue we have just been discussing, which is to take a longer-term view on workforce planning with a potentially increased role for a non-medical workforce to provide medical and social care.

Professor Jane Dacre: And we need realistic aspirations with a workforce where there are enough of them and they are capable of delivering it.

The Chairman: Do you think there is a cohesiveness in thinking amongst all the medical royal colleges and their faculties or do you think they think in silos?

Professor Jane Dacre: It depends how much you divide up what we are talking about. Sue would be in a very good place because she is the chair of the Academy of Medical Royal Colleges.

The Chairman: I am sure you have looked at all the evidence that has been sent to us. Does it surprise you that there is so much diversion in the responses?

Professor Dame Sue Bailey: There will be diversion because they are focusing on different areas. I would have to say, as chair of the academy, that there is a core common purpose and we have a way forward if we can focus down on it. We will not always agree on everything, but no family ever does.

Professor Jane Dacre: I agree with Sue that we share a core set of common values. But, as you look into the detail, because I am a physician and Ian is a surgeon and Sue is a psychiatrist, that detail is a little different.

The Chairman: Do all the colleges of physicians agree on the training modules?

Professor Jane Dacre: We have the same broad outline, yes. We have been working towards it for the last three years and we have achieved diagram stability.

The Chairman: Thank you all very much for coming today; we appreciate it very much. As I said, you will get a transcript of this session. If there are any inaccuracies, please let us know—and if there is any extra material that you think is pertinent to the questions asked, please feel free to send it to us. Thank you.

Royal College of General Practitioners, Royal College of Nursing and Royal College of Midwives – Oral evidence (QQ 207-215)

Evidence Session No. 21

Heard in Public

Questions 207 - 215

Tuesday 22 November 2016

11.05 am

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Dr Helen Stokes-Lampard, Chair, Royal College of General Practitioners; Janet Davies, Chief Executive & General Secretary, Royal College of Nursing; and Professor Cathy Warwick, Chief Executive, Royal College of Midwives.

Q207 The Chairman: Can I welcome our next witnesses? Thank you for coming to help us with this inquiry. I will repeat what I said. You are now in the privileged position that you have heard some of the previous session, so that will pre-arm you. We are on broadcast and, to start with, if each one of you would introduce yourselves and who you represent, and if you want to make an opening statement feel free to do so. Can I, before I start, first of all welcome all of you, but particularly Professor Helen Stokes-Lampard as the new chairman of the council of the Royal College of General Practitioners? I declare an interest: I am a fellow of your college. I was trained by many midwives, and I will declare that interest too, Professor Warwick. Can I start with you?

Professor Cathy Warwick: Thank you. My name is Professor Cathy Warwick and I am the chief executive of the Royal College of Midwives. I would like to say that I speak on behalf of midwives but I also very much collaborate with other members of the professions who deliver maternity care, and I am very focused on the needs of women.

The Chairman: Not only when you choose to do so but all the time.

Professor Cathy Warwick: Yes, and I would like to welcome the opportunity to speak to this Committee and to welcome an inquiry that is focusing on the long term rather than the short term.

Janet Davies: I am Janet Davies. I am the chief executive and general secretary of the Royal College of Nursing. We have 450,000 members from all specialties of nursing, including healthcare assistants. One of our

big concerns, and where we think we need to move to, is far more integration for sustainability and less working in segmented silos, so as to see the full picture of health around the individual. That would obviously lead to workforce planning that met that need, rather than the current model.

Dr Helen Stokes-Lampard: I am Professor Helen Stokes-Lampard. I am a GP in Lichfield in Staffordshire. That is my first and foremost role. I am the relatively newly-elected chair of the Royal College of GPs and I am chair of general practice at Birmingham Medical School. Like my colleagues, I am very grateful to be here to discuss the long-term future of our NHS because I, my college, and I know the other colleges believe passionately that the NHS is sustainable in the long term. It can be done but we all have to work together to make it so. I am delighted to hear that health and social care are being considered together because, from our point of view, this is absolutely integral. As general practitioners, our job is whole-person care, not merely the physical disease elements of care.

My opening pitch to you is that general practice and the whole of primary care underpins the entire NHS, and the NHS can only be sustainable if general practice is sustainable and thriving, and if we have the workforce and resource to do that. If we can do that well, we can allow secondary care to thrive and survive too. Thank you.

Q208 **The Chairman:** My question is: what do you think future sustainable healthcare in 2030 and beyond will look like, and can you also say what we should prioritise now, and begin to prioritise in a timeline that will get us there?

Professor Cathy Warwick: We certainly think there should be far more integration of health care and social care, with local government being brought into the picture, and the aim of that integration would be to have far more focus on population groups, their needs, and public health in particular. It would be our view that most of the issues that end up using a huge amount of resource in my area, maternity services, could be prevented by a stronger focus on the social needs of women and on population groups. We tend to focus very strongly on clinical outcomes as opposed to developing services which meet the social needs of women. Long term, we would pull things round to be delivered far more locally, in a far more integrated fashion. We would have far more children's centres, for example, and far more community hubs where people could get together, work together collaboratively and focus on prevention.

The Chairman: What does that mean in practical terms? What do we have to do and who is to do it?

Professor Cathy Warwick: In practical terms, I think the "Better Births" maternity review, which has relatively recently been published in England, describes a model where care starts in the community, where the women are, as opposed to women having to come into the acute services. We have to make sure that there are facilities. That does not mean building a lot of new facilities; it means using the services that already exist, such as big GP centres, small midwifery units, the children's centres that are left—they have been decimated, but the ones that are left—bringing

professionals together to work in those services, bringing professionals out of the hospital system to work in those local services, and only referring women into the acute services when that is necessary.

What is needed to make that happen I believe is some interim funding. The difficulty at the moment is that we have a model that is the total opposite of what I am proposing, and to get from where we are now into the future we have to fund the transition. It will not happen in a situation where everyone is run ragged and carries on doing the same old same old. Ultimately, I think we could pull costs out of the system by a far more community-based, public health-oriented approach.

Janet Davies: I guess there is quite a lot of consensus between ourselves and the midwives. There is something about seeing the whole of being healthy as opposed to the segments when we may be unwell. That means working with health and social care, local authority and healthcare so as to look further into the future. We will not see the benefit of investment in community nursing, health visitors, and school nursing for quite a number of years. That is where we fall down at the moment, because as long as we are looking at the short term we do not invest in long-term health. There is also something about maintaining people well, keeping people well, and that should be in the community and closer to home. There is definitely a need—I agree with Cathy—to move away from everything focusing on that acute crisis episode and focusing our attention on the whole person. That means working less in silos.

At the moment some really contradictory things are happening. There is a hospital somewhere with real problems with their A&E, they cannot get people out into the community, people are coming in because there is no community support, and we can see that in that particular area they are cutting the number of district nurses because of the budget. It does not make any sense because each of the budgets is in a very separate area, some with local authorities, some within the CCGs, some come in different ways, and as long as we are working in that way, we cannot see that trajectory that will take us to 15, 20 and I would say probably 50 years' time, when the children who are being born now will be starting to clog up our A&Es with their coronary heart disease.

Dr Helen Stokes-Lampard: Thank you. I have a lot of affinity with my colleagues, so I will not repeat what they have said, other than that I have not disagreed with anything they have said. To be clear, I fully support the integration of health and social care, the whole spectrum.

Multimorbidity, that is the multiple long-term conditions that people have, is increasing exponentially. By 2030, which we are talking about, there will be at least another 1 million people added to the list of those with multiple chronic conditions that need managing, supporting, and treating, recognising that, with an ageing population—and our ageing population is a huge success of our health and social care so far; let us not make any mistake about it—the inevitable consequence is an increasing burden on the NHS and on social care. As the burden increases, you will need that joined-up thinking across the community, and I think we need to embrace a wider range of healthcare professionals providing that. It should not just be the specialists we have here today, but the whole range of professionals, supporting us to enable us to do our jobs effectively and

efficiently, so that people are seeing the most cost-effective person to help them with their needs; those people helping to navigate all the resources that are already there but are not joined up; the IT to underpin it, so that we can all communicate with each other; and the right care for the right person in the right place for them, which is likely to be closer to home where possible.

The Chairman: You are all making a case for more of the care, including social care in the community, to be delivered by health professionals who work in the community, and the scenario is a centre where there is midwifery care, physiotherapists, general practitioners, optometrists and any other health professionals?

Dr Helen Stokes-Lampard: Yes.

The Chairman: How can this happen? Who is responsible? Who runs the show?

Dr Helen Stokes-Lampard: I would argue that community-based services are probably best led locally by the expert medical generalists, the GPs, who can see the various things that need to happen.

The Chairman: It is the GP who co-ordinates the whole thing, decides how many of each staff you need, et cetera. Would the others agree with that?

Professor Cathy Warwick: I do not really mind who leads it. It is a question of how you lead, is it not? Anyone can be in charge, but I think there has to be a method of leadership out there which acknowledges and respects the different roles of everyone involved, and which manages the system through some degree of consensus. That is the leadership model that tends to work. At the moment, particularly within our acute health services, we still have an incredibly bureaucratic, managerial system of leadership, and that demoralises professionals, it does not get the best out of your local workforce, and I think we have evidence that when people work in systems where they feel ownership of the people they are looking after, or they can build relationships with them and they can feel responsibility for the outcomes, we get better care. The leadership model needs to be inclusive and respectful.

The Chairman: Helen, does the current contractual model of GP allow this to happen?

Dr Helen Stokes-Lampard: Yes, it does to a certain extent, and there are lots of really innovative ways of working that are happening. We have some fantastic examples of integrated care across the UK, but they have tended to be born out of crisis, where people have been forced to work in new ways. Of course, anything born out of crisis might be creative and innovative, but that is hard to roll out across the UK, so what we are trying to do is share good practice.

The Chairman: The question is about whether the current contractual model of GPs allows this to happen.

Dr Helen Stokes-Lampard: Yes, it does. There is a surprising amount of flexibility within it. We would argue for a change in the future, yes, of

course, but we can do a huge amount with what we have. I would not want to be bogged down with contractual change at this point.

The Chairman: You have obviously excited quite a few of the Committee members—Lord Kakkar, Lord Willis, Lord Turnbull, Baroness Redfern.

Q209 **Lord Kakkar:** If I may pick up on this emphasis on local delivery and localism, are you therefore suggesting that we should move away from a nationally driven strategy for healthcare and have it more locally driven, with accountability through local government, and mobilisation of resources at a local level, with a population capitation vote for the funding for each locality?

Professor Cathy Warwick: Personally, I believe it should be a mixture. I feel in my own career, in maternity services in a lot of different roles, I have seen a very centralist kind of approach under certain governments, and I have seen a shift to an approach where it is much more down to local need. I think a mixture is needed. There are some issues that need quite strong national direction. For example, we have national direction at the moment in maternity services, saying that we must reduce our stillbirth rates, and that is absolutely right. On the other hand, I think there will be local issues. For example, there are some areas where women who are asylum seekers and refugees have particularly poor outcomes and may need a particular focus. Personally, I think it is a balance between some kind of national framework and some absolutely must-do national targets, if you want to use that word, but with some flexibility locally to build a score system around perhaps 10 key targets—a mix.

Lord Kakkar: Do you think there should be sufficient flexibility to allow an individual health economy to deliver healthcare, accepting there are certain standards to be met and delivered, as it wishes to do, not constrained by excessive national regulation or a nationally defined structure for the delivery of healthcare?

Professor Cathy Warwick: I certainly think the national structure should be light touch in both the framework and the regulation and, yes, there should be a lot of local autonomy in the practicality of how it organises that.

Janet Davies: There is also something about what is enabling and what is delivery, and that central function should be to enable good health and social care to be delivered, by the funding, probably by the policies, by the good use of the evidence, by probably commissioning research and evidence, but the delivery is very much focused on individuals, which are local. It will be fascinating to see what happens in Devo Manc, because they are attempting to do that. However, they are still attempting to do it in a very bureaucratic diverse situation. They still have the CQC coming in and doing all the inspections. We should really move to care built on evidence and around those population needs.

Lord Willis of Knaresborough: I was fascinated, Helen, when you made your remarks, that you automatically assumed that it would be GP-led primary care or community care, and I would like to challenge that, and challenge your college's view of that. Last night Janet and I were at an

event, and we heard the most remarkable exposé of a nurse-led GP surgery in Ealing, the Cuckoo Lane Surgery, led by two inspirational nurses, which is one of only 3% of GP surgeries that have an excellent CQC rating. Is that not the way to go forward: not in fact to keep to the rigid silos that we currently have but to look for new ways of delivering inspirational care, simply by inspirational people?

Dr Helen Stokes-Lampard: I really like the challenge. I was answering a very specific question about delivering primary care services locally from the point we are now, looking at 2030. To achieve change takes a lot of time. I love leadership that is the right leadership for the right environment. What we currently have is primary care leadership that is generally primary care focused, and general practitioners have embraced that and are generally very well-connected and equipped to provide that. I would not suggest for a moment that is the only way of doing it, and doing it well. Certainly, in my own locality we have some nurse partners in local practices who do an admirable job. I want to be clear about this. This is not a protectionist view at all. This is a pragmatic view. The reason we use the GPs as likely leaders in the community is because they are the generalists, the ones with the widest ranging view. We are the ones with the mandate to look at the whole person, the physical, social and psychological care. It is a very good starting point. That would be my riposte to the challenge.

Lord Willis of Knaresborough: The Chairman asked about the contractual arrangements, and to bid for a contract for primary care is exceptionally difficult unless you are a doctor, a medic.

Dr Helen Stokes-Lampard: You can be a partner without being a doctor.

Lord Willis of Knaresborough: No, but you can lead that without being a medic; you do not have to be a medic.

Dr Helen Stokes-Lampard: Yes, there are quite a lot of contracts that are not being won by GPs; they are being won privately.

Lord Willis of Knaresborough: I wonder whether you welcome that.

Professor Helen Stokes-Lampard: What I welcome is necessary and pragmatic solutions for the difficult problems we face. We all have to be realistic about what the future holds, and, whilst personally I love the partnership-led model of general practice, I know it is not likely to be fit for the long-term future and that we have to have local solutions for local problems.

Coming back to the other challenges that have been mentioned, about whether there should be top-down or bottom-up approaches, we definitely need a combination, because you have to have some high-level aims and standards that we all aspire to, but we are such a diverse nation that it is completely unthinkable that what will work for inner-city London or Birmingham would be the right solution for remote Lancashire. There might be half a dozen models that will work, but we have to embrace all that, and we have to have the flexibility, and that flexibility will allow for leadership, which may come from primary care, secondary care, nursing, midwifery, or psychiatry. I do not mind where the leadership comes from.

We should not dictate it, but there are some obvious sensible starting points that we should embrace and work with. There is a lot of enthusiasm and passion that is there to be tapped.

Q210 Lord Turnberg: I enjoyed hearing about your aspirations, which I think are excellent. The question is how we get there. Last night I met a young doctor who was working in the accident and emergency department at the Royal Free Hospital. He said they had to stay on duty for 10 hours to deal with the load overnight. They could not get through them all. I asked him how many of them should have been seen in A&E, and he said 90% should have been seen outside by their GPs. We have a situation in which we have a mountain to climb to get to the aspiration you describe. How do we get there?

Dr Helen Stokes-Lampard: Workforce is an obvious one. You touched on workforce earlier. Workforce is a serious problem at the moment, not just the number of general practitioners but the entire myriad of practitioners in the community. We have a massive problem with mental health care workers, and under-provision of mental health care services across the board. There is nursing, district nursing, and all manner of services, but there are a lot of social care services which are necessary. Yesterday in my consulting room I saw several patients who needed a social worker, a care navigator to act as a charity service, a counsellor—they did not need the skills I could offer them as an expert medical generalist, but I was the only person they could turn to. I was the only person who did not have a “We are full” sign at the door, so they came in because we would see them when there was no one else for them. That is the harsh reality of it but, as we fall over and my colleagues’ surgeries close, the push inevitably goes to secondary care, which does not help anybody.

Lord Turnberg: There are not enough GPs?

Dr Helen Stokes-Lampard: Not enough GPs, not enough community nurses, and not enough physician associates, the whole spectrum. Unfortunately, it is a big problem. There are a lot of things we could do about it, there are a lot of things being done about it, and the General Practice Forward View in parallel with the Five-Year Forward View has some excellent aspirations. We need to make them happen—not that I am impatient or anything.

Baroness Redfern: Very quickly on that point, if I may: do you think there should be closer working relationships with the local authorities and their social workers?

Dr Helen Stokes-Lampard: Definitely.

Baroness Redfern: In my area we have community hubs, and it is about helping to keep people in their own home for much longer, and keeping them well, because we want well people living longer.

Dr Helen Stokes-Lampard: Yes.

Baroness Redfern: So you think there is more emphasis on that approach and therefore helping the acute sector, and that more budget should be spent on health and social care and less on the acute sector?

Dr Helen Stokes-Lampard: I do.

Baroness Redfern: Sorry to put you on the spot.

Professor Helen Stokes-Lampard: No, I think primary and secondary care have to accept that if social care is not in the best place, the rest of us cannot do our jobs either, so, yes, inevitably it has to come back to health and social care, and a slight shift there. Much as I would not want to argue for less resource anywhere, the reality is if our health and social care is not right it is making general practice crack, and it is making secondary care crack.

The Chairman: Are you advocating shifting of funds?

Dr Helen Stokes-Lampard: That is the decision you guys have to make but I would say it is probably the inevitable consequence, yes.

Baroness Redfern: Mental health issues come into that, so that is all in that role as well.

Dr Helen Stokes-Lampard: Yes.

Janet Davies: We have nurses working across the two, and we have nurses working in social care, because obviously local authorities employ nurses, and there is a real issue of that gap between health and social care, being able to see the person as a whole. It is either duplication of care, which is a terrible waste, or no care at all, and there is something about seeing the population as a whole and their needs, whether it be health or social care, and which is health and which is social care is so difficult to define, particularly when you are talking about nursing. It is a really false divide. Some people get funding, some people do not, and that is the sort of thing that has to be tackled. Of course, when that falls down, that is when people have nowhere else to go but to an A&E department, which is the very worst place for someone with mental health problems, long-term conditions or frailty, because it makes them worse.

Q211 **Lord Warner:** We might go on to the issue of primary care, but can I bring us back to the day-to-day reality of managing services? At the moment, in hospitals you have a system where you have a hospital board which can exercise governance arrangements, good or bad, in relation to its job. There is a local authority which can do the same thing. In the middle of all this you have a rather strange business partnership called primary care, which may or may not have attached to it nurses and all these other people. I think this is a question for all of you: if you all want to have these services run from the community, how do we get from where we are, with this partnership model of primary care, into a robust governance model for managing these services? It is not just about the GPs; it is also about community nurses. Nurses like having contracts of employment with hospitals; we do not see many of them wanting contracts of employment to work in the community. The number of community nurses growing is not very good.

Janet Davies: We know the reason for that.

Lord Warner: Can we deal with the governance issue? How do we make robust governance for primary care that would work?

Janet Davies: I think we have clinical commissioning groups as well, which were meant to do just this.

Lord Warner: They are commissioners, not providers.

Janet Davies: They are commissioners but they determine what the landscape will look like by what they commission. Community services are now almost entirely governed by the contract placed by the CCGs, so there will be a contract specification, which the CCGs will put together, which then goes out for tender, and then people put in a tender for that service. It has totally changed the way community services are working at the moment.

We have talked to district nurses whose badges have changed three or four times in the period of the last six or seven years because the contracts are changing. It is the CCGs who are currently determining what that will look like, and they will work with the local authorities, but at the moment it is not working well because the majority are going for lowest cost, the lowest price, which does not necessarily meet those needs. Things fall through the gap, and that is what I was saying before: is it social care, is it healthcare? There are certain things in the middle that are then forgotten about or left because nobody wants to take responsibility. There is something about the model that has been determined to do this, but is it working or not? Is setting those contracts the right way of doing it, or do we need to look much more at population health? They also, of course, commission hospital services. If that was to work well it would be that local model, but we are still left with these silos, and I do not know why those CCGs have not managed to get it to that next stage. It was obviously the intention of them in the first place.

Lord Warner: You are agreeing with me that it is not working?

Janet Davies: It is not working.

Lord Warner: What I am trying to get at is the model that would work.

Professor Cathy Warwick: Talking of maternity services, we have certainly agonised over this for a long time, and come up with the concept that there has to be what we are now calling a local maternity system, on which everybody with any responsibility for providing high-quality maternity services sits. I do not see why that kind of model cannot translate into the wider health service so it is a far more collaborative, non-competitive kind of model. Commissioners sit together with providers from each bit of the system—social care, local government, healthcare—and work out what the local population needs. I think the question is what size this governance system should be—the right population numbers to go into this system. Effectively, we need to move away from what has been a very competitive model to a collaborative model.

Dr Helen Stokes-Lampard: Can I pick up on the point about nurses and contracts in primary care? I am a little dismayed by that, and it is not something I recognise. Nurses who are employed by general practices have a very robust contract. They are in the NHS pension scheme, on similar, almost identical terms and conditions generally to the NHS. It is not something I really recognise. We can provide a very interesting and stimulating career structure for nurses, and we know a lot of nurses who

find the shift working patterns in secondary care very restrictive—who, particularly when they have childcare or carer responsibilities, shift to primary care and have extremely rewarding and vibrant careers. I would be horrified if people were not contemplating primary care nursing as an option because of contractual issues. That would be very unhelpful.

Janet Davies: Community nursing numbers have dropped by 14% since 2010, which is atrocious, and that is because the funding has not been there and there have been no training places. There are lots of nurses who want to go into community nursing who are unable to do so. The budget for next year for continuing development for nursing staff is being cut by 50%, so it looks as if there will not be much opportunity with that either. We have to take seriously investment in the education of nurses for the community, including their placements during their education, but we also need to make sure that we have those posts there. This is a product really of the constant look at the cost of community nursing, the cost of the contracts, and cutting those numbers. That is a very large number. We are cutting the number of school nurses, when we did not have enough anyway, by 13%.

Lord Warner: Can I stop you a minute?

Janet Davies: That is what is causing it.

Lord Warner: We keep deviating away from the issue. The issue is how you construct a community system which is robust enough to run these integrated services that we all want to see, and sustain it against the forces of putting more and more money proportionally into acute hospitals. You are all saying that clinical commissioning groups cannot deliver this. That is what you are saying.

Dr Helen Stokes-Lampard: I would strongly advise against another wholesale restructure. That would not be helpful to anybody. I think we need to work with what we have. We have CCGs; they are still forming—unfortunately, new bodies take a long time and some of them are still forming at this stage. However, they are doing their best. The reality is that they are in a very resource-constrained environment and are struggling. If they were resourced and supported, they could do a far better job, and I think that would be embraced. The STPs, however, have to be the way forward. We have the STPs, which are aiming to look to the medium to long-term future but, again, they are being distracted by shoring up the acute sector deficit, which is a real distraction from what they really need to be doing, which is fulfilling the aims of planning for the future. We need to accept the situation that when you have cut away all the fat in any system, all you can cut is the meat, and when the meat goes, the system is weaker. That is unfortunately underpinning a lot of these challenges.

Baroness Redfern: I think many countries are moving away from the bureaucratic system that we have. Listening to Lord Warner, we appear to have too many CCGs with small populations so they do not have the flexibility. We have STPs that are not coterminous with local authorities. CCGs are following their contracts and therefore want staff to fulfil those contracts. I think they are being hampered to a great extent and I wondered what you thought about that.

The Chairman: Lord Bradley, did you want to come in?

Lord Bradley: Yes. Helen mentioned that the drivers for the change that is expected, picking up Lord Turnberg's point, are the STPs. Have you, from your different perspectives, been involved in the development of those STPs? How much of that input has been about transformation rather than sustainability?

Dr Helen Stokes-Lampard: Yes, we have very much tried to be involved in the STPs. The Royal College of General Practitioners has invested members' money in producing an ambassador for every STP, to help the STPs understand the whole context and to provide a channel of communication of information, because we recognise the vital importance of the role they play in the future landscape. We want to help them to get it right because it is in all our interests for them to do so. Yes, we have been there, and what we have seen is a huge variety of engagement, certainly with primary care and secondary care. We have seen a huge variety in the involvement of local government and social care. Some of them seem to be getting the wholesale picture and embracing that, and seeing this as a phenomenal opportunity, which we welcome. Others seem to be so focused on solving the acute sector deficits that they were inheriting that they are completely blinkered and unable to see beyond that. That is a tragedy, and we are trying to help them where we can, and if there is anything we can do further to help we will do it, because we know we have to support the only horse in this race.

Q212 **Lord Willis of Knaresborough:** I think this whole issue of governance is clearly of fundamental importance to move forward in the long term. My particular interest on this Committee—and I declare an interest as an honorary fellow of the RCN, which I have done before—is in the workforce and the skills mix. It seems to me that, looking forward now, not resolving today's problems, we cannot have the same silos of workforce in 10 or 15 years that we have today. I wonder if each of you could say what workforce issues you think are the greatest threat to us transforming the NHS and social care system moving forward, what changes you think need to happen, and in particular could you address this fundamental issue of how on earth we retain the staff already in the NHS so they continue to work a full career rather than bailing out at very short notice?

Professor Cathy Warwick: From my point of view, the greatest threat to maternity services is not having enough midwives. We now know from global research that if you are going to maintain the health and well-being of women and babies, they need midwifery input, and that is best delivered by midwives. It is not protectionism. The fact is that investing in midwives leads to higher-quality care.

However, I would add that those midwives need to be well supported by highly qualified, well-trained, competent maternity support workers, and we need to focus on that workforce as well and help them reach the required standard. We also need to ensure that our maternity services have sufficient clerical support. Midwives are currently spending up to 50% of their time doing non-clinical duties, and that is absolutely

shocking. I think the greatest threat to high-quality care is lack of midwives.

Lord Willis of Knaresborough: Can I stop you there, Cathy? You are describing more of the same silo, and that is what worries me, in that when I look at midwives and the interface they have with some of the poorest as well as the wealthiest communities, every community in Britain is interfaced with a midwife, yet you are describing a very narrow role for them. I want you to look beyond that to ask: what are the midwives of the future going to do?

Professor Cathy Warwick: They are going to be doing public health.

Lord Willis of Knaresborough: They could not even look after my daughter when she was ill.

Professor Cathy Warwick: I do not know what was wrong with her.

Lord Willis of Knaresborough: I am not going to tell you because it is very personal.

Professor Cathy Warwick: The bottom line is, I guess, that midwives need to work collaboratively with loads of other people: they need to work with smoking cessation co-ordinators, they need to work in public health, and they need to work with mental health specialists. I am not saying they should not work collaboratively, and they certainly should fulfil all aspects of the role, but if they are going to do that you need to have enough of them.

The Chairman: That is still, as Lord Willis is saying, silo thinking. I appreciate the importance of midwives. Why would I not? I totally appreciate them, but the question is how you take midwives, and anybody else working in the community and primary care, to think about the totality of the service.

Professor Cathy Warwick: I think what I am saying is that midwives would be looking at the totality of the service. We have done a very big project in the Royal College of Midwives looking at the role of midwives in public health, and there is a huge amount of work we have described that midwives should be doing—not on their own though; they need to work with specialists in this area. They need to work collaboratively with GPs, for example.

The Chairman: Maybe even with obstetricians.

Professor Cathy Warwick: You know we work with obstetricians all the time. No, I am not saying midwives do not work with other people, but I am saying it is incredibly important that you have enough midwives to carry out the full extent of their role.

Janet Davies: There is something as well about how we plan for our workforce. At the moment we plan it in a poor way. We should be looking at health needs and the demand on health services, and what we currently do is think how many people we want and then how much we can afford, which is why we are in the state we are in, I believe. We need a smarter way of looking at it—not necessarily in silos, I would hate to see that, but there are certain numbers of doctors and nurses we need as a basis before we start looking at probably some sort of way of moving

between disciplines and working at the top of people's ability. There is something about population need and population health and we should be a bit more radical with how we plan our workforce.

We know some countries look at their population, so you will have so many doctors per head of population, which gives you much more flexibility than how many nurses you need for this hospital and how many doctors you need for this surgery. As we move into the future we would perhaps have a bit more ability.

I do not think we are in such a bad place as it might seem. I think we have moved amazingly. Last night we saw a nurse managing a practice and employing GPs in a surgery which is giving excellent care. One of the things the college has done is to have emergency care practitioners: it does not matter whether they are a nurse, doctor or paramedic; they have exactly the same competencies and the same postgraduate training programme to fulfil that need. That is quite revolutionary. We have co-badged it. That is moving away from silos, but we need to make sure that is what we look at. I worry about some of the assistant and associate roles if they end up being stuck, so whatever associate roles we build, I think it needs to be across professions, not building yet more silos, all with different associates.

There is a bit of a push, I know, from one of your colleagues in the Lords to stop calling them nurse associates but to call them associates, so they can move across and cover that rather than have yet more silos. They need somewhere to go at the end of it—so keeping our current workforce, giving them lots of continuing professional development, which we know is what people like most, and enabling them to develop their practice. All these new roles that are created need to have somewhere to go. Talking to some of the physician associates—which is of course not our topic—they have nowhere to go at the end of it. A career for young people now is 20 or 30 years of not necessarily doing the same thing. We need to build that flexibility in.

Q213 Baroness Redfern: We have heard evidence on the significant and unwarranted levels of variation in both care and outcomes which persist across the country. Why do you think such little progress has been made in tackling variations? What do you think of the role of technology in tackling those variations in health, and why has there not been a greater uptake in the use of technology in the NHS to date?

Professor Helen Stokes-Lampard: The inverse care law applied many decades ago, and still applies today, in that the health of populations is least well served by those who most need it. I think we have all established that. There have been huge advances in improving variation in care in the Quality and Outcomes Framework in general practice, which brought national standards, which brought the level up, so that at the very least care that was happening was being measured in a way that had never been done before, starting in 2004. We know that there is a correlation between the number of healthcare professionals per head of population and the standard of care received. There is a 20% variation throughout the UK, and the Centre for Workforce Intelligence has shown a 20% variation in the number of GPs per head of population in the most

deprived parts of the country and the most affluent parts of the country, so there are things that we can identify.

Baroness Redfern: There is a shortage of GPs in certain areas.

Dr Helen Stokes-Lampard: Absolutely, in the areas that need them most, the most deprived areas generally.

Variation in provision of care is matched by variation in demand. We can identify the problems; we can see where there is clinical quality. We have heard about the CQC earlier and have mentioned the Quality and Outcomes Framework, which have helped. However, looking to the future, it is back to the integration of health and social care, and recognising that the needs of local populations will be served by local solutions and flexibility in delivering that care.

Janet's point about numbers of clinicians per head of population is helpful. The King's Fund and Nuffield have done a lot of work internationally looking at this, which provides a sensible basis to go forward. The problem we have is that we are not even meeting the minimum level starting point. We need a minimum starting point and creativity in the ways we work together. Yes, definitely, let us get out of our silos; I think we are all keen to embrace that and move forward. There is a lot of passion for this out there, but somebody needs to let the reins go, and unfortunately it needs a big cash and resource injection to get it started. That is the hardest problem in the current climate.

May I say something about IT, information technology? We desperately need to embrace technology. Healthcare professionals love technology generally; it is just getting standardised, joined-up systems that we can use across the board. We want to be able to communicate with each other efficiently and effectively. It needs resource to do that, because IT will help us enormously with our jobs. When I hear that midwives are spending 50% of their time on admin tasks, we know that if we had better IT systems that could be reduced massively. Certainly it is true in primary care and certainly it is true through secondary care. Massive investment in IT would be helpful but it has to be designed with the patient at the heart of it. The problem is it is sometimes designed by somebody who has a novel idea in a silo. There has to be a cross-system approach to it. That is a very bold, radical move, starting with IT from the patient working backwards, not from the computer, the database, working forward.

Janet Davies: The other thing with IT is that it is often seen as a project, and it is not a project; it does not start and finish; it needs to be a level of investment that continues, because we are developing IT systems all the time. Having a whole segment of the budget for IT, as most big companies do, is essential for healthcare.

Professor Cathy Warwick: The only other thing I would add on variation—I agree with everything that has been said—is that there is some really good evidence emerging now around clinical variation and the disparity of outcomes. It links back to Lord Willis's question about morale and how we keep people in work. There is no time in the current system for groups of clinicians to get together and address some of these really good pieces of information that are emerging. Somehow or other in the

future we have to rebuild into the workforce time for clinicians of all varieties to get together and talk about how we improve care. I am not sure how we do that, but the first step would be to at least acknowledge that unless teams can work together and talk about outcomes it will never change. That is what I would plead for as we try to eliminate variation.

Q214 **Bishop of Carlisle:** Can I return to the purpose of this Committee, and the theme that has lain beneath our discussion so far? I think all of you in your answers have helpfully suggested that long-term planning is tremendously important, and you will have heard us ask previous witnesses who they thought should be responsible for that long-term planning, given that most of it does not seem to be happening at the moment. Can I ask what your answer to that would be? Who should take charge of long-term planning, including integration with social care, numbers and skill base of workforce, and all the other things we have been talking about?

Janet Davies: I think the knack is to focus away from delivery. I think as long as we look at delivery it becomes very confusing. Really, there is something about the funding and the sustainability and looking at what might happen in 20 or 30 years which is very problematic when it is a service that is so politically driven, because obviously those effects are not going to be felt till about three, four or five parliaments later, but there needs to be some sort of central oversight with health and social care. Whether that is bringing health and social care together at government level, with a stronger Department of Health which can deal with the population needs, or whether we need something different, it cannot be the NHS as such, because not all care is provided in the NHS, and that is why we have that provider model. For instance, in the Royal College of Nursing a third of our members do not work in the NHS; they work in the independent sector, they work in charitable sectors, and they work in social care, and that is the way we need to see our population's health. By putting it into these segments we are missing a whole raft of services that are provided for people which might make the biggest difference. In the current system there is nowhere obvious it would sit.

Bishop of Carlisle: Do you think the NHS should therefore be redefined in some way?

Dr Helen Stokes-Lampard: I do not think the NHS needs to be redefined, and we certainly do not need to shake it up, but I agree we need a department for health and social care that is all-embracing and recognises the intimate relationship between health, social care and public health. Having them split up is destructive and wasteful, I would suggest. Within that—so that is the top end—at the bottom end, at the patient-facing end, we need services that are responsive to what patients need, delivered close to home, in efficient ways, with teams of multiple healthcare professionals and other professionals working together to deliver patient-centred care. Collaborative care planning would be the patient-facing end of it, and I am sure there is a way to get through that, but it will be a very courageous step to bring it together at the top end.

Bishop of Carlisle: That is very helpful. Would the department for health and social care be the department responsible for doing this long-term

planning, do you think?

Dr Helen Stokes-Lampard: I would have thought so.

Q215 **Baroness Blackstone:** What is your single key suggestion for change that the Committee ought to recommend to support the long-term sustainability of the NHS?

Professor Cathy Warwick: I think looking at the workforce is absolutely critical. Modelling the future workforce need on the care provision we want really has to happen, so we have to work out how we get a workforce that can deliver care in the community and take responsibility for that. Within that, I think I would say we need far less constraints around the workforce; we need to enable our workforce to work in far more innovative, enterprising sorts of ways. At the moment the regulatory and government structures make that incredibly difficult.

Baroness Blackstone: What you are suggesting is less regulation and less attempt to use bureaucracies to enforce particular ways of operating.

Professor Cathy Warwick: Absolutely. We need a framework which is much looser and allows grass-roots innovation, the kinds of initiatives that Janet has already described in nursing, to flourish.

Janet Davies: If it is one thing, for me it would be more investment into community services, and getting rid of those barriers between health and social care, focusing on that person and having that system looking at that.

Baroness Blackstone: Does that mean that local authorities might be the best people to run these services?

Janet Davies: They may be—I would not know—but I think there has to be some overall organisation, which is combined in some way, whether that is health coming into local authorities, local authorities coming into health or taking the health elements, I do not know, but whichever way you look at it, a person's health is very much what happens to them in their life and their community. Local authorities have a lot more effect on that in public health, housing, and the conditions that people live in, which need to be seen together, as they were originally, when we established the NHS.

Dr Helen Stokes-Lampard: Building on what both my colleagues have said, without primary care thriving, without the community sector thriving, the NHS cannot survive. Therefore, my plea to you would be to ensure that the promises given in the GP Forward View and the Five-Year Forward View are delivered on so that the workforce in the primary care sector, the whole workforce—I am not just talking about GPs; I am talking about the whole primary care workforce—is built so that the primary care sector is sustainable for the future, particularly the mental health care side of things, which we have not spent much time on today but it is a serious concern, and I think you will get a lot of buy-in from the profession if that happens.

The Chairman: Thank you very much indeed. If any of you have further material to submit—you might even disagree with some of the responses you heard from your fellow witnesses—feel free to do so. You will get a

Royal College of General Practitioners, Royal College of Nursing and Royal College of Midwives – Oral evidence (QQ 207-215)

transcript to look at. Thank you for coming today.

Chartered Society of Physiotherapy, Royal College of Radiologists and English Pharmacy Board – Oral evidence (QQ 216-223)

Evidence Session No. 22

Heard in Public

Questions 216 - 223

Tuesday 22 November 2016

[Watch the meeting](#)

Members present: Lord Patel (The Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

I: Natalie Beswetherick, Chartered Society of Physiotherapy; Dr Nicola Strickland, President, Royal College of Radiologists; and Sandra Gidley, Chair, English Pharmacy Board.

Q216 The Chairman: Good morning. Thank you very much for coming today to assist us with this inquiry. You are important witnesses because we hear a lot from nurses and doctors, even managers, but we need to hear more from other healthcare providers. I know it might seem a little strange, Dr Strickland, to have the Royal College of Radiologists included in that, but you might also have experienced other diagnostics and what the future might be for the long-term sustainability of diagnostics, and we would like to hear about that. I know we have had a change of witness because of illness, but we welcome Ms Natalie Beswetherick. Sandra Gidley, you have had experience of the Health Committee and politics before.

Sandra Gidley: I was hoping you would not notice.

The Chairman: This is a different kind of experience for you. If I may start with you, please say who you are, and if you have an opening statement to make, please do so, and then we will move on to questioning.

Sandra Gidley: Thank you. I am Sandra Gidley. I chair the English Pharmacy Board at the Royal Pharmaceutical Society. The Royal Pharmaceutical Society is the professional leadership body for pharmacists, something akin to a royal college. We represent the third largest healthcare profession in the UK. We do not just represent community pharmacists; it is hospital, academia, pharmacists in any setting. We have been doing quite a lot of work thinking about how we could make a more useful contribution to the health service in the future.

Dr Nicola Strickland: I am Nicola Strickland. I am the president of the Royal College of Radiologists. I am sure you are all totally aware of this but I want to be absolutely clear in the beginning that we are a college of doctors. We comprise clinical radiologists: doctors who interpret X-rays and scans, and perform interventional radiology on patients. We also comprise clinical oncologists, who are doctors who oversee the cancer pathway and administer chemotherapy drugs and radiotherapy for both curative and palliative care.

As for what our specialties represent, it is important to bear in mind that there is almost no medical diagnosis made nowadays without some form of imaging preceding that diagnosis, be that plain X-rays or a scan of some sort. There is almost no cancer that is treated without clinical oncologists as part of that pathway, and it is only clinical oncologists who can administer radiotherapy. Also remember that there is not a single surgical operation of any gravity performed which is not preceded by imaging, so our specialties underpin the whole of modern healthcare and the whole of the cancer pathway. In fact, the NHS will collapse if our current workforce crisis is not solved, because we underpin the whole of modern healthcare. That is my major concern as president of this college at the present time.

The Chairman: Whilst it is true that you are a college of doctors, you work with other health professionals, and of course, the key reason for having you here is to hear how you work with other health professionals.

Dr Nicola Strickland: We do indeed. Absolutely. We form a team.

Natalie Beswetherick: My name is Natalie Beswetherick and I am director of practice and development at the Chartered Society of Physiotherapy. I am here instead of my colleague Professor Karen Middleton, who, as you heard, is unwell today. My first notification of this was late last night, after returning from a Christmas shopping spree with my 80 year-old mother. The CSP is the professional body for physiotherapists in the UK. We have 52,299 registered physiotherapists here. Not only do we represent them and work with them but we also cover the support workforce as well as our students. Physiotherapists work across the care continuum and they work in every speciality. Many of you may not have met one in person. I am one. It often depends on your personal experience or your family's experience whether you have received care from one. Thank you very much for inviting me today.

Q217 **The Chairman:** Thank you very much. Looking ahead to 2030 and beyond, what do you think would be the impact of changing demography, changing patterns of disease and models of care, and how do you think—this is the important question—not only the workforce that you are familiar with in your own area but the workforce that you work with should change? What contribution can a workforce like yours make to that change?

Dr Nicola Strickland: In clinical radiology and clinical oncology one of the biggest challenges is the pace of the advance of technology and what we are able to do nowadays as doctors within these specialties. Certainly, even in the time in which I have been a radiologist, there has been a massive increase in the complexity of the investigations we perform. If we

take, for example, CT scanning, we can now do complicated non-invasive studies such as CT colonography, CT cardiac scans, MR cardiac scans and whole-body MR scans, so not only has the diagnostic capacity that we can offer increased but the imaging that we produce is far more complex, and it takes far more training and time to interpret those scans. The other branch of our college is clinical oncology. The complexity and planning in the types of radiotherapy that we can offer, targeted at particular types of cancers in particular patients, has also increased enormously, as well as the training and time required to administer that.

There are also, on the other side, spiralling healthcare requirements, in that patients are tending to live longer with their diseases and require more imaging and more treatment. They are surviving longer with their cancers because treatments have become more effective, and therefore they are requiring treatment for far longer. The incidence of cancer is increasing, partly due to our ageing population and partly due to our unhealthy lifestyles, with obesity, smoking and other risk factors increasing the number of cancers we are diagnosing. We know that there is a big focus on screening to try to diagnose cancers in particular early so that we can treat them effectively.

The Chairman: Apart from the workforce in radiology and clinical oncology, you also work with other health professionals such as radiographers, physicists, et cetera. Is there a role in looking ahead to expand their role in delivering the service?

Dr Nicola Strickland: I understand from the latest survey from the radiographers that they have an even greater deficit in their workforce than we do. Across the UK they have a 13% shortage of radiographers, so we do not have enough radiographers to acquire the imaging to work the scanners to take the X-rays, therefore I am loath to suggest that we try to move them into medical roles to perform diagnosis. In clinical radiology we have a 9% across-the-board deficit in our workforce and, unfortunately, of that 9% deficit in consultant radiologists, 41% of those consultant posts have been unfilled for over a year.

I have some solutions I could suggest that might be helpful for addressing that deficit. We need to divide it into the short term and the long term. In the short term we need qualified bodies on the ground effectively to do the work. Since it takes a minimum of five to six years to train a radiologist and about seven years to train a clinical oncologist, training more radiologists and clinical oncologists is what we need to do as the long-term solution. On the short-term solution, we could have, and there is a desire for, radiologists from English-speaking countries—I am thinking in particular of Australia, New Zealand, South Africa, Canada, and the United States—to work over here for a couple of years. I am not pretending for a moment it is because they aspire to working in the underfunded, overstretched, under-doctored NHS, but they have other reasons for wanting to experience a different healthcare environment. They like to be near Europe and to be able to visit countries and so forth in their spare time.

The Chairman: Do they have an excess of these people?

Dr Nicola Strickland: They do not have a shortage, and in some of those countries they have an excess. The most important thing is that they take a higher specialist exam that is at least as difficult as the FRCR, the fellowship of the Royal College of Radiologists, and it is a national exam across the board. In fact, some of those exams I would even venture are more difficult than our exam, because they take pathology as well, so we know they are well trained. We know that they are very keen to do fellowships in this country. At the other end of the spectrum, when they reach their late 50s and their children have grown up and so forth, again, they are quite keen to return to Europe for a couple of years. There are certainly enough qualified radiologists out there to come over here.

The barriers are that, first, the GMC will not recognise their higher board's exams as being equivalent to our own, and they have to go through a lengthy and costly equivalence process, even though they have a national exam—which is not true for other countries in Europe, I might say. I have been to the head of the GMC and put this issue before him. The other main barrier is the Home Office visa requirements, which would be tier 5, I understand. They need to be relaxed so that these people can come over without barriers. That is certainly one answer.

The Chairman: Let me go back to the original question with the other two, because I need your thoughts, too.

Sandra Gidley: I think it is worth clarifying the extent of training a pharmacist has. It is now a four-year master's degree with a year's pre-registration training, and the vast bulk of that training is in medicines and the use of medicines. It seems clear that we cannot keep on doing what we are doing and expect something different to miraculously happen by 2030. We believe that wherever medicines impact on the patient journey, pharmacists should be involved in some way. For example, with stable long-term conditions, pharmacists would be very capable of managing that, preferably working with other people in the healthcare team, such as general practitioners. The community pharmacy would be ideally placed to take on that role because a lot of people find their community pharmacy very accessible.

With the number of people who have a number of long-term conditions increasing, we have to recognise that it is far from unusual now, and this will only worsen, that people have three or four long-term conditions. I work as a community pharmacist as well, and it is not unusual to see somebody on 20 to 30 medicines. Those medicines have generally been added in fairly ad hoc by the poor hapless patient seeing a variety of different consultants for their different conditions, and the GP has not really the time or the capacity to review the medicines, because in many cases if the medicines are rationalised or optimised the patient is on fewer medicines, they feel better because they are not subject to so many side effects and it would save the NHS a bit of money too.

I know there has been some talk in this Committee about generalists and specialists, and whether it is perhaps wrong to have too many specialists, but I think it is worth saying that pharmacists are advanced generalists, because they have a very broad, overarching knowledge of all the drugs. There are some who specialise in certain areas, but there is a great capacity there for a workforce who can work with the medical profession

and help make medication and its use much better, because if people are on a simpler medicines regime, they are more likely to take their medicines and, one would hope, get the benefit of them.

The Chairman: Physiotherapists?

Natalie Beswetherick: On the impact for the model of care, for me, and for the profession, the model of care that we need for that timeframe is already here. The problem is it is not everywhere; it is in tiny pockets. The model of care I think your witnesses were probably alluding to in the last round is that community-based, multidisciplinary, integrated team, which will focus on earlier prevention as well as rehabilitation, and making sure that care is outside hospital and before anybody needs to go into hospital.

On the role of physiotherapists, we work with the nursing profession and a range of other professions—health and social care, occupational therapists, speech therapists—depending on the condition, but we need to make sure we have enough of everyone across the workforce. We are also in short supply. Our colleagues tell us they cannot recruit new graduates. At the moment there are vacancies across England, and they are not getting any better. Not only are we seeing those in graduates, what we call band 5 in the NHS, but they are also being seen in the higher grades, which is of great concern. To develop the team within that model—and I will come back to the interesting question about the generalist versus specialist—people do not seem to value the generalist as much as the specialist historically. Whether that is cultural I am not sure, but we need to pay attention to this. People working in primary care teams often work with very complex medicine and multiple conditions, and they are not seen as having that specialist-generalist approach. I concur with my colleague that we need to—I use the term advisedly—“sex up” the generalist, because we need to make it more attractive to a whole range of practitioners who at the moment are spending most of their careers in hospitals. We need that fundamental shift out of hospitals, in our view, into primary care—the wider GP primary care team as well as the community teams working across health and social care.

Q218 **Lord Bradley:** Continuing on the workforce theme, you started to identify significant issues around workforce. Would you like to say a little more about that, and about issues around staff shortages, particularly how you would address those issues?

Dr Nicola Strickland: For radiology and clinical oncology, we need to plan for the long term as well as trying to stopgap the short term. For the long term there is untapped capacity in the district general hospitals. We are not using district general hospitals for training radiologists and clinical oncologists as much as we could. Although there are staff shortages in many DGHs, there are also district general hospitals where there are consultant radiologists who could and would like to train juniors across the board, from year one to year five. There is a vast untapped potential out there. In fact, our college has been identifying specific hospitals which could accommodate more trainees if funding could be found.

The other thing we have done already is to set up academies to speed up training, to concentrate training, such that there are dedicated lectures,

simulation and so forth within these academies. We have three already: one in Plymouth, one in north Norwich and one in Leeds. There is potential for several more, and there are business plans under way already for one in Wales and one in the East Midlands. There would be room for one in the West Midlands, one in Kent and one in Scotland. Those academies could train more radiologists than they do; throughput could be far greater. They could also be used to train radiographers on a parallel pathway, so the same building, the same focus and the same supporting district general hospitals and teaching hospitals could be used to train the whole team, if you like. Those are two important ways of planning for the future.

For the stopgap, we could also use our international medical graduates better and facilitate them coming over. We would also advocate making their visa entry requirements much smoother so that they could stay longer if they wished. We would advocate maintaining the pre-Brexit situation whereby radiologists and clinical oncologists from the rest of Europe are accepted automatically as having equivalent training to our own radiologists. At least that means there is freedom of movement, and we need those radiologists at the present time to support our health service and to support our workforce.

The Chairman: Natalie, what is your response to that question?

Natalie Beswetherick: The main issue for the physiotherapy profession is that we are in short supply. Demand has exceeded supply for the last few years, made worse by the decision by Health Education England for 2016-17 to reduce the number of people being trained by 6.2%, so we are adding insult to injury. We have also relied, like many professions, on EEA as well as overseas-trained physiotherapists. Currently 12% of our profession is trained overseas, and that is 7% European and 7% outside Europe. To maintain our workforce we need that pre-Brexit position to be maintained, otherwise we will add further to an already significant impact on our profession.

Changing to more people working in a different way, we have to sort out this supply side. If we do not sort it out, we cannot increase the new models of care that we need—they are in existence but we need them everywhere—to deliver a sustainable NHS. As previous witnesses have said, we cannot carry on doing things the way we always have, which has been very much around a hospital-based service. We need to start investing much more in primary care and community-based services.

Sandra Gidley: I have some good news and bad news because, unlike the rest of the workforce, pharmacists are not in short supply. The reason for that is very simple. It is because the funding for a pharmacy degree is different from that of a medicine degree. Over the past 10 years or so the number of schools of pharmacy has doubled, and there are a lot more graduates who are keen to embrace new roles in new models of care.

The bad news is that, probably as a result of some in the profession regarding this as an oversupply rather than an opportunity to use more pharmacists, the number of pre-registration places looks as though it will be capped, and it is becoming clearer that not all pharmacy graduates will be able to take up a pre-registration place.

The Chairman: Who does this capping?

Sandra Gidley: I think Health Education England. We do not have the full details. Nobody is completely transparent about the numbers at the moment, but if you have Health Education England in front of this Committee it might be worth probing this in some detail. We are concerned that there will potentially be a cap. This will mean that there are highly trained pharmacy graduates with a master's degree who will not be able to qualify as pharmacists.

The Chairman: What do you think is the reason for capping?

Sandra Gidley: Probably finance. Partly finance, because there is a cost to the NHS in funding the places, and partly a reaction to some of the concern that too many pharmacists are being produced. If we are looking ahead to 2030, I would say we are not producing too many pharmacists; we are producing a lot of very useful graduates we could be making use of, but that is not the short-term view.

The other thing that is increasingly clear is that, as models of care change, it is helpful to have an adaptable workforce. When somebody takes up a pre-registration place, it is worth looking at the model used in Wales, where the pharmacist will have experience of hospital, community and working in a GP practice, because all three roles are very different.

I also want to make a quick comment on Brexit, because 13% of our new registrants are from the EU, and EU citizens represent 5% of the workforce. We do not know what the impact of Brexit will be but it is worth taking into consideration.

Lord Warner: This is a question mainly directed at Nicola and Natalie. Can you tell us a bit more about what proportion of your registered members work in the NHS and work outside the NHS, and is there a shift going on which we should be worried about in the longer term?

Dr Nicola Strickland: In clinical radiology and clinical oncology the vast majority of those doctors work in the NHS. They may do some private work in their spare time or in a single session.

The Chairman: They are not exclusively private?

Dr Nicola Strickland: Not exclusively. I do not have the absolute figures but definitely less than 10% would work in the private sector. The only thing that is changing, which you need to be aware of, is that there is a huge backlog of unreported radiological examinations, plain X-rays and scans now in the UK—and to give you some idea of that, I am afraid that 230,000 examinations on patients are waiting over a month to be reported. Of course, associated with that is not only the inefficiency in the pathway but the fact that there are patients on the end of all those examinations who are anxious about the results of their scans but are not being told what they are for over four weeks, because of the workforce, and the fact that we do not have enough radiologists, even though they are working pretty much flat out. What has happened to fill that gap is that private teleradiology companies have sprung up, and those are mostly staffed by NHS radiologists but one would say that is outside the NHS.

The Chairman: Physiotherapists?

Natalie Beswetherick: The breakdown for the physiotherapy profession is that about 75% work in the NHS and 25% in the private sector. There has been a shift over time, but more recently we have seen two important things that cloud it. One is that quite a lot of NHS contracts go to private sector individuals through the any qualified provider commissioning route. The other thing we have noted is that far more people are what we call portfolio workers. They do a bit of both; they do NHS and private work side by side, so you might have two contracts. That is the general division.

Lord Lipsey: What is happening in pharmacy is quite astonishing to the Committee. Here we are short of resources, and we are preventing people who have been trained from becoming pharmacists. However, would you agree there is a problem, in that so many pharmacists are in fact working as small shopkeepers and not in the wider role you have had? Is there a route forward by giving pharmacists much greater prescribing rights, which would enable them to do a lot of work which at present goes to GPs?

Sandra Gidley: Yes. It is unfortunate that the shopkeeper image predominates, because for most of those shopkeepers there is a shop front but 90% of the income from most businesses, most community pharmacies, is from the NHS these days. That is for medicine supply and giving medicines advice, some of that in relation to long-term conditions and some of it in relation to the New Medicine Service. There is probably a little bit of an image problem but that is for the profession to take on.

You are absolutely right that increasing prescribing pharmacists would help with some of the workforce pressures. When Maureen Baker was in front of you she mentioned pharmacists working in GP surgeries. This is a new role that was not exclusively the province of the RCGP; the Royal Pharmaceutical Society had quite a big part in developing this role alongside the RCGP. These pharmacists—I am not sure if the Committee is aware—are not dispensing inside the doctor's surgery; they are performing the medicines use reviews and taking on the work which GPs have to do at the moment without a pharmacist which is medicines-related. For the average GP about an hour of their day is spent on medicines-related issues, and that is what the pharmacists in GP surgeries aim to help with. What we have found is, where they have been in place a while, they have gained the trust of their medical colleagues, and they have increasingly taken on responsibility for things like asthma clinics and sometimes diabetes clinics.

The Chairman: So there is wider role that a pharmacist can play that we need to think about in the long term.

Sandra Gidley: A big value: if they can prescribe, they can take some of the burden off the GP, but we need to have more pharmacists prescribing.

Lord Kakkar: Can I ask each of the three organisations how frequently you meet with HEE to discuss new models of care and how that should inform longer-term workforce planning?

The Chairman: There should be a quick answer to that.

Sandra Gidley: We are trying to meet them monthly at the moment, because we really need to be plugged into them, but they like to keep things to themselves.

Dr Nicola Strickland: We have no fixed meetings with them. I took up office in mid-September and I have had one meeting with Wendy Reid and discussed my proposals for solving the workforce crisis with her.

Natalie Beswetherick: We meet regularly, basically as a HEE group for the allied health professions. That is on a regular basis, and we make our point time and time again.

Q219 **Bishop of Carlisle:** Sticking with the workforce for a moment, I would like to focus, if I may, on the skills mix of individuals within the workforce. There seems to be a general agreement that extending the scope of the skills mix would be a good thing in the longer term, or could be a good thing, and you have all hinted at it in a variety of ways. Natalie, you talked about valuing generalists more than specialists. Nicola, you talked about collaboration and the co-operation that is required. Sandra, you talked about adaptability just recently. I wondered what you all felt was necessary for training in your particular professions for that greater skills mix and adaptability to be a regular feature.

Dr Nicola Strickland: One of the issues with the radiographers that we have noticed is that there is no way they can easily progress their career pathway, and I think that is one of the reasons why they have this enormous deficit of 13% in the profession. The answer is clearly not to try to make them do roles that will deplete them further from taking the images and producing the scans. The only way to increase their banding, which is the only way they can earn more and progress up their pathway, is to recognise that there are things they can do within their own skillset that would be hugely beneficial to team working, which should be better remunerated and should enable them to increase their banding—for example, post-processing of images. I spoke earlier about the increasing technology and the complexity of the scans. There is no point in giving me, as a radiologist, a whole-body MR scan which will contain at a minimum 3,000 images that are not stitched together so that I can review each different magnetic resonance sequence from the head down to the toes in one complete package. What will tend to happen is that, without the proper post-processing of the images, they will all arrive on my PACS, on my digital reading machine, in small bits, so that I will have the neck imaged in five different ways, and then the chest imaged in five different ways, and so on; they are not stitched together.

In the few centres where there is sufficient funding, radiographers will take on that role. They understand the anatomy, they will stitch the images together, and they will be served up to me in a report in a way in which I can efficiently report them and compare them with the same body parts on a different imaging study. That is quite complex work, and radiographers need to be trained to do that, and they need to be remunerated and recognised. There are many such examples in cardiac scanning, colonography and so forth. Other examples would include paediatric radiology. We know that there are a lot of medicolegal cases relating to non-accidental injury and child harm. It is difficult to image a

child who may be frightened and crying, and to image that child well. It is a skill, it requires training, and it should be recognised and remunerated. There are all sorts of ways in which radiographers could stay within their profession of radiography.

What is happening at the present time is that the taxpayer is effectively funding radiographers to be trained within the NHS, and as soon as they are trained they will go off into the private sector or will join industry and become demonstrators for machinery, or will join locum agencies and are then employed back, as it were, to the NHS at large cost. Without the incentives for radiographers to move through their banding and be better reimbursed, there is not any career pathway. It is foolish, in our opinion, to deplete the workforce of radiographers more, to train them to report complex scans, when they do not have a medical background and therefore they would be working at a disadvantage. Those are all ways we could progress that profession.

Sandra Gidley: It has been alluded to that the biggest training change or change to skill mix would be to increase the number of pharmacists who can prescribe, and to do that one of the easy changes to the law would be to allow pharmacists to supervise that. At the moment we can only be supervised by a doctor or a dentist because of the way the law was written at the time, so it is sometimes difficult for pharmacists to find a mentor for this role. That would enable pharmacists not only to play a greater role in GP surgeries and help with the GP crisis in staffing, but to play a bigger part in care homes. Care homes are very often overlooked. They contain some of our most vulnerable citizens, who are on the most medicines, and who, quite frankly, often receive the poorest care, because the GP contract does not enable GPs to devote enough time to properly reviewing the medicines. We have demonstrated that by basing pharmacists in care homes as part of a multidisciplinary team. The multidisciplinary aspect is very important—we could save £135 million a year. That is with reduced prescribing, reduced hospital admission and reduced waste. This is not insignificant and should be given more attention.

The other greatly overlooked group of patients are those who are being supposedly cared for in their own home but are being neglected in their own home, because there is no time to visit them to see if they receive the care they need. Pharmacists can also be based in accident and emergency, and again, a recent study has shown that by giving extra clinical training there, pharmacists can take on about 60% of what is coming through the door.

There is a need to think about investing in the workforce, and unfortunately all we have heard about at the moment is cuts in the community pharmacy grant. To me, this is the wrong way of looking at the problem. We should be looking at the capacity to deliver services rather than trying to achieve short-term savings.

Bishop of Carlisle: Can I be clear on that? That means pharmacists would be diagnosing and prescribing.

Sandra Gidley: No, not diagnosing. I need to be clear on that, because pharmacists are not trained to diagnose. Some become quite good at it by

dint of 35 years of looking at people over the pharmacy counter, but that diagnosis should always be made by a medical practitioner. This is why the multidisciplinary team aspect is so important.

Bishop of Carlisle: Thank you very much. Physiotherapists?

Natalie Beswetherick: In most cases the scope of the profession does not need to be extended but rather fully utilised, with an expansion, I believe, in advanced practice skills and the optimisation of the support worker workforce. On those two elements, we need that wider skill mix, and we need an increased workforce. The percentage changes might need to be more in that support worker workforce and optimisation of the voluntary and third sectors.

That is against a background of people being enabled and supported to self-manage. The more we can do that with all ages, the more effective that will be for the long term. At the minute we are fighting a war on two fronts. Many elderly people are having to go into hospital at crisis point. We have a system that is arranged around that. We need to start much earlier on, in my view, in primary care, where we can help people to understand how they can self-manage, to understand when they might need to call in support and additional work.

Some great work is being done by advanced practice physiotherapists, as some of you may be aware, in the field of musculoskeletal—the bones and joints system. We are doing quite a lot of work putting advanced practice physiotherapists into GP practices, where they can see, assess and diagnose a range of musculoskeletal conditions. This work is being imparted on a number of GP practices across England. The joint guidance on this was published this month by the CSP, the Royal College of GPs and the BMA. We believe we need to pursue that, look at that model and look at that effect, because that can be a way of releasing some GP time to look at those more complex elderly patients with several comorbidities.

In the physiotherapy profession we have quite an extensive workforce that we often share across the professions. They have myriad names; whether they are called healthcare assistants, rehab assistants, therapy assistants, there is a whole range of them both in health and social care. They will often have work delegated by a range of those health and social care professionals, but we ensure that they are providing the appropriate ongoing rehabilitation and exercise programmes for people who need to maintain health and fitness, I would hope increasingly in their own homes or closer to home rather than in a hospital setting. Even if people have gone into hospital, we need to see the workforce increasingly doing that when people leave hospital, because many, especially elderly patients, fall off a cliff; there is nothing for them then, so we need to optimise that support and voluntary sector workforce to help us.

The Chairman: A quick question from Lord Willis, then I will move on to Lord Kakkar.

Lord Willis of Knaresborough: This question is for two of our witnesses. First of all, is there any empowering of other people within the healthcare service to deliver physiotherapy services at a lower level going on? It seems to be incredibly frustrating that you are waiting for a physiotherapist to come for a community visit, but also in hospital, for

very short periods of time, when there are care assistants there who could do some of those basic tasks. Does that ever happen? To Sandra, when I go abroad, I always go to the pharmacist, who is able to care for me very well, in my fluent French or Spanish or whatever, to deal with my problems. Surely that is a step we ought to be taking.

Natalie Beswetherick: Yes, it does happen. Increasingly, whether it is in elective care, planned care or emergency admission, the support worker workforce will often be the person who you will be seeing and who will be carrying on your care, educating carers and family members to support that person with their rehabilitation after hospitalisation or in the community. That happens, and in some cases, particularly in the community, there is not enough of it being done, and I think that is a gap. As with any qualified professional and like all allied health professionals, physiotherapists are autonomous professionals; it is a three-year minimum BSc Honours degree, but many are now qualifying at master's level, to deliver the care, and as they become expert and are working at advanced practice levels, they may be doing that assessing and diagnosing and doing that management plan. They are increasingly also helping with the support worker workforce, enabling them to teach others, because a lot of this needs to be done day in, day out. We do not have a physiotherapy workforce, and never will have, that could be with every patient every day. That is part of what we do. We teach others and enable them to self-manage and perform that essential rehabilitation.

Sandra Gidley: I would hope you do this in the UK as well, because pharmacy could be the gatekeeper to the NHS, and if there were a properly funded national minor ailments scheme, where people access the pharmacy first, this could take a lot of pressure off GPs and a lot of pressure off A&E. I have noticed—it is probably a function of the fact that everybody gets everything free on the NHS—that when I work in inner-city Southampton, people will go to the GP and take up the GP's time for painkillers, things that are fairly standard but would need a prescription. When I work in leafy Winchester, mothers buy their Calpol and people with backache buy their painkillers, so it is a very different demographic and a different way of using pharmacies. It seems to make sense to think of a way where people who have lower-level needs, who see a GP—we ought to be using more of the GP's skills—could be accessing the pharmacist for the help and support they need.

Q220 **Lord Kakkar:** We have heard an awful lot about the need to reorganise the way healthcare and social care systems are delivered, and in particular that there needs to be much more integration between the two to achieve long-term sustainability in the NHS. Why do you think that has not been achieved so far? How could it be achieved moving forward, and who should be responsible for trying to make that happen?

Sandra Gidley: People have been talking about this for more years than I care to remember. One of the basic problems is that social care is not free at the point of delivery, it is rooted in poor law, and healthcare is on a system that is mostly but not exclusively free at the point of delivery. Coupled with that, you have two different systems and two silos where budgets are guarded very zealously. Going back 15 years or so, we had huge problems with delayed transfers of care because the money was not

in the right place. It has got better but it seems to be getting worse again.

The right care fund seems to be a step in the right direction, because unless you have pooled budgets which force people to work together imaginatively it is not going to happen very successfully, and, rather than thinking of the patient, people will think of their budget. This is not something that is major Royal Pharmaceutical Society thinking but it is clear that some attempt needs to be made to integrate this more fully. One of the suggestions made in the earlier session was that there could be a department of health and social care. Unless you start at the top, it does not send the right message anywhere else.

Dr Nicola Strickland: From the perspective of the Royal College of Radiologists, I think I have already outlined how one could incentivise radiographers to remain within their profession, even though they do not come under the remit of our college, and recognise that there are complexities within the work that they perform which should lead to a higher banding, and that would encourage them to stay within the NHS team and not go into industry and so forth.

The overwhelming shortage in the workforce for us, as radiologists and clinical oncologists, means we are so overwhelmed and swamped with the amount of reporting and interventional work that we need to do that we can almost think of nothing else, if you like, because there is such a huge burden in that respect.

We have integrated care across regions to some extent with regional multidisciplinary team meetings. I think that could be extended. We need decent information technology networks whereby we could work within regions more than just within our little hospital trusts or groups. The Health and Social Care Act did not in any way facilitate that, because it really promoted competition between different hospitals rather than working as a unit within referral patterns within regions. Our college has put on our website, if anyone is interested, a comprehensive document, which is a specification for how to implement regional networks whereby imaging studies can be shared across region. The reason why that is so important is that we could then share out specialists—for example, those in particularly short supply, like paediatric radiologists, head and neck radiologists and so forth. You could get an expert opinion across region if you could transfer those imaging studies between hospitals in a seamless manner.

This particular document, which happens to be called *Who Shares Wins*, if you would like to look at it on our website, not only specifies the need and the reasons for implementing that but it gives a technical spec, because we have consulted with industry as to how that could be implemented so that trusts would simply have to take that document and use it as their specification. I think that would also help to integrate healthcare in our particular disciplines as much as possible.

I think it is important to realise, and it is not always evident to the public, that issuing a diagnostic report on a scan—or indeed on a chest X-ray, which is one of the most difficult areas in fact to report, as you will be well aware—is not just a yes-no answer; it is not like taking a blood

sample, putting it through a Coulter counter machine and finding out whether the haemoglobin is normal or abnormal. It is very much dependent on a medical background and the entire medical knowledge. Therefore, there is no way out of increasing the workforce in clinical radiology and clinical oncology because of the need to have that knowledge to be able to issue what is in fact a consultant opinion, based on one's knowledge of the possible disease states that could be giving rise to the appearance of the scan, and to issue a diagnostic and actionable report, rather than a descriptive report. Any of you around the table here could describe to me what you see on a chest X-ray—I could give you the jargon so you could describe it so that it sounds correct in medical terms—but you could not tell me what that patch of whiteness in the left upper lobe represented, whether it was a cancer, whether it was a longstanding area of fibrosis, whether it was an asbestos plaque or whether it was pneumonia, because you need a medical background. We have to recognise that, while we can integrate across the different hierarchies, from doctors to radiographers to healthcare workers, there are certain medical tasks that we just need enough workforce to be able to do.

The Chairman: Natalie, the original question from Lord Kakkar.

Natalie Beswetherick: Thank you. I agree that nationally we need a joined-up health and social care department. At a more local level the sustainability and transformation plans seem to be the best bet we have. They are the only show in town. They are, as I understand it, trying to bring together local authorities—local government—with health and social care, and we need to see whether that will work. They are all different sizes, so whether that will work I am not sure, but we need to make sure they are given enough time to be able to make a transition.

We are really great at changing systems and processes but what we never do—and I am thinking about sustainability—is think about culture and what it means to the average person in the street, the population, about what the NHS is and what care they can expect. For a lot of people out there at the moment, we need sustainability and we need to think about doing things differently, but we need to engage with the public so they understand that, because a hospital is going to be closed and needs to be closed, for the right reasons, it does not mean a loss for them. What we need to be able to persuade them is that they will have the care delivered in the most appropriate place. I do not think we ever spend enough time thinking about the local people, and getting them on side to understand that we will be having a sustainable care delivery system for the future that their future generations can enjoy as well.

Lord Kakkar: With regard to the STPs, have your members working in the 44 footprints for them, in your opinion, been adequately consulted and participated in the development of these programmes?

Dr Nicola Strickland: They have not been consulted at all but our college has made an effort. When I found out from the Academy of Medical Oncologists that STPs were going to come into existence and there were 44 of them, we found out who they were, their names, and I personally emailed every single one of them with some suggestions, in particular this document about setting up regional IT networks, so that

they would be in possession of that information to help them to further their work.

The Chairman: All of you shook your heads.

Q221 **Lord Warner:** Could you each say a few words about the extent to which the incompatibility of IT systems is one of the major barriers to joint working, and indeed enabling professionals to supervise lower-level people to carry out work?

Natalie Beswetherick: Our experience, whether you work in the acute hospital sector or in primary care or social care, is that there is no compatibility between the majority of systems. I live in Gloucestershire and I know the community system, all the GP practices and the local hospitals, as in the community hospitals, are all on SystemOne. They have a fantastic opportunity to share information as they need to, but that is rare. Nothing seems to talk to anything else, and it is a major barrier, in my view, to people being able to work at the top end of their abilities, because they constantly return to paper when you should not need to. Hospital systems are completely different from everything else and social care is even more different again.

Dr Nicola Strickland: In imaging we have standards that mandate the interoperability between a number of systems. If you take the imaging system, the PACS—the picture archiving and communication system—where we now store all our images, and all the modalities, the CT scanners, the MR scanners, ultrasound scanners and so on, adhere to a standard called DICOM, which specifies certain fields. The RIS, the radiological information system—that is where you enter your patients as they appear and where the reports go—adheres to a standard called Health Level Seven, HL7. So there are standards, but the problem is that the vendors of the EPRs, the electronic patient records, of which there are only a couple in the UK, Cerner and Epic, and the GP systems, of which SystemOne is one of the larger providers, generally do not adhere to those standards, and therefore doctors are left in the community and in hospitals in different regions logging on multiple times to different systems. That is very time-consuming, and unsafe and dangerous, because you cannot directly compare information and you cannot gather information—images, for example—which are in one part of the country and see them on your system when the patient is being referred to your hospital. There should be mandated fields that vendors have to adhere to. One simple example is the National Health Service number; the NHS number is not specified to go into a particular field in all these systems, which would seem the most basic thing, and would also mean that these systems could search for information in other systems across the country. There are certain things that could be mandated by law that would help this interoperability.

Sandra Gidley: I am wondering whatever happened to Richard Granger and the NHS IT project. All this was supposed to have been sorted by now.

Lord Warner: I resigned.

Sandra Gidley: Right. From a pharmacy perspective, the problem we have is that we have only just been given access to a summary care record, which only has limited information on it, and the potential to deliver better patient care would be so much more enhanced if pharmacists could have read/write access to a fuller care record, which could also be accessed by other health professionals. There is resistance to this in some quarters but, if the permissions were in the hands of the patients, they should have the ultimate say in who has access to their records.

Q222 **Lord Lipsey:** A sub-theme of our inquiry has been regulation and the amount of it. I quote from NHS providers' evidence: "The regulatory environment has become much more complex over the past 12 months". Also, "The regulatory burden has significantly increased over the past 12 months particularly for foundation trusts". Would you agree with those assessments and what would you do about it?

Dr Nicola Strickland: I think in the medical profession much of this regulation stemmed as a kickback from the Shipman incident. The laudable idea was to reassure the public that doctors were keeping themselves up to date and were not up to any malpractice. Unfortunately, the net result of revalidation, which is a five-yearly assessment by the General Medical Council, and the yearly appraisals we all undergo, has not been to safeguard the care we give to our patients; it has just been incredibly burdensome and time-consuming and, worse than that, is causing many doctors, certainly in clinical radiology and oncology, to retire early. As soon as they are in a position to retire, they will retire, and we are now finding that there is a 15% to 18%—

The Chairman: If that is the common consensus in medicine that that is what revalidation has caused, how does the profession deal with the GMC in that respect?

Dr Nicola Strickland: There is very little we can do, because it is mandated that we have revalidation. One thing that could be done is that, when you speak to the GMC, as I have done recently, we need tailored revalidation, so that supposing I am a radiologist towards the end of my career, this is how we would deal with it.

The Chairman: How do you deal with a regulator whose processes you do not agree with?

Dr Nicola Strickland: The way that it can be done is to take what the GMC mandates, which is that you revalidate in your area of practice—you keep yourself up to date, current and knowledgeable. The problem is that at the hospital level and the trusts level, on the yearly appraisals that doctors go through, this is being enacted in a blanket way, so that doctors who are, for example, in my area of interest, reporting plain X-rays and CT scans, never see a patient, and there are quite a lot of radiologists like that. They do not need to do compulsory courses in patient handling and resuscitation and so forth, because that is a complete waste of their time and it is counterproductive. It is so burdensome that they would rather retire than have to keep going through this. The appraisers, those doctors whose task it is to assess those doctors, need to talk to the revalidation officer and say, "Look, this is unnecessary. I want tailored appraisals for

what this doctor is doing. He or she does not have to undergo patient-handling modules.”

The Chairman: To go back to Lord Lipsey’s question, Sandra?

Sandra Gidley: One thing I noticed, having 10 years out of practice, was that when I went back, the world had changed completely and you had to complete a lot more paperwork to keep various organisations happy. All of that has added to the everyday pressures on the pharmacy workforce. We have yet to go down the revalidation route, and, from what I have heard from the medical profession, there is some trepidation as to whether we will get it right. The tendency of the regulator is always to overegg the pudding, without thinking necessarily of the patient or whoever needs to be protected, or what is an appropriate balance. The vast majority of health professionals will do what they need to do to keep current, but it is the recording and all of the paperwork and processes around it that become difficult.

The Chairman: Apart from the professional regulation—and, Natalie, you might answer that, too—Lord Lipsey’s question covers other regulations, such as CQC and Health Improvement.

Natalie Beswetherick: On an individual level, so I will cover that first, physiotherapists, like all the other allied health professions and social workers, are covered by the HCPC, and that level of regulation I think is fit for purpose. That can be evidenced by the low number of cases they hear. The balance of ensuring that patient safety is adhered to is the principle I would want to emphasise, and if the level of regulation is fine, what you should see is minimal cases that need consideration by that regulator.

At system level, I would agree that our members are saying that, especially in foundation trusts, it is almost that you have to do everything to make sure you have a positive CQC rating rather than dealing with what you need to every day. The CQC and all the work that goes with that is overly burdensome. Most people would say you are either going to be under improvement or in special measures, and all that seeks to do is make staff more depressed than they were, having to do the work for the regulation of those services and systems, rather than spend their time with patients, which they want to do.

Dr Nicola Strickland: There is no proof that these inspections lead to better practice or protect patients. That is one of the issues. There is no evidence to show that either revalidation on a personal level or the CQC or NHS Improvement inspections has improved things. That is a concern. There are inconsistencies in the inspection. If you take, for example, CQC visits, they assess radiology with outpatients. In our particular trust we were taken to task because outpatients did very badly, whereas in fact radiology did very well. Nevertheless, we were tarred with that brush, which is pretty depressing for every radiologist in the trust, obviously.

Q223 **Baroness Blackstone:** What is your key suggestion for change that the Committee ought to recommend in support of a more sustainable NHS?

Sandra Gidley: I think it would have to be think pharmacy first. We have not spoken about prevention today, but the network of healthy living

pharmacies deliver a lot of public health interventions which will delay the onset of illness. As I have said, community pharmacies should be the gateway to the NHS, with the pharmacists part of any clinical team and pharmacists at each level in the NHS. The Health Select Committee in the other place frequently advocated medical leadership, which is now a concept that has been much more fully embraced, and we have the NHS Leadership Academy. However, with the Health and Social Care Act, I think it was a mistake not to ensure that pharmacists had a place on the boards of the CCGs. There has been low involvement in STP planning. I would contend that, unless you think pharmacy first, a vital piece of the jigsaw is missing.

Dr Nicola Strickland: Overall for the UK it is essential that we increase the percentage of GDP spent on the NHS if we want to see results, remembering that France and Germany spend about 11%, the USA spends about 16.5%, and we in the UK, depending how you measure it, spend about 8.3%. In our disciplines, it is workforce, so we need to address the short term and the long term.

The Chairman: We need to make sure our record is correct, because we have heard different figures on GDP spending. With the new OECD ways of calculating, we are not far off Germany.

Dr Nicola Strickland: It would be 9.9% if you take social care out.

The Chairman: We need to make sure what those figures relate to. Your figures are different.

Dr Nicola Strickland: They were figures that I looked up. All I know is that the UK spends less than France and Germany and less than the USA, and we should spend the equivalent of the mean of Europe or of other westernised societies, so that we can aspire to the same level of healthcare. At the present time, whatever the figures may be, we are spending less than those other countries. I would argue that we should spend the same, or have the same level of healthcare. With respect to radiology and clinical oncology, we need to address the short-term shortage in workforce by trying to get radiologists in particular from overseas, as I have outlined—from Australia, for example—maintain the numbers coming from Europe, international medical graduates, and in the longer term use the potential for training in district general hospitals for training more radiologists and more clinical oncologists, and increase the number of academies we have and the throughput through those academies.

The Chairman: Natalie?

Natalie Beswetherick: I do not disagree with my colleagues. We have to get the money right. We cannot make the major changes we want unless we do some pump-priming to enable services to be developed in primary care and in the community before we remove them from secondary care. You cannot do it. You cannot just whip them out on a Friday and put them into the community on Saturday morning. That money is essential, because we have to get the supply right. Physiotherapy workforce is in short supply. The one ask I would make is that we need national accountability for the 10,000 workforce expansion for allied health professionals and nurses that was made in the last

comprehensive spending review, and at the moment there is no accountability to deliver that. Without that workforce across allied health professions and nurses, we will not be able to get that sustainability in future. Thank you.

The Chairman: Thank you all very much for coming today. It has been very helpful. If you have further evidence that you would like us to receive that is pertinent to some of the questions we asked today, please feel free to submit it. You will get the transcript to look at. You cannot change it but, if there are any inaccuracies, please let us know. Thank you for coming today.

Greater Manchester Health and Social Care Partnership, Greater Manchester City Council and Professor Kieran Walshe – Oral evidence (QQ 224-235)

Evidence Session No. 23

Heard in Public

Questions 224 -235

Tuesday 29 November 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord McColl of Dulwich; Lord Lipsey; Baroness Redfern; Lord Ribeiro; Lord Turnberg; Lord Willis of Knaresborough.

Examination of witnesses

I: Nicky O'Connor, Chief Operating Officer, Greater Manchester Health and Social Care Partnership; Steve Wilson, Executive Lead, Finance and Investment, Greater Manchester Health and Social Care Partnership; Sir Howard Bernstein, Chief Executive, Greater Manchester City Council; Professor Kieran Walshe, Professor of Health Policy and Management, Manchester Business School, University of Manchester.

Q224 **The Chairman:** Good morning, lady and gentlemen. Thank you very much for coming to help us with our session today. I am sorry to have kept you waiting, but we had some private business to deal with. We are on live broadcast, so any conversation you might have may be picked up, and that applies to all of us. The members of the Committee, if they have not declared an interest before and it is specific to this session, will do so when they ask their question. The transcript of today's session will be available to you after the session. If you feel that there are any corrections to be made, please make so, but you cannot change it. Before we start, would you introduce yourselves from my left? If you wish to make a very short opening statement, please feel free to do so, and then we will get on to the questions.

Professor Kieran Walshe: I am Kieran Walshe. I am a professor of health policy and management at the University of Manchester with an interest at the moment in research on health and social care devolution, work that is being supported by the Health Foundation and the National Institute for Health Research. I will not take up time with an opening statement.

Sir Howard Bernstein: I am Howard Bernstein. I am chief executive of Manchester City Council. I am also head of the paid services of the Greater Manchester Combined Authority, and it is in that role that I have

joint accounting responsibilities for the transformation fund that was negotiated for Greater Manchester health and devolution.

Steve Wilson: I am Steve Wilson. I am executive lead for finance and investment at the Greater Manchester Health and Social Care Partnership.

Nicky O'Connor: Good morning. I am Nicky O'Connor. I am the chief operating officer for the Greater Manchester Health and Social Care Partnership.

Q225 **The Chairman:** Let me kick off with the first question. We know that there is a devolution of health and social care to the Manchester area. This Committee is about the long-term sustainability of health and social care beyond 2025/2030, so the first question is: do you think the model of health and social care devolved to Manchester is the way forward in sustaining health and social care in the long term? How would we measure the success of that, and what happens if you fail?

Sir Howard Bernstein: When you start to address the requirement for place-based approaches to integrating health and social care services, it is inevitable that it can only be done at the locality level. All previous attempts through traditional national improvement programmes have, in my view, largely failed, so the whole question of fiscal and clinical sustainability is a fundamental part of how you develop locality approaches. The whole approach in Greater Manchester has been to work through what works at the locality level and, more particularly, what works at GM level: what things you need to commission once rather than, in our case, 10 times. The overarching framework that we have developed gives us confidence that we are very much on the right lines on a whole range of programmes, which I am sure we can talk through as we go along.

I would identify two "buts" to this. One is that it has to be place based, not organisationally based, and it has to be how you place health and social care as part of the wider reform of public services underpinned by early help and early intervention. That is what we have been doing in Greater Manchester for some time. The other "but" is that you have to have the robust and mature partnerships to be able to deliver also at leadership level the scale of programmes that we are talking about.

The Chairman: Can you give us a picture of where you think social care, for example, is just now, what it looks like, and where you will be in 15 years' time on the delivery of social care?

Sir Howard Bernstein: On social care in Manchester, one of the three pillars of our locality plans is single commissioning, a new independent care organisation and a single Manchester hospital service—priorities you could talk to anyone in Manchester about for the last 10 years. They have been identified as clear priorities for delivery, and within four or so months of devolution we are well on the way to establishing those priorities.

Social care, therefore, will form part of our independent care organisation, to be followed in 12 months' time by our children's services. We are seeking to join up community services with social care, mental health and primary care in order to provide the integrated offer that is necessary not

only to support a transformation in our population's health through prevention and early intervention but in effect to reduce the demand for services in our hospitals. That is how we see this strategy. Of course, there are particular pressures in social care at the moment, which I am sure Steve can take you through.

The Chairman: To answer my question, where do you think you are just now, and where will you be in 15 years in the delivery of social care?

Steve Wilson: In the wider sense, the devolution platform has been a real enabler for making change happen locally, which is about integrating social care, healthcare, physical health and mental health care within localities and communities. Within the 10 localities across Greater Manchester, there are individual plans to deliver that. The original plan for Greater Manchester to close the financial and clinical sustainability gap over the next five years was based on social care funding being protected. There is a risk to delivering those plans at the moment because we have a gap of about £176 million at the end of our five-year planning period for delivering social care. There is a real risk in that, because the transformation that we need to deliver over the coming five years will be the key to that vision in 15 years' time of social care integrated with mental and physical healthcare.

The Chairman: My two subsidiary questions earlier on were: how will we know what success will look like, and what will happen if you fail? What happens to your five-year plan if you cannot deliver it in the first five years?

Steve Wilson: I think the risk is that, unless we are able to use the transformation funding that we have available in Greater Manchester at the moment to transform services now—that is what all our local plans and our submissions to our local transformation fund are all about—we will not be able to deliver those integrated services of the future that will deliver clinically and financially-sustainable services for the 10 localities within Greater Manchester. Success looks like a system that is clinically and financially sustainable over the medium and long term, and that is what we are using the transformation fund to deliver, but there will be real challenges in delivering that.

Baroness Blackstone: Is that understood by NHS England, the Department of Health and, indeed, the Treasury? A huge amount hangs on this. It is, in a sense, a kind of pilot for what the future might look like, or you could describe yourselves as a role model for other big metropolitan authorities taking a similar approach to the one that you are taking. Are you communicating with these people at the centre who hold the purse strings?

Sir Howard Bernstein: Yes. Jon Rouse, who is the chief officer for delegation, Lord Peter Smith, who chairs the Health and Social Care Partnership, and I wrote a joint letter to the Secretary of State for Health, copied to the Chancellor and elsewhere, particularly to Simon Stevens, explaining our particular challenges in social care funding, which, unless resolved, will gnaw away at our capability to create the sustainable funding platform that we have committed ourselves to within the next five years.

The Chairman: Was this a private communication?

Sir Howard Bernstein: No.

The Chairman: Can you supply us with a copy?

Sir Howard Bernstein: Certainly.

Baroness Blackstone: Can you demonstrate what the long-term savings might be if you have adequate funding for social care? Presumably, there will be substantial savings in relation to NHS funding for hospitals with geriatric wards?

Sir Howard Bernstein: Yes, exactly.

Baroness Blackstone: You can demonstrate that, can you?

Steve Wilson: Yes. Our financial strategy over the next five years demonstrates that, and that was set out before STPs came along. We presented our Taking Charge financial strategy in December 2015, which identified a gap of around £2 billion for Greater Manchester health and social care. We have identified solutions, which will not be easy to deliver, but they will, through the transformation activities we have described, release efficiencies across the system. They will move care closer to home and they will build care around the patient in integrated local services, which will deliver about £880 million of savings across the system. That, combined with the extra income that we are getting through our share of the £8 billion investment plus some social care precept funding and better care funding, will close most of that gap and, with the protection of social care, would present a strategy that enabled us to close the financial gap.

Baroness Redfern: Is that embedded in the STP?

Sir Howard Bernstein: Yes.

Steve Wilson: Yes.

Q226 **Baroness Redfern:** There will be savings from your acute sector that will be moved into health and social care across those 10 localities. Are the CCGs also picking that up, and are they in agreement with that?

Steve Wilson: Yes. All our 10 localities have their own locality plan. That is shared between health commissioners, local authority commissioners, as a single commissioner for health and social care, and all the providers within those localities: the acute provider, the community service provider and mental health provider. They are all signed up to those locality plans. It is those locality plans, working with some of the additional savings that we can lever across the whole of Greater Manchester, as Howard said delivering local savings and looking at things that need to be delivered pan-GM around standardising approaches and particularly around acute services, where they will deliver those savings, if they are delivered. None of that is easy, and devolution is not a magic bullet that enables that to happen, but it is enabling the conversation to happen through a place-based approach, with all parts of the local economy working together rather than individual organisations.

Baroness Redfern: Would you have more flexibility if you had fewer locality plans so that you could integrate across?

Sir Howard Bernstein: The fact that we are working within 10 local authority areas is important.

Baroness Redfern: I know that local authorities do work together sometimes.

Sir Howard Bernstein: Exactly right, which is why, for example, within the Pennine footprint area, you will see Oldham, Rochdale and Bury particularly working in commissioning together.

The Chairman: Are the leaders in the acute sector in agreement that they could deliver these savings to you?

Steve Wilson: The locality plans that are submitted are signed up to collectively by all the leaders—by providers and commissioners. They form the basis of the bids for the transformation fund to do the enabling work to make that happen, to pump-prime and to double-run services so that that can shift.

Q227 **Lord Willis of Knaresborough:** The complex organisation of 12 clinical commissioning groups is not of your making. Do you have plans to apply for those to be made into one commissioning group, and how quickly does that need to happen?

The Chairman: A quick answer, please.

Sir Howard Bernstein: In Manchester, we have three and are moving to one voluntarily. All three commissioning groups have agreed that in order to underpin our single commissioning arrangements they need to become a single commissioning focus. We will be doing some work with our commissioning colleagues over the coming months to do a further analysis of the overall effectiveness of commissioning arrangements. My view, without pre-empting the outcome of that work, is that there will be fewer commissioners. Whether or not we want to move to a single commissioning group for the whole of Greater Manchester is not something that I think we could support, certainly at this time, but I think that the trend towards integrating commissioning will mean fewer commissioning foci.

Q228 **Lord Bradley:** I am pleased to hear that the locality plans are based not only on the integration of health and social care but on physical and mental care, but is there a tension between what you are trying to achieve through devolution and controls that are put on you from central government regarding financial and efficiency savings that you need to make through the acute sector, which makes the transfer of money in the social care system more difficult? Have you profiled that shortfall in social care over the planning period of five years, and are you planning how that integration and the financial underpinning of it over the longer term leads to a sustainable position for Greater Manchester?

Steve Wilson: The social care gap that remains in our plans is profiled across the individual localities and over those periods. There are a number of things that we would seek to get more flexibility on as we move into 2017-18, and some of that relates to some of the business rules operated by NHS England and NHS Improvement. It is not enormously significant, but, taking a reasonably evolutionary approach to

that, there are things we would want to ask for in 2017-18, such as flexibility in control totals for foundation trusts and NHS trusts and between providers and commissioners, and how we can look at Greater Manchester as a whole. A lot of that is doable within the current system. We just need to ask.

Lord Bradley: That is clear?

Steve Wilson: It is all based on a system control total, which is the way business rules are evolving; it is not about looking at individual organisations in isolation. I think we are ahead of others in the way we are looking at that. The locality plans are a good example of that, and we offer ourselves as a test bed nationally to do that sort of work.

Sir Howard Bernstein: When we did the devolution agreement and the delegation instrument, which was executed on 1 April, it was always intended that there would be regular reviews of those arrangements. We are at a point, as Steve has said, where we want to start engaging our colleagues at NHS England about the next iteration of that agreement in order to improve efficiency and to deliver the flexibility the team needs to manage both performance and finance.

Lord Bradley: Are you able to start planning 10 or 15 years down the line, or are you very much concentrating on getting sustainability and some transformation over the next three or four years?

Sir Howard Bernstein: It is three or four years. Certainly that is where our primary focus is.

Q229 **Lord Willis of Knaresborough:** Can I come on to the workforce? I am very excited by the Manchester proposals; I think there is a huge opportunity here. What worries me is that the workforce arrangements and working practices, which tend to be silo-based and focused very much on individual professions, are very hard to shift. What advantage do you feel the Manchester model has in effectively planning for the workforce of 10 or 15 years ahead? In particular, where are the system barriers to changing the workforce and its practices that we could point up in our report?

Nicky O'Connor: There are probably three advantages in our current arrangements. We have clarity of ambition through our Greater Manchester strategic plan, which enables the 10 localities to plan their workforce needs around that ambition, which we can then aggregate up, as we need to, at a Greater Manchester level. We have clarity about our operational requirements, which enables us to have Greater Manchester-wide recruitment campaigns for shortage specialities. At the moment, we have some work going on around urgent and emergency care consultants particularly, which is a shortage speciality across the country, and we can use the aggregated power of all the Greater Manchester authorities to do that. We are also able to use our funding to create apprentice roles, nurse associate roles, et cetera. We also have a single leadership board on the workforce, which is chaired by one of our acute sector chief executives but has health and social care senior representatives on it. We are in discussion with Health Education England about devolving the resources

from them to a Greater Manchester level so that we can use that to plan our workforce for the future on a locality and Greater Manchester basis.

Potentially, some of the risks that we have are to do with the reductions in health education funding coming forward—these are risks to Greater Manchester as well as to other parts of the country—but the power that we have between us probably enables us to mitigate those risks, unlike perhaps in other places. One of our plans is to create a centre of excellence that brings together the university sector in Greater Manchester, all the employers, Skills for Care and Skills for Health in one place so that we can plan our workforce for the future with all that knowledge and skill around the table.

Sir Howard Bernstein: Can I add one particular point, which Nicky has mentioned, which relates to the whole culture? What we are seeing, interestingly—not at the front line as much nowadays, because front-line workers see the frailties and the inadequacies of the existing system on a day-by-day basis—is huge excitement, I think, across the public sector for the sort of cultural and organisational development process that is required to get us to start working as integrated teams. It has not been easy in the NHS, but I think it will become a lot easier at the front line.

What we have to do, and Nicky is part of that, is create the leadership structures that will be seen to drive that cultural change. That is a particular focus of mine in Manchester at the moment with the new independent care organisation; we are looking to put so many different services together, working in a holistic, focused and targeted way in all parts of Manchester, which is a big cultural as well as organisational development.

Lord Willis of Knaresborough: You have an ability, given your population size and budget, to develop a bespoke workforce for your population. Are there any barriers to your creating new roles and being able to develop those specialisms within an integrated sector?

Sir Howard Bernstein: We are looking at that. We do not want home care or social care; we want care assistants. We want to address how we introduce apprenticeships as part of the developing nature of wider health and social care provision. We have a fantastic working relationship with our trade union staff representatives, who are working with us in similar ways. Of course, there are constraints. I want to see a greater level of devolution to Greater Manchester to enable us to plan more effectively for the skills requirements we have within our services over the next five years.

Lord Willis of Knaresborough: Devolution of what?

Sir Howard Bernstein: Health education spend. They spend, I think, £70 million to 80 million, from memory, or is it less than that now?

Nicky O'Connor: The totality of the budget for Greater Manchester, which includes the medical and dental education budget, is £271 million.

Lord Willis of Knaresborough: Is most of that on medics?

Nicky O'Connor: Probably about half of it is on medical and dental education.

Sir Howard Bernstein: Building on our key assets of Manchester University, Manchester Metropolitan and our colleges of further education, we have the capability to develop very integrated and strong pathways that are very much linked to all our institutions in Greater Manchester, which is what we want the ability to do.

Nicky O'Connor: On the cultural aspects of where Greater Manchester has got to, one thing that I have been very struck by is how we have integrated the GP workforce into everything that we do. That has been a powerful voice to help us in all our efforts, and particularly around workforce models for the future. We also have a greater ability to grow our own workforce, which has significant social benefits alongside benefits to the NHS and social care system in terms of getting people back into work.

Q230 **Lord Ribeiro:** One of the things that has come out of the STPs so far is the lack of engagement of patients and clinicians in the process early on. Clearly, you came ahead of STPs, and I would like to think that you did that, but one of the things that concerns me about how you are going to organise your training programmes for doctors, et cetera, is that currently these are at a national level and placements are usually done on a national basis. How are you going to make this work for you in Manchester, mindful of the national profile of training research?

Lord Willis of Knaresborough: People may need to move.

Sir Howard Bernstein: We want to be co-commissioners. It is the same sort of arrangement, I think, that is in our minds, and it is not about where we will assume direct responsibility for every penny. We want the ability at a place level to join up with Health Education England and say, "These are the particular posts and skills that need to be provided in Greater Manchester over the next five years or so. How do we secure support and co-operation to deliver those skills outcomes, and how can we help you by organising our education and skills provider sector in Greater Manchester to support those outcomes?" Rather than a national delivery model, which is almost blind to place, we are saying that we want a clearer focus on place through a co-commissioning model with Health Education England.

Professor Kieran Walshe: We all know that the history of Health Education England is relatively recent and that the hollowing out of regional governance in the NHS as a result of the Health and Social Care Act 2012 has created, in many ways, the fiscal and financial crisis and the governance crisis in the NHS that you now see playing out in STPs. What is most interesting about health and social care devolution in Greater Manchester is that it is providing an opportunity partly to reinvent some structures that existed in the past—the North West Deanery, the Greater Manchester Workforce Development Confederation and things like that, but what is really different is the engagement and the role of local government.

Baroness Redfern: Nicky, can you give me a workforce example of sharing back-office staff? Have you started with that, or where are you?

Nicky O'Connor: Absolutely. Perhaps my colleague would be best to answer that in the first instance.

Baroness Redfern: Your faces lit up when I asked that.

Steve Wilson: One of our transformational themes relates to clinical support services and the corporate function, and there is a whole piece of work going on on a number of different work streams. On the clinical support service side, work is being done on radiology, pathology and pharmacy services across Greater Manchester, led by individuals within organisations on behalf of Greater Manchester, and how can we best deliver those support functions.

Baroness Redfern: Are you working with other local authorities or other organisations not just within the NHS?

Steve Wilson: Absolutely. Particularly on the clinical side, obviously there is more focus on the NHS. On the corporate support side, we are looking at working across health and social care. All that is happening already at a local level. We are seeing social care commissioning coming together with local authority commissioning, but there is a whole extra tier we can look at in Greater Manchester. We now have a Greater Manchester support service that delivers all the business and back-office support for CCGs, and we want to see how that can work with what is coming out of the work done by the combined authority and what comes out of the local authorities. We have a particular focus on things like IM&T and estates, where there is such an additional benefit in working across not just social care but wider government. We have examples on estates in Wigan where you have the co-location of PCSOs with healthcare services, which is not only delivering a better service but is much more efficient, because you can utilise buildings better. So getting the right level of shared function across GM for corporate functions and clinical support is absolutely key.

Baroness Redfern: So you will save a substantial amount of money, will you?

Steve Wilson: An element of savings will be delivered through that, yes.

Baroness Redfern: Revenue and capital?

Steve Wilson: Certainly revenue, and it will reduce our capital requirements. As you will know, one of the constraints on STPs is the availability of capital. One of the solutions is not finding extra access to funding but about making sure that you utilise buildings across the wider public sector.

Q231 **Bishop of Carlisle:** You have all spoken very interestingly and encouragingly about the way in which you are attempting to integrate just about everything, including health and social care, especially in localities and with good leadership and so on. Could I focus our discussion a little on the whole issue of prevention? What difference is what you are doing making to prevention, how do you see that working out in the future, and what are the chief obstacles to it?

Sir Howard Bernstein: One of the key areas or programmes is how we radically upgrade our population health and new models of leadership for

public health across Greater Manchester. We are designed to deliver a much bigger impact to reduce need at the point of crisis.

Picking up the point we have already discussed, it is also about how we develop a much stronger integrated role for early years and mental health and, crucially, make the link between health and social care services generally, how we tackle worklessness and how we integrate a comprehensive public service offer that is designed to support people and families in communities to move on. That is the whole approach that we are taking to that particular issue, which I think is very distinctive.

Bishop of Carlisle: Can you see that working in practice already, or is that still an aspiration?

Sir Howard Bernstein: We have done lots of pilots across different parts of Greater Manchester, that is true. Through that better investment and better sequencing of services in early years, we have demonstrated that we can have an impact on the lives of young people, certainly on their school readiness. Through our health and work programmes, we have seen how we are achieving far better outcomes in getting people into work than what has been delivered through traditional programmes. What we have never done, because nobody has, is attempt this at the scale that we have throughout Greater Manchester, but that is what we are determined to do and that is what we will do through each of our locality plans.

Nicky O'Connor: To illustrate that a bit, Tameside is one of our localities, and it is one of the areas that decided early on to bring health and social care together through a joint leadership structure, so the CCG and the local authority are led by the same individual. Through their preventive programmes and the integration they have managed to achieve, they have already reduced their teenage pregnancy rate by half, which was very high in that particular borough. They have also had reductions in infant mortality, they have really good rates of immunisation, and their healthy life expectancy has already improved by 2.2 years over the last year or so just through the preventive work that they have been able to focus on.

Bishop of Carlisle: For you, what are the chief obstacles to continuing down this track?

Sir Howard Bernstein: The social care spend must be a constraint, if we are being frank. We will not be able to deliver the scale of change that we all want to deliver if we do not provide the full level of service that we need to support vulnerable members of the community. That is almost the single biggest challenge that we face in Greater Manchester at present.

Q232 **Lord McColl of Dulwich:** On the preventive side, as you know we are in the middle of the worst epidemic for 97 years, the obesity epidemic. How successful are you in coping with that?

Sir Howard Bernstein: It is one of our priorities, and we will see greater awareness. We want to create a movement for social change and a much stronger capability for early help. Early intervention through our enablers,

and a focus on childhood obesity in particular, will be a fundamental part of that strategy.

Professor Kieran Walshe: I would add a slight note of caution and say that it is about influencing the shape of the future demand curve and not necessarily bending it downwards. Ever since Wanless, there has been a received wisdom that doing prevention-related things will change people's future use of health services, but we also know that we not only perhaps influence people to use health services more effectively, more wisely and more economically but we uncover lots of unmet need when we do this, and you have to think hard about that.

The difference with devolution is perhaps that, traditionally, trade-offs between health and other sectors were rather difficult to make real because of the siloing of financial flows. What devolution perhaps offers is an opportunity to see those trade-offs made more real between, in the example you gave, health and worklessness. If you think about the spend in the social security budget against the spend in the health budget and the opportunities that might emerge in the future, you start to see greater place-based thinking about issues such as worklessness, health, and school readiness, which opens up opportunities that people have talked about for a long time.

Baroness Redfern: Could I just come back on Lord McColl's question about obesity? Sir Howard, you did not really answer that particular question. Have you set targets for when you want to achieve those things by, or the number?

Sir Howard Bernstein: We are currently in the development of our final population health and we have not set targets.

Baroness Redfern: So it is too early to say?

Sir Howard Bernstein: I think the report is promised early in the new year.

Nicky O'Connor: It is due in January, so we have a whole stream of work on population health and prevention, and obesity will form part of that.

Lord Kakkar: I just want to be clear about what you consider to be the limitations to the devolution settlement that you have for health and social care at the moment, and what changes you would suggest are implemented in the overall opportunities that you are being given to overcome those limitations. If you are unable to overcome those limitations, what do you think the consequences will be for your ability to deliver on your ambitions?

Sir Howard Bernstein: The point was made earlier that the existing devolution instrument is not cast in stone; it is subject to review. Steve has already given a number of examples of how we would wish to see that devolution flexed certainly in time for next year, including co-commissioning on health education and specialist commissioning services and additional commissioning responsibilities. I think that will be important to us. The most important requirement, which I keep emphasising, but I think it is true, is a settled, stable pattern of social care spend starting from next year, because it is absolutely pivotal, in my

view, to making the sorts of transformational changes that we need to make to create a sustainable system within the five-year period.

Lord Kakkar: If you were not to have devolution of the Health Education England function in a way that you could utilise effectively for what you want to achieve in workforce development, and if you did not have a stable settlement with regard to social care, would that mean that what you have projected as your current devolution settlement being the bridge to longer-term sustainability of the NHS and social care for your devolved area would not be delivered, and that in the long term it will not happen?

Sir Howard Bernstein: We have already said that very clearly. We are looking already at a difference of £190 million over the five years, and £176 million of that difference is attributable to social care spend within Greater Manchester over that five-year period. We will not be able to deliver our target of financial sustainability within the five years if that position remains.

Lord Kakkar: More broadly, workforce sustainability is another very important aspect that has been drawn to the attention of this Committee in repeated evidence sessions. Are you saying in addition that what you need to do beyond funding for social care will not be deliverable if you do not have further changes to your devolution settlement?

Sir Howard Bernstein: I would not go so far as to say that we would not make significant progress, given the enormous commitment of staff throughout the system to make this work—and I really mean that. I think it would be harder. It is more to do with the cultural requirements that are needed—not just at the front line, I hasten to add, but at the leadership levels and senior management levels within organisations. Being able to create the right sort of template for training for the skills that we need in Greater Manchester and the reform programmes that we are delivering is, I think, a massive part of the challenge that we have to face.

Lord Kakkar: Just to be clear about your view with regard to regulation more generally and the multiple regulators that you have to deal with, do you believe that there are any changes that would be required to ensure that the approach that you mentioned—place-based care—would be better delivered with some changes, and are there limitations in that area?

Sir Howard Bernstein: Steve can come in in a minute, but I would place on record the co-operation that we have received from NHS Improvement and the CQC. NHS Improvement has the senior relationship manager, we are working with Nicky, Steve and John in their team day by day, and I think other agencies have promised the same. I think everyone is starting to recognise the significance of a place-based system approach. The particular task we have to perform, and we show all the signs of being able to deliver this, is how we integrate the functional responsibilities of NHS Improvement as part of our transformation plan without necessarily undermining the legitimacy of discharging separate statutory responsibilities. There is a balance to be struck there, but I think that so far we are very comfortable with the way that balance has been struck.

Steve Wilson: I would echo that. We are on a journey and I think those relationships will need to evolve, but at the moment, within the current national structures for NHS Improvement for example, we are able to create a place-based approach.

On the issue of locality assurance, we now have a single assurance meeting, so it is not NHS Improvement having an assurance meeting with an FT or NHS England having an assurance meeting with a CCG; we have a single assurance meeting. On our side of the table, if you like, we have NHS Improvement representatives, and, as Howard said, one of our senior management team is embedded from NHS Improvement. On the locality side, they will have the local authority, the CCG and one or two local providers, a mental health provider and a physical health provider. We are doing all that within the current structures and the current national requirements.

As we go forward, they will need to evolve, but what we are doing on locality assurance is likely to be followed by most other areas, because, as we said right at the start, the only real way to deliver the challenge ahead is to work on a place basis, and you can assure only in that way.

Lord Kakkar: Do you have any observations, fully accepting that it is working well at the moment on this journey, on how it might change, in order to make sure that, in the future, regulation does not inadvertently undermine the ability to deliver place-based care effectively, not only in your own devolution but in relation to lessons that might be learned for the rest of the country?

Sir Howard Bernstein: I think we are going to find out over the next six to nine months. A number of big transactional processes will be under way, particularly around the creation of our single hospital service. We will be very much in the detail of that in March and April next year and we will find out whether those will become fundamental constraints. We believe not. Based on all the work and discussions that we have undertaken and all the analysis that we have produced, we believe that those transactional changes can be delivered efficiently in the way that we would want.

Professor Kieran Walshe: I would turn the question around. It is a question for government, because all that has been done so far has essentially been done without statutory change. As you said, it is a process of delegation really rather than devolution, which has some real advantages. In Greater Manchester and elsewhere, increasingly the structures and facts on the ground look less and less like the legislative provisions of the Health and Social Care Act 2012. Therefore, the question for government and Parliament will be at what point they think something needs to be done to align the statutory provisions and the legislative responsibilities, which apply and will continue to apply until they are changed to foundation trusts, to NHS trusts, to CCGs and others, to make those things fit for the present and the future.

Steve Wilson: One of the risks is whether, if individual areas hit difficulties, there is a retraction to the centre of some of things, because a lot of that is being delivered through relationships and cultural change and not embedding in statute.

Lord Kakkar: I think those are fundamental points. Beyond regulation, do you have concerns that competition law might have an impact on what you are trying to do?

Sir Howard Bernstein: In a nutshell, again we will find out the answer about our ability to navigate those processes with the development of our single hospital service over the next six months, so we will be putting all our views through the most robust tests feasible. We think we have a way through all that.

Q233 **Lord Willis of Knaresborough:** I am a little concerned—and I declare an interest as a consultant for Health Education England—that you seem to feel that there is a pot of gold in Health Education England that will resolve your staff and workforce problems. Clearly, as Lord Ribeiro has illustrated, the fact that we are delivering particularly medics and dentists, et cetera, on a GB-wide basis is a different thing, and they have no responsibility for social care. What has surprised me is the fact that you have not seemed to include the 0.5% of your payroll across the whole of Greater Manchester and your organisation, which will be massive with the training levy, as the major driver for workforce in-work development, which is currently one of the biggest problems; not the people coming in but the people who are already there who have to be transformed to deliver. Why have you not included that sum of money, which is massive as far as your training budget, rather than on Health Education England?

Nicky O'Connor: That is perhaps because we did not have a chance to cover it before.

Lord Willis of Knaresborough: This is your opportunity.

Nicky O'Connor: We are in discussion with all our organisations about how we make the best use of that training levy, because, as you quite rightly say, that is a big opportunity for us to both create and grow our workforce in the right areas. In conjunction with Health Education England, we are looking at how we can pool those budgets so that we can maximise the benefits of what we have across Greater Manchester rather than in individual organisations. This is definitely part of our plans.

Q234 **Baroness Blackstone:** In many ways, this is one of the most interesting and challenging changes to the delivery of health and social care for a very long time. I wonder whether there is an independent evaluation going on to monitor how the implementation of this is going and to identify some of the barriers that Lord Kakkar was talking about. Is somebody doing this work and, if not, why not?

Sir Howard Bernstein: There is an independent evaluation project, which is largely led by Manchester University, and there are conversations going on with Harvard and Manchester University. Harvard is very interested in the work that we are doing in Greater Manchester, because of its wider application, so I can assure you that the work will be independently validated.

Baroness Blackstone: It is happening. That is good.

The Chairman: Before I come to the last question of Lady Blackstone's, from reading the information sheets and the evidence that you have given

before, the budget that is devolved to you is £6 billion, which is for a population of what size?

Nicky O'Connor: Some 2.8 million.

The Chairman: The plans have identified seven population-based outcomes, none of which is in social care or prevention health, but there are 1,300 fewer people dying from cancer, 600 fewer people dying from cardiovascular disease and from respiratory disease, et cetera. Are these targets any more ambitious than nationally the health service is required to deliver on?

Sir Howard Bernstein: When we produce all the locality plans, I think you will find that those targets will be exceeded in the context of the benefits that will be generated as a result. What we saw there, if I may say so, was an analysis about a point in time. It was before we got into the absolute detail, the fine grain of locality planning, which is generating significant additional benefits that will be captured, and we will bring that forward as part of our review of our plans in the early part of next year.

The Chairman: When do we know if you are succeeding or failing?

Sir Howard Bernstein: We are monitoring ourselves on a monthly basis. One important thing, which I do not think we have mentioned, is that when locality plans are approved and transformation funding is provided, there will be an investment agreement between our colleagues at the Greater Manchester level and individual localities. That will bind the system in those localities to deliver certain outcomes about how the money will be used and what particular care models will be driven forward. It is through those investment agreements that we have changed or varied the accountable relationships between place and the holders of the transformation fund. I think that is possibly one of the most exciting things that we have brought forward and done.

Q235 **Baroness Blackstone:** Could you each say which key suggestion for change the Committee might want to recommend to support the sustainability of the NHS?

Sir Howard Bernstein: Funding for adult social care, really.

Professor Kieran Walshe: I would say that it is a combination of financial stability and organisational stability—so the issues I raised in relation to thinking about the legislative framework and how it serves the interests of the system rather than acting as a barrier to it and thinking about the longer-term financial stability. I think the arguments that you have heard advanced that Greater Manchester, because of the change in governance, will be better placed to respond to the financial challenge are probably true, but that does not diminish the financial challenge, which is unprecedented.

The Chairman: Thank you very much for coming today. I know that you had a fairly long journey to come and assist us today and we appreciate it very much, so thank you very much indeed.

PHG Foundation, NHS Digital and Professor Sir John Bell – Oral evidence (QQ 236-242)

Evidence Session No. 24 Heard in Public Questions 236 - 242

Tuesday 29 November 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord McColl of Dulwich; Lord Lipsey; Baroness Redfern; Lord Ribeiro; Lord Turnberg; Lord Willis of Knaresborough

Examination of witnesses

I: Dr Ron Zimmern, Chair, PHG Foundation; Professor Keith McNeil, Chief Clinical Information Officer for Health and Social Care and Head, IT, NHS; Andy Williams, Chief Executive, NHS Digital; and Professor Sir John Bell, Regius Professor of Medicine, University of Oxford

Q236 The Chairman: Good morning, gentlemen. Thank you for coming to give us evidence today and helping with our inquiry. Our inquiry is looking at the long-term sustainability of health and social care beyond 2025 to 2030. In that respect, we are interested to find out from you the developments that are likely to impinge on how health and social care may change in the next five to 10 years and beyond, in the short term, in the medium term and in the long term—the developments in science and technology that we can be confident will be delivered in time to be used in clinical settings and in social care settings.

We are on live broadcast, so any conversation you have will be picked up. At the end of the session and in due course, you will get a transcript, as you know. If there are any inaccuracies, please feel free to correct it, but you cannot change it. If there is any material in the discussion that comes up that you are able to send us afterwards that will help us with the evidence, please feel free to do so.

Before we start, could you introduce yourselves from my left—of course, I know most of you. Welcome also, Professor McNeil; I know that you have replaced Dr Sood, and thank you for doing so at the last minute. If anybody wants to make an opening statement, please feel free to do so.

Professor Keith McNeil: I am Professor Keith McNeil. I am currently the chief clinical information officer for health and social care and head of IT for the NHS. It is wonderful to be able to come and speak to you about the potential power and opportunity that we have in getting the IT right, particularly in the data and the information that will flow out of it.

Professor Sir John Bell: I am John Bell. I am the Regius professor of medicine in Oxford, but I am also the chair of the Office for Strategic Co-ordination of Health Research. I have been involved in writing the Accelerated Access Review and I am now leading for the Government the

industry group thinking about the industrial strategy for life sciences, all of which I think are material to this discussion.

Andy Williams: My name is Andy Williams. I am the chief executive of NHS Digital, which is responsible for delivering the national technology systems, the data infrastructure for the health and care system and, in the future, the national developments to support the National Information Board, in partnership with Professor McNeil.

Dr Ron Zimmern: I am Ron Zimmern. I am a public health physician and I chair the think tank, the PHG Foundation, which I started in 1997. Basically, our strapline is “Making science work for health”. For the last 19 years, the concentration has been on genomics, but more recently we have widened our brief to include the whole gamut of personalised or precision medicine.

The Chairman: Thank you very much. Do any of you wish to add anything?

Dr Ron Zimmern: I have four small points to make, if I may. First, sustainability is a problem in all health systems, which is to say that the three drivers of the lack of sustainability are demography, the rising expectation of the citizen and technical and scientific advances. Whilst we cannot do much about demography, we firmly believe that dealing with the expectations of the citizen and science and technology will help solve some of the problems which it has created.

The second point is that, although we have people, such as Andy here, talking about IT, and Keith and John, who are very familiar with the biological and genomic, as we observe it there is very little inter-discussion. The guys who discuss digital do it out here and the guys who discuss genomics do it out there. Looked at from the outside, it seems to me that there would be a bit more to be gained if there were more connection. In that context, I prefer the term “personalised medicine” rather than “precision medicine” because it is not sufficient just to deal with the biological and the biological risk; we have to put the patient or the citizen at the centre of the new healthcare system.

The final thing, and probably the most important, is that, sitting where we are, looking at the whole health system, we firmly believe that muddling through is not enough and that, if we are to get the benefits from the science and technology, we have to redesign a new health system that puts the patient at the centre.

The Chairman: Does anybody else want to make an opening statement?

Andy Williams: I would just say one thing, if I may—and perhaps, Ron, to your delight—we are working very closely with Genomics England.

Dr Ron Zimmern: Yes, that you are.

Andy Williams: Sir John Chisholm, who heads up Genomics England, is a member of the NHS Digital board, and we are working very closely with them to work out how the data, in particular, can be worked together over the coming years.

Q237 **The Chairman:** That leads me on to the first question, which is: what

technologies which are now in the process of development are likely to be embedded into health and social care—and presumably it is more healthcare—by 2025 to 2030, and what effect will that have on the sustainability of the health service?

Andy Williams: There is a wide range of technologies. I will confine myself to information technology and data, which is not all-encompassing, and some of my colleagues can perhaps comment on some of the wider things. I think there are three main areas where information technology and data will come together.

The first is to help on this point of personalisation. I think we can do much more, as far as the patient is concerned, by better use of digital technologies to allow patients to understand more, to access their health records and increasingly to use intelligent systems to allow them to look at self-diagnosis—so, one big trend.

The Chairman: Give me a real example so that we and the public can understand what you are talking about. How do you use digital technology to self-diagnose?

Andy Williams: Two examples would be that in the short term I think we can make relatively straightforward transactions, if I can use that phrase, with the healthcare system, so ordering a repeat prescription or booking an appointment can be done very effectively using digital technology.

In the future, as patients start to have access to their health records and so-called “artificial intelligence” can be used to understand what is wrong with them and to compare their health record to the health records of the broader population, they can come up with smart diagnoses to help the patient understand what they should do next, and it could be to go to A&E or it might not be. So those are the sorts of things from the patient’s point of view. With apps and wearables, I think in the next five to 10 years we will see a revolution in the way devices will be monitoring people, and using technology to take the data that comes from that is another big advantage as far as the patient is concerned, so that will be the first thing.

The second is that we can use technology better to create more efficiencies in the way the system works, through interchange and passing information around, so if the age-old problem arises where you turn up at hospital and the information about you is not there, we can get information flowing much more effectively. Within hospitals, technology systems can not only improve quality but can increase efficiency and effectiveness.

The third area is a much better use of data generally. Before I say anything about that, it is worth saying that we have to be very conscious of the public’s understanding of the use of data and the need to have the public’s trust in how their data or data about them is used. If we can do that, data can be used in all sorts of ways in the future: to understand how effective the system is; to develop new treatments and new drug treatments more effectively; and linking genomics data to phenomics data. The whole world of data is the third area. That is the path that every industry other than healthcare has been on for many years and that is what we have to do in healthcare.

Professor Sir John Bell: If you are trying to think about that problem, you have to look back, as it were, at the natural history of new innovations in healthcare. Most of them start in the physical sciences more than 20 years before they are applied at scale. Digital would be a good example of that. From the time people start waving their arms around about it being a revolution in healthcare, you could start a stopwatch and it would be 20 years until you got to the point where it was of any use to anybody. There is a long gestation period for most innovations, but I think there is an opportunity to think about what those innovations might look like 20 years from now, for example. As part of the life sciences industrial strategy discussions with industry, we have been talking about what they perceive the world might look like, which is an interesting view, and many of those things overlap with what Andy has described.

There is a wide view that digitisation and large sets of data will lead to quite a lot of artificial intelligence applications across medicine. We are starting to see a few of those now, but the AI revolution—particularly in places, such as MIT, Caltech and Stanford—around robotics and intelligent use of data to draw conclusions out of a rather noisy set of data as to what is going to happen to people is a huge play. The UK is not very good at it, to be honest, but we could get better in the health space.

Implantable nano-sensing devices will almost certainly be there—things floating around in all of us that will be radioing out to say, “Keep an eye out for that”. That, I think, is inevitable and will add to this personalisation component because, of course, those signals will have to be interpreted on an individual basis.

The other area which is extremely interesting is that if you look at the natural history of all the chronic diseases—cancer, cardiovascular disease, diabetes, heart failure—all the things that are causing such a huge problem in the healthcare system, we diagnose them in the last few years and then we prop people up and therapeutics are entirely symptomatic. What we know in all those settings is that early diagnosis of those diseases completely changes the way you manage them and completely changes the outcomes. With cancer, for example, we have a lot of very expensive drugs which we give to people at the very end stage of their cancer, they get an extra three months alive, which is all fine, but the truth is we know that if you diagnose cancer really early, you can often, in fact usually, cure it. I think there needs to be quite a lot of attention paid, and there are now technologies which will allow us to analyse for very early malignant disease based on circulating tumour DNA, which should allow us to identify people who have very early tumours, maybe even before they would appear on a scan, and allow us either to track them or to excise those tumours at a very early stage. That frontloads the costs, but it saves you a lot of trouble downstream because the expensive bit is propping people up at a late stage of life. The same is true with diabetes, hypertension and cardiovascular disease.

Prediction and early diagnosis is going to be, I think, the new world of healthcare 20 years from now. Interestingly, the NHS is about the best place in the world to apply that at scale, but the problem is they keep talking about it and not doing anything about it. We cannot just keep

saying, “It is going to be a public health-generated healthcare system”, but we have to say, “Okay, but what exactly are we going to do to get it to where it needs to get to?” That is my view.

The Chairman: So most of the technologies over the next 20 years that we now use—and you are right, the gestation period is long—end up delivering maybe more efficiency and better outcomes, but increase the cost?

Professor Sir John Bell: I disagree with that. I think the fundamental problem with innovation in healthcare is that we do not systematically look for the ways that innovation can extract cost from healthcare systems. In fact, the definition of “innovation” should be to improve outcomes and to save costs, and it saves costs by changing pathways, allowing you to re-profile the workforce, which is essentially where healthcare systems spend all their money, and you should be able to extract very large amounts of money out of the system using those tools.

The problem is that the healthcare system is really bad at doing that; they layer innovation on innovation and they do not say, “Okay, this is an innovation, but it saves money because we can shut those beds over there and reduce the staff in this area of the hospital” and save money in those domains. My view is that innovation should be seen systematically through the lens of how they save money and that data needs to be robustly generated by these guys, who will have the digital data to show it is true, and that is how innovation needs to be implemented. We describe that a bit in the AAR report, but it does need real focus. Therefore, I disagree with that premise. Innovation that just raises costs is going to be unaffordable by everybody.

Dr Ron Zimmern: I would like to add that innovation can save costs, but not if it is added on as an extra layer to the system that we have today. We have to have a new bottom-up-based system where care starts at a much earlier stage with the healthy individual.

The Chairman: That system does not exist just now? Is that what you are saying?

Dr Ron Zimmern: It does not exist. I would only agree with John, I think, if we were talking about a much more disruptive sort of situation. By layering technology on to the existing system, it could increase costs, but, if we do it in the right way it will save costs. It has got to be done in the right way.

Professor Keith McNeil: Following on John’s point, to give you a practical example of innovation and costs, when coronary angioplasty came in, which is putting a balloon in a coronary artery to treat a heart attack or a blockage, the previous treatment would be to open someone’s sternum and do an operation. The cost of doing an angiogram is much less than doing an operation, but the angiogram enables that technology to be available to a much wider population, so you get the balance between an individual procedure which is less costly and innovative but is available across a wider population and, in fact, the aggregate cost is greater.

I think of technology in two ways. There is technology that enables us to interact with the patient more effectively, say, to do an operation with a robot or a laparoscopic device. Then there is technology that enables us to gather information, such as an MRI machine or a CT scanner, which effectively gives us information. As we have alluded to, the power of what we can do now—or we are starting to be able to do with aggregating that information—is to feed that information back to the individual clinician-patient interaction to make that more effective. There are a million of those every 36 hours across the NHS and if we can make each and every one of them more efficient, effective and more productive, that will start to embed sustainability. We feed it through for business intelligence so that we can run systems more efficiently and productively, which is the whole business intelligence tool, and we feed it through to research so that we can prosecute the issues around genomics and phenomics and how we bring that back into personalised and precision medicine. That is the platform we have set out with the National Information Board portfolio and that is exactly what that portfolio is aiming to do: to enable us to gather information and make it available to people when they need it and in the form they need it as a real-time technology.

Bishop of Carlisle: I do not need to ask my question now because you have just answered it; it was about costs.

Lord Turnberg: Is the problem the timing: that the cost of an innovation is quite high when it gets put in, but the savings are downstream? The savings are not necessarily made to the health service but they are made to the productivity of the country and the Treasury, and the Treasury does not recognise that the NHS is providing it with some extra money. So how do you get that right?

Professor Keith McNeil: That is a really good point. Even within a hospital, for instance, in the way we cut the budgets, often where you will spend money is not necessarily where you will gain the reward. Right across the system—from the very bottom to the very top, if you like—it is difficult to figure out how you follow the paths where you get those productivity efficiencies and cash-releasing savings.

It is not outwith our capacity to be able to do that. In fact, particularly with the digital stuff we are doing, it is important that we consider innovative ways of looking at the return on investment. We have to do that to know where we can most usefully invest, because it is expensive, but there are great gains to be made, as you say, for UK plc in a lot of areas around data.

Professor Sir John Bell: It raises the interesting point that, first, introducing innovation always causes an uptake in the cost because you have to change the pathways in order to make the savings, which always means you have to change some things, so there is always a real increase, sometimes modest, in what it costs to get things to happen.

I think the problem is further upstream because what we are not very good at is understanding where you extract the savings before you introduce innovations. You can only do that in a closed system because it is not helpful for a hospital to think that it is saving money for the costs to be dumped on the primary care docs or vice versa. Therefore, unless you

understand the integrated pathways as to how making an innovation changes things in cost terms and how you can change pathways where you capture the savings across the whole system, you do not really have an innovation. We are not very good at doing that.

The advantage of the digital agenda is that you will be able to capture data on the same patient in primary, secondary and social care, and you will be able to know the captured cost of that whole pathway and then manage that to try to get yourself in a better position in terms of cost reduction.

Q238 Lord Kakkar: I would like to explore the question of whether you can provide evidence that adopting an innovation or technology has provided improved efficiency in the measurements that Sir John was talking about—understanding the tick up not at the initial introduction of that innovation but downstream, that that innovation has provided efficiency and financial gain in the delivery of healthcare. I should declare my interest as the chairman of UCL Partners, which hosts the national Innovation Accelerator. What systems and processes exist to take these innovations and embed them at scale across the NHS at the moment?

Andy Williams: With all the data and technology systems that we run nationally within NHS Digital, we measure the costs and the benefits. A lot of that data has been provided to certainly the PAC once a year, but there are some good examples of national technology systems that are producing very significant benefits versus their costs. There is a national e-referral system, which used to be called “Choose and Book”, where the benefits of electronic referrals across the system are massively higher than the costs of running that system.

Lord Kakkar: By what proportions?

Andy Williams: In the case of the e-referral system, I would have to provide the data, but it is multiples—perhaps 7:1, 8:1, 9:1—of benefits versus cost. If I could sidetrack just for a moment, the evidence across all industries, not just healthcare, in what is now called “digital technologies” is that, generally speaking, a well-implemented digital system produces annual savings of between one and two times the cost. The issue that we were getting to in some of the previous discussion was that those come, typically, one to three years down the line. In healthcare, one of the difficulties we have had in technology systems is the speed of take-up. Only 50% of all first referrals across England currently go through the ERS system, so it is producing big benefits, but its uptake is not as high as it could be. With the EPS system—repeat prescriptions—you can order those online and have them delivered to a chemist or a pharmacy of your choice and go and pick them up. That produces significant benefits above its costs, and there are other examples of national systems which do produce significant benefits.

The Chairman: What you have described about prescriptions happens now, does it not?

Andy Williams: Yes, it is the system that exists today.

Professor Sir John Bell: It is not just digital. In fact, we are at the beginning of a digital revolution, so I would not expect a catalogue of

examples where it is saving a ton of money because it is not yet, but, if you look historically, the list is very long. We do not do duodenal ulcers anymore. In 1990, 50% of all hip and joint replacements were due to inflammatory arthritis and last year it was 0.5%, so, even in absolute terms, there are dramatic savings. With the use of antipsychotics, which allowed us to close all the asylums around the country, there are huge savings if you add them up over time and, of course, those drugs are all generic now, so they cost very little and have a huge impact. In stroke care, which is an integrated set of innovations, integrated, highly effective stroke care saves a ton of money in the healthcare system. It is not just one but multiple things that get done in that pathway, and London is probably the best example of that nationally.

There is a list of really spectacular savings from innovation, but it is quite hard to predict at the beginning which ones are going to give you a really big hit. When the anti-TNFs were introduced 20 years ago, I remember the debate with people saying, "They are really expensive" and, in fact, they did get embedded and they cost the system quite a lot of money, but, if you look at the numbers they are terrific. Most hospitals do not have wards anymore for rheumatoid patients because you do not need them, and all the surgery has gone because you do not need surgery for hands that used to look like that. There are a lot of savings in a lot of domains that are not digital which I think are very real.

Lord Kakkar: Do you think we have a system that allows the adoption of this innovation at scale in such a way that we can quickly realise the financial benefits to drive long-term sustainability? If we do not, what needs to be put in place in the adoption of, let us say, disruptive innovations which, by definition, will attend some local controversy in terms of the disruption created?

Dr Ron Zimmern: It is absolutely true and, although innovation is necessary, it is not sufficient. There are huge barriers at the moment to diffusion—although we should not use that word because it is passive and, if you allow it to be passive, it will not happen. Change management is the thing. If we are going to have disruptive change, we need to have change champions. There are issues about both having and developing clinical champions, clinical leadership, managerial champions and managerial leadership for change management. It will not happen by itself. It is an explicit activity.

Indeed, in dealing with this, the other thing—and we are doing a lot of it now but nowhere near enough—is to use citizen power. In patient groups in the whole rare diseases environment, a lot of this is being driven by the patients. Those are the active things.

In addition, we have to get rid of certain things that are barriers. I do not believe that our regulation is proportionate enough in many areas. We need to break down barriers, particularly between clinical and research, where the governance mechanisms are at the moment different, but clinical and research are coming together. Indeed, there are barriers between clinical and public health because, to get the big data revolution going, it is dealing with huge populations of data and that is where we need a public health input. But at the moment most of my public health

colleagues have no interest and no expertise in some of these areas, so there is a huge divide between clinical and public health.

Finally, another barrier is the realisation that politicians' timescales are short term. Here we are talking about a 10 or 15-year strategic change management programme, which I firmly believe—unless we act—will not happen.

The Chairman: John, you were shaking your head when Lord Kakkar asked the question.

Professor Sir John Bell: I agree that one of our biggest limitations is a system-wide approach to try to take advantage of innovation in extracting money from the system. We tend to allow innovations to go in and for local healthcare economies to cook up how they are going to use them, and there is no systematic approach to how to change pathways. The two ways to save money in healthcare systems are to completely alter the way a patient flows through a pathway and to re-profile the workforce. I am sorry to say the workforce in the healthcare system is hugely, in a sense, unionised; they are deeply conservative; they do not want to change what they do; they are dug in.

The Chairman: You have brought a smile to Lord Willis's face.

Professor Sir John Bell: Sorry, I did not anticipate that. Those are real obstacles and, unless we are prepared to bite the bullet on those things, we will never extract the savings.

Lord Kakkar: So how do you think we should bite that bullet, because that comes down to the core question for this inquiry? How is that going to happen?

Professor Sir John Bell: One of the things we recommend in the AAR, which is important, is that you should not introduce these innovations unless you have a clear view about how you will change the pathway and the workforce in the way that you apply these in real life. Very often, we will say, "That's a nifty gizmo. Let's see if we can use that", and what it really needs is some rather more systematic work in a closed system supported with digital data, so that you know what the benefits are. Then, as we suggested, NICE takes the role of saying, "This is not just cost-effective but it's cost-effective if you do the following things to save money". This is an anecdote, but rather interesting. Twenty years ago we introduced PACS systems for X-rays. We went digital on X-rays and the view was, "Well, you have a lot of ladies in white coats in the basement putting X-rays in folders and sticking them on shelves and the X-rays always get lost, we cannot get them and it is hugely costly", and those of you who have done a bit of clinical medicine will understand what I say.

The Chairman: Yes, every day of the week.

Professor Sir John Bell: It was kind of obvious to do the digital thing, so they did the digital thing. There was a graduate student in my place who did some rather interesting analysis as to what happened and it turned out that the cost of maintaining the digital system was exactly the same as having the little ladies in the basement, so you were now cost-neutral. All the savings came from the efficiency of the radiologists who could flick through 10, 20 or 30 X-rays from individual patients or multiple

patients much faster, so their efficiency hugely improved. In America, where they introduced the same system, they fired a lot of radiologists. In the UK, everybody just drank more tea and ate doughnuts. That is the problem and that is what you have to fix.

Lord Kakkar: Do you think that, as currently constituted, we have the flexibility in the system to be able to address those two critical issues: the definition of clarity with regard to pathways of care, and the modification of the workforce to allow us to take advantage of innovation that we might introduce? Where is the impediment in both those areas?

Professor Sir John Bell: The impediment in the pathways is that the structure of the healthcare system at the moment is multiple balkanised states, even at a local level, all of which carry a yellow card and can stop you from doing almost anything. If you have a good idea that changes the pathway that runs right through the system, there are all kinds of people who say, "Sorry, we are not doing that", so there is no command and control to make things happen. That is the pathway thing.

On the people thing, it is this heavily—"unionised" is probably the wrong word—consolidated view of healthcare workers who form groups and tribes within a healthcare system where they defend each other, defend their space, and they do not want to change. Worse than that, we train people to be highly focused on doing one thing and if we want them to be doing something else later in their careers, they will fight for their lives to stay doing what they were doing, even though we all know it is not cost-effective, so it is a real issue.

The Chairman: Including doctors.

Professor Sir John Bell: Including doctors, or doctors more than anything.

Lord Willis of Knaresborough: Consultants are worse, Chairman.

The Chairman: You are speaking to one or two there.

Q239 **Baroness Redfern:** Following on from that questioning from Lord Kakkar, I know it has been mentioned that speed is an issue on the take-up of new technology and is a barrier to innovation, but how can we incentivise a greater take-up of those technologies and innovations, and who monitors progress nationally on that?

Andy Williams: My answer to that comes back to the discussion we had a moment ago. I have been doing this job for about two and a half years and previously I had spent time implementing technology in all sorts of other industries, so I have spent a lot of time reflecting on why things are different in healthcare compared to some of the industries I have worked in. Part of the reason I say that is that you can always find across the health and care system in this country examples of really good, innovative uses of technology, but they do not spread at anything like the rate you would expect them to. Why is that? I would point to two things, and one of them we have talked about. Quite often, in large, complex organisations, the benefits of something sit in a different part of the system from where the costs lie.

Baroness Redfern: It is about the silo mentality?

Andy Williams: Yes, this sort of silo, I think, is one of the inhibitors. Another one is a technology inhibitor. Without going into too much of the detail, new technologies quite often get plugged into the existing technology of one of those organisations and it is unique to that, and trying to replicate it somewhere else requires an awful lot of planning, so it is hard and difficult; it is not simple just to take something from here and put it over there. From a technology point of view, over the next few years we have to make that much simpler. Despite the organisational constraints and the costs and benefits lying in different places, we ought to be able to do much more so that, if technology innovations exist over here, you can make them work over there and it is much easier. That is a big task, I think, over the next few years.

Baroness Redfern: Do you think that will happen in the next five years?

Andy Williams: I think we can make big strides in that.

Baroness Redfern: In five years?

Andy Williams: In the next five years, yes. That is one of the aims.

Professor Keith McNeil: Following on from your point, one of the issues about anybody adopting innovations is headspace to do it, both in terms of funding—because it is always expensive, as John said, before you start to see the benefits and, unless you can access a fund or something, the trusts, hospitals and providers do not have the funding to invest to save—and the time involved. To put most of these things in, it needs to be done properly and usually it is added on to what you are doing already, as you assess the impact, and it takes a lot of time and effort for people, which is quite often discretionary, and there is no headspace on the ground to do that. I can tell you, from having implemented an electronic health record in Cambridge, that it is unbelievably disruptive, and we all know we have to do it. We had to do that with virtually no headspace at all, added on to what we were doing already, and that is spreading. That adoption of technology is really hard because you are so focused on just getting through day to day and dealing with the demands. I do not know what the answer to that is. I think some of the digital things that we can do, providing there is persuasive evidence that you need to do this and to have the system invest in doing this, will be really important. Having the space for people to do it in real time is a problem.

Lord Willis of Knaresborough: All the questions and answers have been, for justifiable reasons, about tertiary care, intensive care and serious long-term care. My concern, and this Committee's concern, is that the issue of social care impacting on health budgets is absolutely massive. Can you give us any indication at all of where there is going to be a technological or digital revolution to deal with the intense monitoring of long-term care in order to save the sums of money that are needed to make the system sustainable?

Andy Williams: It sometimes comes across as being a tertiary care focused conversation, but everything that certainly Keith and I are talking about applies also to social care. The remit of my organisation is health and social care, not health only. Much of the patient revolution from a technology point of view, and the shift towards prevention rather than cure as part of that, also applies to social care. When I talk about

stitching things together much more effectively using technology, that includes social care. When we are talking about information flowing around the system, that has to include social care. I do not know whether that answers your question.

Lord Willis of Knaresborough: Not really, because I spend a part of every week in social care settings and the use of technology is virtually non-existent in monitoring quite vulnerable patients, particularly those in domiciliary settings. If you go to McLaren Technology, which has offered the most wonderful sensing systems to use to monitor those patients, they can monitor their Formula 1 car out in Abu Dhabi, but elderly patients in the North Yorkshire moors cannot get that sort of simple technology. I find that really quite disturbing when we are looking ahead to 10 or 15 years' time.

Professor Sir John Bell: The point is a good one, but those systems are actively under development. You can, off the webcam of a PC, measure pulse, respiratory rate, temperature and, believe it or not, oxygen saturations in a patient. You can track virtually everything that is going on with webcams and monitor people at home and probably get somebody to them if there is a problem as fast as you can get a house officer to level seven in their local hospital. I think the opportunity, say, to manage people who are having acute episodes in their chronic illness and track their mobility—are they going to the shops or are they spending all their time sitting in a room immobile?—should be relatively easy to do with digital sensing technologies. There is a project near my place which is doing exactly that to try to increase the effectiveness in functionality of domiciliary care. At the moment, people do not use it because they are worried that bad things will happen when they are at home and they will not get healthcare. The truth is that bad things happen in hospitals too and, in many ways, if you can get that set up, it would be a better place for patients.

Lord Kakkar: Do you think that the STPs, the 44 or so which have now been described, are more or less likely to overcome the two impediments—the pathways of care change and the workforce change—to allow innovation adoption at scale?

Professor Keith McNeil: Yes, I think they are more likely. The STPs, particularly working across with constructs, such as academic health science networks, will be able to spread that technology and innovation much more effectively. The short answer is yes, they should absolutely help in this space.

Professor Sir John Bell: Conceptually, it is a good idea, but the execution is poor, in my view.

Dr Ron Zimmern: There is one other thing, which relates to the last two questions on clinical pathways and the workforce—I totally agree that it is essential to get those changed—which is the citizen or the patient. We see in the rare diseases sphere and in whole other spheres that public engagement is seen to be absolutely key. It seems to me that, if we are to have this transformation, we have to take the patient or the citizen with us and put them at the centre of the healthcare system. Because of all the political forces and so on, there is much more likelihood of that if

we have the patient or citizen behind us. Also, the perspective of the patient or the citizen takes us to an earlier point of using these technologies—to keep the patient healthy before they have even had the need to engage with primary care, let alone secondary and tertiary care. With clinical pathways and workforce change, putting the citizen at the centre is an essential part of everything.

Q240 **Lord Ribeiro:** The Health and Social Care (Safety and Quality) Act 2015 provided a legal framework to share data. I have heard both Andy Williams and Ron Zimmern talk about patients and patient trust and, in fact, we know that, because of a lack of patient trust, the care.data system failed. Realising that this Committee is about the long term, how will we make sure that we use the data effectively to create a sustainable NHS in the future—and that clearly means starting with the patient?

Andy Williams: This is one of the crucial challenges. A lot of people talk about there being a balance between the patient's trust on the one hand and the use of data on the other. In that sense, it feels like it is an either/or where you do a bit more of one and less of the other. I do not think that is the case at all, but you can do both effectively, which we have to. Dame Fiona Caldicott wrote quite a long and important report on this recently, in my view at least, that is currently beyond consultation and there has been wide consultation. The Department of Health is currently ruminating on that consultation, and I do not want to in any way prejudge what they may or may not say, but the recommendations that Dame Fiona came up with and what we do about them are really important. You are right that care.data, in part, failed through a lack of public trust in the use of the data that was going to be generated. When we are thinking about the benefits of data in the future, which are enormous, we have to bring the public with us and this comes down to the public having to trust that we are handling their data with care and respecting whether they agree with the use of their data. We have to convince the public that we are doing the right thing and involving them and asking them.

Lord Ribeiro: This is a challenge because, in fact, the Caldicott principle is about the ability to share information being almost as important as the ability to care for the patient. Inevitably, we try to do things top-down. What you are describing is a situation where patients may, in the future, have implantable instruments put inside them which will monitor what they are doing, but they will not allow you to do that unless they trust you and what you are doing. How will we take that mechanism forward?

Andy Williams: We have to allow patients the option to tell us whether they are happy or not for their data to be used, particularly for secondary care and what is called the "secondary use of data", and Dame Fiona's report talked quite a lot about that. We have to convince the public that, when it comes to the use of their data, the NHS brand is as trustworthy as it is in general. We have some work to do on that. I think it is possible to do it, we have to do it and that gives us the right then to use the data in the ways that we talked about earlier, to the benefit of the patient. That is the crucial thing: nobody wants to use the data in any way other than for the benefit of the patient.

Professor Keith McNeil: It is absolutely critical. This agenda will not go forward without the effective sharing of information, and that relies on citizens and patients being confident that we do what we say we will do, so it is pushing forward the imperative and making sure that people understand that. Secondly, it is about having robust security, data guardianship and information governance systems, having transparency in how that data is used, giving people options as to how their data is used and doing it in an open and transparent way.

The Chairman: Do you think that currently, there are mechanisms in place to communicate this information to citizens?

Professor Keith McNeil: Not as widely as we would like, but they are being put in place.

The Chairman: How will that happen then?

Professor Keith McNeil: When we have the response to the Caldicott review and the whole system comes to a view as to what to recommend, there will be a media campaign, for want of a better term, to explain what has happened, why and what we will do moving forward in terms of how this will all play out.

Professor Sir John Bell: There is an important point here, which is that engagement is unlikely to be done by Government Ministers. It is very likely to be done at a local, not a national level. If you get a letter from these guys—who are terrific, I have to say; NHS Digital are terrific—saying how they are going to use your data for X, Y and Z, you will flip. If somebody in the local GP surgery or the local hospital says, “We are going to try to get a system where you can look at your records. Will that be okay with you?” you are likely to say, “Yes, that is kind of interesting”. If they say, “We would also like a system whereby the hospital consultant can see the GP records and the GP can see the hospital records”, if the patient knows the GP and they know the hospital, they will say, “Well, I thought you did that already”, which we do not, and then they will say, “Well, of course you can do that because then, when I go to see the consultant, he will know what the GP said and vice versa”. If you can build their confidence at a local level, it becomes much easier to make those things associate with each other and you then end up with very powerful master databases, but it is all done with consent on things that will benefit the patient. If this does not benefit patients, it is going nowhere.

Q241 **Baroness Blackstone:** Last year, the National Advisory Group on Health Information Technology was set up to advise the Department of Health on secondary care digitisation. Which of its recommendations do you think we should be focused on, and how far have they been implemented so far?

Professor Keith McNeil: Are you referring to the Wachter review?

Baroness Blackstone: Yes.

Professor Keith McNeil: As you know, there were 10 recommendations and they were all widely accepted. That report, when considered in its whole, both complements and informs the national information strategy,

so there is a nice piece of synergy there. To my mind, the important thing to take away from that is that the report encompassed expectations— what you can expect from digital maturity and from having to go through the journey to achieve it, which was important because it is a difficult journey in some instances. The second thing was interoperability and how the systems should come together to enable effective data flows so that information can be available where and when it is needed. The third critical thing from my point of view is the absolutely vital need to engage clinicians in the whole gamut of what we are doing in this space, because they will be the end users with the patients and citizens. The report in its entirety is important, but those, to me, are the three things we take away.

Andy Williams: Can I just add one thing to that, if I may? There is another recommendation in there which applies to a lot of what we have talked about, which is the importance of leadership around the use of technology and data. If we are to get much more effective use or uptake of these technologies in the future, working with leaders across the health and care system locally and nationally to understand, by doing this set of things, how your organisation can change to effectively take advantage of this, and how it helps patients and clinicians, is really important. It was one of the recommendations of the Wachter review to focus on the leadership community across the health and care system.

Professor Keith McNeil: There were two pieces on leadership. One was around upskilling the clinical workforce and not just in digital capability but in thought leadership and actual leadership in leading transformational change underpinned by technology, which is important. The other leadership piece was around the exemplar programme, which was picking hospitals that are already showing investment and maturity in this instance, and getting them to a high level so that they can act as system leaders right across the country to pull the rest of the system up to that level.

Dr Ron Zimmern: Can I add technology to this, if I may? It is not something I know a lot about, but some of my colleagues are telling me that, since we have this tension between the patient wanting data protection and the clinical and scientific community wanting the sharing of data, blockchain technology may be one way to go—it is almost a network because no one is dominant and everybody plays a part in it. I do not know whether this will take us anywhere, but it seems to me, on my very superficial look at it, that it could be a promising way forward whereby we can get a greater link between the two.

Baroness Blackstone: I think the Committee recommended that a more realistic date for achieving 100% digitisation in hospital trusts was 2023 rather than 2020, but do we have enough people who can train all the hundreds of thousands of clinicians, both nurses and doctors, in this new digital world to achieve it by 2023? It is a huge task, is it not?

Professor Keith McNeil: It is a huge task and it depends on what we mean by what we want to achieve, because this will be ongoing beyond 2023 into 2025, 2030 and beyond. We will accomplish an enormous amount by 2020 and are driving very hard at the original 2020 vision. In reality, will we get everybody there? Probably not, but we will cajole,

incentivise and inspire people to try to get as far as they can. There are organisations starting at different levels, so we want everybody to raise the bar, if you like. We have a tremendous capacity in the workforce right across the NHS and across social care. The key is to engage them and empower them to make these changes. We cannot do it from the top and, in fact, the ethos of the programme is to devolve wherever possible and centralise only where critical and necessary. That is really important because, if we do not empower the workforce to do this, it will flounder.

Professor Sir John Bell: It is worth remembering that the Americans did this in a really short timeframe. They, essentially, digitised their entire healthcare system, which, as you know, is chaotic at best, and they did it by incentivising the hospitals and making sure that reimbursement was directly related to the ability to digitise. If the NHS tomorrow said, "Do it at whatever pace you like, but you will not get paid if it is not digital data", I can tell you that, by Christmas, you would find a lot of stuff had happened. Hospital trusts have a lot of stuff on their plate, so why would they do it when they are doing everything else? There is a bit of a problem in incentivising these places in the way we need to. The American example shows that it can happen really fast.

Andy Williams: I do not want to underestimate the point that you are making, but one of the characteristics of digital technologies is that they are easy to use. One of the things we have to work on with technology and its use across healthcare is making it easy to use, not just for the patient but for the clinician. That is one of the things you could look at over the last 10 years where we have not done as well as we could have, so we have to do better.

Q242 **Baroness Blackstone:** Of all the things that we have discussed today, what single key change should the Committee be recommending to sustain the health service over the longer term?

Professor Keith McNeil: If you are asking around digital—

Baroness Blackstone: Broader really.

Professor Keith McNeil: Broader, we have to get social care up to speed. That is where the money is, for me.

Professor Sir John Bell: I think it is about being really rigorous about taking innovations and trying to evaluate how you can extract the costs of innovations in a closed system, measuring and evaluating everything and then recommending that across the system. That will make a huge difference.

Andy Williams: I would say that, in many ways, this is not a technology challenge; the technology largely exists and will continue to exist. Like everything, it is a people challenge, so the one thing I would point to is to get the leadership at all levels across the system to understand the benefits generally and the benefits in particular to their organisation of these sorts of technologies.

Dr Ron Zimmern: I think data is at the centre of all this. No matter what technology you look at—epigenetics, microbio, liquid biopsy—in the end it is about data and data sharing. To do that properly, you have to engage

the citizen, you have to break down silos and you have to actively develop leaders. Without that, you will not get the data sharing which is absolutely at the heart of everything that we want to do.

The Chairman: Thank you all very much for coming today. You have been very helpful. If you do think of something else that will help us, please feel free to send it in and we will record it as evidence. Thank you for coming today.

Department of Health, Public Health England and Professor Dame Anne Johnson – Oral evidence (QQ 243-249)

Evidence Session No. 25

Heard in Public

Questions 243 - 249

Tuesday 29 November 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord McColl of Dulwich; Lord Lipsey; Baroness Redfern; Lord Ribeiro; Lord Turnberg; Lord Willis of Knaresborough.

Examination of witnesses

I: Mark Davies, Director, Health and Well-being, Department of Health; Adrian Masters, Director for Strategy, Public Health England; and Professor Dame Anne Johnson, Professor of Infectious Disease Epidemiology, UCL.

Q243 The Chairman: Good afternoon. Thank you very much for coming today to help us with this inquiry that we are doing, as you know, into the long-term sustainability of health and social care. This session, which is related to preventive aspects and the benefits of that, is crucial to us, so welcome and thank you.

You will get a transcript in due course, which you can check for accuracy and, if you find in the conversation today that there is some other additional material that might be helpful, please feel free to send it to us. Anne, would you introduce yourself? If you want to make a short opening statement, please do so.

Professor Dame Anne Johnson: I am Anne Johnson. I am a professor of epidemiology at UCL and I was the chair of the Academy of Medical Sciences' working group on improving the health of the public by 2040. This report addresses the question of how to optimise the research environment for a healthier, fairer future, which I know has not necessarily been the focus of your inquiry, but research and evidence are at the heart of improving the National Health Service and health more broadly.

In particular, our report emphasised that we needed to shift the focus of research to prevention and early intervention at scale. I do not need to remind a committee like this that, of course, many of the drivers of our health, possibly 50% or more, are determined by socioeconomic and environmental factors outside the health service. Investing in prevention also means investing in effective prevention outside the health service, within economic and environmental factors, for example, as well as

aspects such as fiscal and legislative interventions. For that, we need transdisciplinary research evidence including disciplines beyond the traditional biomedical sectors, in which I would include social sciences, the built and natural environments, law and ethics and so on. As we have heard commented on in the earlier session, if we look at the investment that is made outside the health service in prevention and improving health, the cost falls outside the health service and the benefits lie within it. It is really a challenge across government about how and where you invest in prevention.

The recommendation of our report was on the importance of co-ordinating and implementing research for improving the health of the public, and to do for preventive health and preventive medicine what we have done for treatment in the NHS, particularly through what has been done through OSCHR, the Office for the Strategic Co-ordination of Health Research, the National Institute for Health Research and the Academic Health Science Centre, which have brought evidence bases into clinical practice. The challenge now is to see the same effort to bring the stronger evidence base into public health practice and prevention within and outside the health service.

The Chairman: Thank you very much.

Adrian Masters: I am Adrian Masters, the director of strategy at Public Health England. I do have a few opening comments just to set up the discussion. I want to say something briefly about progress in cardiovascular disease, because it brings out some things we might want to discuss.

Over a 20-year period, we saw life expectancy increase by five years. The major reason was a fall in premature death due to CVD; the likelihood of dying of cardiovascular disease before the age of 75 halved. The analysis of the cause of that suggested that half the fall was due to a reduction in risk factors which you would target through prevention—in particular, a reduction in smoking and better diet. CVD is still a major cause of tens of thousands of premature deaths, and perhaps two-thirds of those deaths are preventable. One estimate of the cost of CVD deaths for the NHS is about £14 billion a year; as for the extra cost to wider society, there is an estimate of, say, £16 billion per year, because it includes things such as lost productivity. I want to use that as an example to bring out some themes.

Prevention is a big opportunity to save lives. It is also linked to improvements and productivity in the economy, and it can make a contribution to reducing pressure on NHS spending. I would say that the value of prevention is in that order: saving lives; helping the economy; and its contribution to the finances of the NHS.

Mark Davies: I am Mark Davies. I am the director of population health at the Department of Health. I was not planning to make an opening statement because I have appeared before you in the first session and you heard from me then.

The Chairman: I was going to say that this is your second visit.

Mark Davies: It is indeed, yes.

The Chairman: What do you think about the current preventive strategy, and is it sustainable in the long term?

Professor Dame Anne Johnson: I think you will be well aware that the NHS Five Year Forward View makes a big pitch for investing in a radical upgrade of prevention and public health. This has been a familiar theme in a number of reports. The reality is that we spend about 5% of the health budget on prevention, which is about £5 billion across the piece, and about half of that is spent in local authorities while the other half is spent in the health service. You can argue about what counts as prevention. Similarly, we spend about the same amount of our health research budget on research into prevention, which has increased over the last few years.

Let us stick to prevention within the health service. Some of the things that are done lie either within the health service or outside it, including screening programmes, vaccination programmes, smoking cessation programmes, programmes on diet and so on. But I would say—and there is not much of me left as a clinician, but I did train as a clinician—that we need to change the focus of how we practise medicine and, more broadly, healthcare, so we take a view which is focused not just on what we now call “personalised medicine” but on personalised prevention. I think that means a fundamental shift in how we train health professionals to think about prevention so that they think, when they have a person with a heart attack in front of them, they do not want to treat just the end stage of the condition—they want to intervene much earlier in the course of that disease, either in primary care or earlier on. I do not think we have that mindset yet.

Some of you will be familiar with the concept of the four Ps of medicine—that in future medicine should be predictive, which means we need the kind of data which say, “These are the risk factors for ill health”; pre-emptive, which means that we act early; personalised, which means that we act for the individual, looking at their competing risks; and, finally, participatory. We need to take the public with us on this, because they now have the textbook—they have Google Health, and know a lot more about their health. We have to change the way we practise medicine.

The Chairman: Does anybody else have a comment about the current strategy for public health and prevention?

Adrian Masters: I think there has been a significant change in the last few years in the understanding of the importance of prevention and early intervention. Both the five-year forward view and the programme of work coming from that in the NHS and the shift, following the Marmot review, of the public health system to local government reflect the recognition of the increased importance of prevention and early intervention. At the moment, we have a very ambitious, full agenda on prevention, and we are at a stage where we have to spend the next few years seeing that through. As we get towards the end of the Parliament, we will want to come back and see what is next on the prevention agenda. My view at the moment is that we are ambitious on prevention and we do have a good agenda of change in the NHS and with local government.

Lord Lipsey: Perhaps I can focus for a minute on the third of your points,

Mr Masters, which was about savings to the NHS, which, obviously, as we are a Committee on the sustainability of the NHS, are very important. There is a problem here. We see figures such as those stating that obesity costs the country some £8 million a year. The fact is that, if they do not die of a heart attack caused by obesity, they will die a few years later of some other cause and, as ever in healthcare, most of the costs of the treatment will come in the last two years of life. What is the evidence that it could actually save the NHS money to improve health through the kinds of measures that we are talking about this morning?

Adrian Masters: I think those were excellent points, by the way. If you look at the long-term modelling—for example, that done by the OBR; Wanless did something similar back in the early 2000s—and at what is driving health expenditure, you get a list. First of all, you see some interaction between people’s expectations as we become richer and the technology, then you see something to do with productivity in provision of services, then you see something to do with the demographics and the ageing population, and then you see something to do with health behaviours. The OBR recently looked over 50-year period. It saw that the difference between keeping productivity as it is now, on trend, and improving it from, say, 1% to 2%, was about 5% of GDP. If you look at what it said about the healthy behaviours, trend versus a more healthy population through better behaviours, it saw an effect of about 1% of GDP. That ratio of about 5%, to do with more productivity, and 1%, to do with healthy behaviours, is a fair reflection of what the opportunity is on the cost side.

However, the point about the two different scenarios is that, in one of them, you have a healthy population as well as lower costs and, in the other one, you have a sicker population and health expenditure. Prevention makes a contribution, but you have to think about it in terms of its contribution to saving people’s lives and its contribution to helping the economy, which we might come back to—that is a big thing. Although those numbers for prevention are bigger than for their contribution to the finances, the contribution to the finances is still significant; as I say, it is potentially 1% of GDP over 50 years compared to 5% of GDP if you get the productivity better.

Baroness Redfern: Adrian, you mentioned the ambition to do more on prevention and said it was really important. Why do you think we spend only 5% on prevention in the NHS?

Adrian Masters: One consequence of the introduction of the new care models and the agenda of the five-year forward view is that we are going to find ourselves over time spending more of our total NHS budget outside of hospital on earlier intervention in the community. Naturally, as we do that, we will see the proportion of spend on things that you might call “prevention” go up. At the moment, we have not really adjusted the system to reflect the fact that we have more people with long-term conditions and we still have a very acute system-focused spend.

Baroness Redfern: Prevention saves money is what I am saying. That is the impetus.

Adrian Masters: The point I was trying to make is that I think we will see those proportions change as we implement the five-year forward view agenda because we will do more outside of hospital. I think there is more that you can do on prevention. If you look at individual interventions, you will see that they are often very good value for money. So there is an argument to say that the proportion spent should go up, which I think it will because we are shifting with the five-year forward view agenda.

There are other factors which mean that we probably have biases in the way we make decisions. It means that we are always going to have to make a stronger case for preventive action, because it tends to have a long-term effect rather than, often, a short-term effect. The effect tends to be lots of gains over a large population rather than certain individuals gaining, plus we are pushing against inertia. We have organised medical care in a particular way and we are trying to change the way we organise the NHS, which is a very big agenda. I think that spending on prevention will go up and should go up, but, because of those biases, we will have to continue to make a very strong case with very strong evidence for prevention. You have to make a stronger case to justify it than for immediately responding to acute problems, which is probably what we have done more of in the past.

Q244 **Lord McColl of Dulwich:** What is the greatest barrier to progress in preventive medicine? Is it simply a question of funding or are there more significant issues, such as the confusing and conflicting advice from the Department of Health, NICE, the food industry and the media?

Adrian Masters: I would put the case in a different way because we have made a lot of progress on prevention over the last 15 years. Because of the big changes we are making to the pattern of care in the NHS and the change in the role of local government in terms of the public health agenda, we have addressed some of those barriers and I think we are going to see significant changes in the amount of prevention and preventive activity. At the moment, the big challenge at this stage is delivery on the changes we have made. We have made plans to make changes and we have to see those changes through, so I would say that delivering on the agenda that we have is the biggest challenge we have now rather than anything else.

Professor Dame Anne Johnson: I want to comment on the use of evidence in clinical practice. We have had an acute hospital management approach to health and we talk a lot about primary care, which, I agree, is making a lot impact on prevention through the management of hypertension, the use of statins and so on. In the acute setting and the management of people with chronic diseases, we are not necessarily adequately joined up and we do not always use the evidence to implement the most cost-effective interventions.

I heard a very good example presented on the management of chronic obstructive pulmonary disease, where one of the cheapest and most cost-effective interventions is smoking cessation therapy and flu vaccination. When you look at what people actually receive with chronic obstructive pulmonary disease, you see that it is some of the most expensive and least effective therapies. They do not receive smoking cessation therapy,

and only 60% receive flu vaccination. Although we have evidence, we are not always very good and logical at putting it into clinical practice and implementing it. That is also compounded by the fact that, while there are great advantages in having prevention services within the local authorities, on the other hand, it is difficult to have good smoking cessation services in the NHS when they are funded outside it. It is those links between social services, prevention and acute services which are critical. Sometimes it is about implementation science and organisational science in that we know what to do but we are not always very good at organising ourselves to do it.

Lord McColl of Dulwich: But we know what the science is in terms of preventing obesity, and obesity is increasing enormously.

Professor Dame Anne Johnson: That, of course, is extremely complicated and exactly plays to what I was trying to say at the beginning: that obesity is driven by an enormous range of economic, environmental, industrial and behavioural factors. Your own Committee here—in fact, the House of Lords report on behaviour change—looked at the paucity of evidence on behaviour change and the importance of a range of interventions which go right across the piece, from the individual to the fiscal and legislative, when dealing with big environmental changes which drive health behaviours and health effects.

Baroness Blackstone: Can I just ask Mr Davies, who has been very silent so far but sits in the centre in the Department of Health as a senior official, how he would answer the question that was put earlier on prevention?

Mark Davies: In a sense, I agree with what Adrian said. The fact is that we have a relatively new system where we have shifted responsibility for public health into local government. We have the development of STPs locally, which are starting to set out the argument for prevention. I think things are moving in the right direction, but we have to let them play out. This is about implementation. There is a very strong emphasis on prevention in the STPs. We need to make sure that we follow those through to make sure that the benefits of prevention which they set out are realised. There are some very complicated elements at play here.

Lord McColl, you referred to the conflicting advice from different organisations. We try to base our advice on the best evidence, which is what Public Health England is here to do, but that is just advice. Influencing behaviour is not just a matter of providing advice to people, otherwise people would just listen to what the Government said and do what was the best thing, but that is clearly not the case. There is a lot of complexity around making beneficial change happen. As Anne pointed out, obesity is a complex set of factors—environmental, societal, some clinical and some to do with the food industry and retail policies. Trying to get a grip on those to make things progress in the right direction is challenging for a Government who have their hand on only a few of the levers.

The Chairman: But is what you are saying not the key problem? We have, as already mentioned, the five-year forward view, which had high ambitions about preventive aspects of healthcare, yet it has no role to

play at all.

Baroness Blackstone: Could I just add to that? What is your evidence that it is moving in the right direction, given that we have a huge amount of preventable disease, both mental and physical?

Mark Davies: By moving in the right direction, what I meant was that we have a new system which we have established and we need to let play out in the right way, but some things are moving in the right direction. We have the lowest rates of smoking we have ever had in this country. The data released earlier this year showed that we have a prevalence of 16.9%, which is a significant fall from the previous year and we have gone further than we expected, so progress is being made in some areas. We have a relatively new system, it has only been in place a number of years, and we have to allow that system to operate and to start to deliver. I think the STPs are an important part of that in setting out the ambitions locally to put prevention at the heart of the NHS.

Lord McColl of Dulwich: Do you have a system now in the department which looks at the advice that is put out, such as “Do not have more than two eggs a week”, which is completely wrong?

Mark Davies: The advice all comes from Public Health England at the moment and the Department of Health tends not to put out advice.

Lord McColl of Dulwich: Well, whoever does it, we have had a lot of really bad advice coming from the centre, and which centre does not matter. How can we put in place a mechanism to monitor and stop the stuff going out in the first place? Fat is quite good for you, for instance.

Mark Davies: The reason we established Public Health England was to provide the source of evidence and advice for the public.

Q245 **Lord Willis of Knaresborough:** I am sorry, Mark, that we always seem to give you a hard time when you appear here. I am going to be exceptionally nice to you now because I am sure you are a very nice man.

Baroness Redfern: You can pass the bucket.

Lord Willis of Knaresborough: I really cannot let you off the hook on this one though.

The Chairman: That is him being nice.

Lord Willis of Knaresborough: What you seem to be saying is, “We have passed this down to Public Health England, so that is our job done and we can forget about that now”, but there is masses of evidence which demonstrates that, in fact, you can do serious things to improve the health of the nation. On smoking, it has taken 50 years to get through gestation to where it is now, yet if you go into secure mental health units, you see that they are not included in smoking cessation programmes. You can smoke in those because it is thought that it might affect your mental health. There is no evidence whatever to say that it would, yet there is masses of evidence to say that that will help those people die earlier. In terms of salt, sugar, alcohol, all of which have significant effects on public health, it is your responsibility, yet that does not seem to feature in your response. That is being kind, Mark.

Mark Davies: Thank you for being so gentle with me. Let us take a few of those examples. On salt, we have had a huge reformulation of foods to reduce the amount of salt. That was led by Public Health England as well because it does the negotiations with industry, and the same will be happening with sugar. The childhood obesity plan, which was published in August, set Public Health England the task of having that conversation with industry, and that is going on already. That is not to say that we do not take responsibility for it. I am the senior responsible owner of the childhood obesity plan and, therefore, everything that happens flows through me and I hold the various agencies to account. Responsibility sits in different parts of the system and it certainly sits with me at the moment in terms of making, say, the sugar reduction happen.

Similarly, on alcohol, the safe drinking guidelines, which are produced by the chief medical officers of the four nations, were based on evidence and were published by the department, so we do take responsibility for these pieces of work; we convene the system, if you like.

It is an interesting point you make on smoking in mental health facilities. You are absolutely right that it is a killer for people with mental health problems as much as it is for anyone else. Interestingly, I have been to trusts which run medium-secure mental health facilities where they have introduced a no smoking policy and it works.

Lord Willis of Knaresborough: In Sheffield.

Mark Davies: In Sheffield; I have also seen it in south-east London, in Oxleas. It is fantastic to see it happen. We do not have a current tobacco control plan, but we have one in development and I would hope that, subject to Ministers agreeing to publish a new plan, we will address these issues in there. It is a really important issue and I do not dispute that is the case. The Department of Health has a leadership role and a convening role. It is a very small organisation compared to Public Health England and we do not have the experts sitting in the Department of Health, but our job is to bring it together and to make that advice properly available. I think we have a role and we do not abrogate our responsibilities in these areas.

Lord Kakkar: Just to be clear, you mentioned the movement of the public health agenda into local authorities and local government. Are you clear that, with that move, the mechanisms are now in place to ensure that the health and public health agendas are properly co-ordinated to provide the opportunity for long-term sustainability, or are there impediments in the relationship, despite the creation of STPs, that we should be concerned about?

Professor Dame Anne Johnson: I think there are many advantages of having a public health service in the local authorities because of the ability to deal with some of the environmental areas and, to some extent, education. Issues such as outlets for alcohol sales and so on as are the broader determinants of health.

However, there are concerns and they were very well expressed in the House of Commons Select Committee report on public health, which I think was published in August or thereabouts this year. I would be concerned. You are addressing prevention in the health service. Let us

assume that we can improve the general health of the nation—it is always a hope that we have, but we seldom succeed in it—so that they use health services less. People have higher and higher demands, but let us say that we have a healthier nation because we deal with some of these other drivers. You will still have to address issues of prevention in the health service. When public health experts were within the health service, in a sense that expertise did also reside in the health service. It is not clear to me that we have these two things entirely joined up, and I gave the example of smoking cessation services.

The other area which may have come to your attention, which is an interesting example, is the discussion which has gone on about the use—and it is my own area—of pre-exposure prophylaxis for the avoidance of HIV transmission. To let you know, there is as much HIV being transmitted among men who have sex with men in London as there was probably at the end of the 1980s. In the last 10 years the incidence has not changed, there is a lot of risk, and we can reduce that risk with pre-exposure prophylaxis. HIV prevention services reside with the local authorities and HIV treatment services reside with the NHS. There was the demonstration: the NHS initially declined to fund pre-exposure prophylaxis because prevention was not its remit. There has been a legal judgment on that and it has been said yes. So there is a kind of mismatch, I think. We cannot run an NHS that does not engage with the prevention agenda, even though public health is perhaps led from another area. I think there are acute NHS trusts now which recognise the need for public health and prevention input into the NHS. We have to join that up, otherwise we will not be using our resources effectively. It remains to be seen whether the STPs, the sustainability and transformation plans, might be a mechanism for trying to join that up in the long run, but I think that was well discussed in the Commons Select Committee report.

The Chairman: Mark, do you have a comment?

Mark Davies: Just to note exactly what the House of Commons Select Committee said, but it also suggested that we would not want to start reorganising the system again. The point is that we have to make the system we have work, and the drivers to integration, which are really important because of the need to have the most efficient and effective system we have, will push us to the situation that Anne is describing, where NHS organisations will start to see that prevention is part of their business. Indeed, if you look at things such as cardiovascular disease, you see that secondary prevention takes place in primary care, for example, which is control of hypertension and atrial fibrillation. Clearly, the NHS has a significant role to play in prevention. The trick is to make the system we have work rather than spend time designing another one, which would have a different set of boundaries.

Q246 **Bishop of Carlisle:** Following on from both those responses, I wonder, Adrian, if I could push you a little and go back to the comment you made about the greatest challenge, in your view, being the implementation of the organisational changes that are recommended, not least, in the five-year forward view. What, in your view, are the most important things that need to change—those recommendations or something else? Do you think the STPs are crucial to that change and, if not, what are the best levers

we have to effect it?

Adrian Masters: I think that the STPs and the process following on from them are critical to the change. What we are looking for to happen over the next few years is new, more integrated services outside of the acute setting done at scale in primary and community settings. Developing those new services and doing them at scale, I think, is the biggest single challenge. It is interesting that, if you look at the contribution on the finances—because we are in the tightest finances in the NHS and public finances in general since the Second World War—you see that the most important thing is the productivity of existing services.

At the same time, we want to make a significant change to the pattern of care, which is developing new services to look after people with long-term conditions in a community setting. Those two agendas are what we have to do through the STPs and the trick is to make sure we do a good job on both agendas, which I think is the biggest challenge.

The rate that we can make the improvement in the development of those new long-term condition services will depend partly on the rate of investment that we manage to free up to make into those services. I think that this agenda will continue beyond 2020, so it will not be done by the end of the five-year period, but the trick is to make as much progress as possible in that period. We are expecting it to make some contribution to the finances, but the big contribution from the shift will come post-2020.

Q247 **Baroness Blackstone:** The Academy of Medical Sciences' report had a number of recommendations, some of which were related to higher education. Can you tell us a bit about how you have been able to get higher education institutions to take this seriously? Higher education is a very diverse and diffused system and, because of the autonomy of universities and the freedom of that, it really has to be picked up from below and then introduced. I do not know how easy it is to get the things that you want done picked up by HE institutions and implemented.

Professor Dame Anne Johnson: Obviously these sorts of reports are of use only if something happens as a result of them and if people feel that the recommendations are useful. We are in the implementation phase of the report as it was just published in September. We have been working with a number of groups. A number of the recommendations on higher education start with the training of healthcare professionals, which is an issue that came up earlier, in the use of data and how we can use data to change clinical practice. That seems to me to be the most useful thing that we can do. That is where we need to engage with the public, and it is really important that we can show the public the benefits of having records that link up.

One thing to think about is how we train medics, for example. We are now working with the Medical Schools Council and Health Education England to think about how we take these ideas forward, and we are having a series of workshops next year to look at implementation.

In the broader context of the universities—I come from a large multidisciplinary university, UCL, and to some extent this comes out of

the work we have been doing—we already run a number of courses. In our global health course, for example, we teach people in health about climate change and health, and our architecture school has courses on the built environment and health. Some of this is changing the culture, and, as you know, if you produce courses that are attractive to students, that is a very good incentive to higher education institutions because they pay the fees.

On the computer science front, that is looking like an extraordinarily important development. From talking to higher education institutions, it seems that we have done less work in this area, but it is a piece of work that we need to take forward because of the demand now. If we want to use the data that we have, the thing we are most short of is people who can analyse it as well as people who can ask the right questions of it. They are two separate issues. We might have to incentivise universities but also some of the funders to build more PhD programmes, MSc programmes, and so on. Some of this, of course, is being taken forward through major investments such as by the Farr Institute on digital health, and some it is being taken forward by bodies such as the Alan Turing Institute. Those are good end points for people, but you need both push and pull factors.

Of course, in industry, which we have not talked about much, the whole data and technology industry needs people like that, and it seems to me that it will also provide an incentive in the system to stimulate that kind of activity.

Baroness Blackstone: So you are attaching quite a lot of importance to technology, data and digitisation in public health and prevention as in other areas of healthcare.

Professor Dame Anne Johnson: Critically, the same sets of data that were used to say what kind of care I need and what my personal risk of something is come from analysing many people's records to say, "Yes, for people who have certain characteristics, be they genetic, behavioural or biological, if we combine those things, these are your risks, so I know how to intervene". The complex data that says what I should do for this patient is actually the same data that can say, "Actually, on balance, this NHS trust is doing better with its heart surgery and its management of stroke". It is the same data. Similarly, if you can look at how the data links to environmental and socioeconomic exposure, it is incredibly important.

The other piece of data is that people, as I think I said earlier, can now understand their health in a different way. They have access to information about health, which fundamentally changes the relationship with the practitioner. Very often, the patient knows more about their complex disease than the doctor in front of them, so it changes the relationship and the doctor's interpretation.

Finally, if we really think that technological solutions will change things, we will have to change the way we deliver the health service, such as through remote diagnostics; you heard John Bell talking about remote sensing. It is all very well having the technologies and the remote diagnostics, but we need the care pathways as well. We have done some work on the diagnosis of chlamydia and worked out the care pathway for

how people could actually be treated without sitting in front of a medical practitioner, but that involves a whole set of regulations going through the GMC and so on. It is that pathway that we need to work on alongside the techy bit.

Q248 **Baroness Redfern:** We have heard about strategies and targets for prevention in physical health. What is being done to support a greater focus on prevention in mental health and to bring that to parity?

Mark Davies: I think this was raised the last time I was here and it is a significant issue, which we recognise. I think it is fair to say that since July it has become a more prominent political issue across government, so more is being done and quite significant investment is being made in early years services and in children's and young people's mental health services, where we are making up to £1.4 billion additional investment in services. It is fair to say that early intervention and intervening in early years is almost certainly one of the best preventive measures for people who are showing signs of mental ill-health. There is a relatively good story to tell; we are starting to recognise the need to address problems when they first emerge, often in teenage years and in young people.

It is also slightly harder to associate the intervention with the outcome in mental health. This is to do with the science and the causal factors of mental ill-health. We know in physical health, for example, that you can vaccinate against certain diseases and the outcome is pretty certain; you will not get the disease. Similarly, if you encourage people to stop smoking, tremendous health benefits accrue that we can identify. It is slightly more difficult in mental health services, so preventive measures often sit in the family, in early years or in areas that are outside the individual's control.

Baroness Redfern: So you think that closer working relationships with local authorities are important?

Mark Davies: Indeed.

Baroness Redfern: That brings me on to the next question: how is the NHS working in the judiciary services?

Mark Davies: I am sorry but I cannot answer that, because it is not something in my area of expertise. I think it is fair to say that there is a growing recognition of the causal factors and the fact that they sit within the responsibility of a number of different departments and agencies, the Department for Education, the criminal justice system and those sorts of things. There is more to be done to understand the causal factors of mental ill-health and to join up the work across government. Again, some of the Prime Minister's statements about addressing the needs of vulnerable people are an important starting point for that discussion. I am not saying that the problem has been solved; there is a lot of work to be done.

For example, we have some evidence emerging from Professor Mark Bellis, who is working in Wales at the moment, that once adverse childhood experiences, which are defined as experiencing parental domestic violence, family breakdown or parental drug and alcohol misuse, start to cluster, they start to predict future health behaviours, such as

taking up smoking or drug misuse, but they also predict future mental health problems. We are starting to get a better understanding of how those very early childhood experiences have an impact on later mental health issues, and that is a big challenge for us. It is not as simple as stopping smoking, reducing sugar or stopping drinking; it is actually about changing the way families work and how they are supported.

Baroness Redfern: So mental illness should not be an add-on to what is being driven within the NHS?

Mark Davies: It is more complicated in many areas but something none the less that we have to work on. As I said, there is a really good argument for investing in children's and young people's mental health because of the preventive effect that has in later life. That is starting to happen, and it should be seen as very positive.

Q249 **Baroness Blackstone:** Could each of you in turn tell us what single key change the Committee should recommend to make the NHS more sustainable?

Professor Dame Anne Johnson: I would like to suggest, unsurprisingly, a recommendation that we invest in the kind of research and evidence for prevention that brings together a range of actors outside the traditional sphere of biomedicine. It is the kind of thing that could be done by working across research councils and the key charitable funding agencies, not just within the NHS, really thinking about prevention research and all its ramifications, so that we have the evidence base that can then be built out into practice. That should parallel the efforts that we make, and have made very effectively, in clinical practice for the evidence base for optimal treatment. That is a mechanism for improving the use of resources within and outside the NHS, and I would add that evidence is only as good as its implementation.

We have worked through the NIHR, the universities and the academic health science networks in treatment, and we must do the same thing for prevention. Critically, that means a really strong alliance between the universities and the practitioners, which could be led, as we have suggested, by regional hubs of engagement with Public Health England and the devolved equivalents, to try to build up the same kind of thing that we are doing for clinical medicine, so that we go all the way from evidence through to investment in implementation for the broader benefit of the population. We must use evidence more effectively in this space to maximise the use of our resources.

Adrian Masters: If I could be allowed two points, I think the changes we are trying to make through the five-year forward view and the shift of public health roles into local government are going in the right direction, and I would ask for the Committee's support to say, "Deliver those changes. They can, and will, make a big difference to the success of the system in the long run", so my first recommendation is support for the changes that are already in progress.

The general idea of sustainability in the long run is about public support for the NHS, which depends on what value they feel they get for the spend on the NHS as well as its affordability. As I say, I think there are

three elements to that: helping people to live longer, healthier lives; the finances; and, importantly, the contribution of the health system to the economy. An emerging issue that we need to give more thought to is this question of healthy ageing. We will need to increase the participation of people between the ages of 50 and 70 in the workforce, and how we manage it will be critical in an ageing society. That will depend upon the quality of the health system and the preventive system in order to keep people well so that they continue to participate in the workforce. That area of healthy ageing and the contribution of the health system to the economy is worth further thought.

Mark Davies: As a civil servant, it is always very difficult for me to make suggestions, because I might have to implement them.

The Chairman: We may quote you if it is a good idea.

Mark Davies: Of course, I agree with my colleagues. One of the things that we have learned—I heard the end of your previous evidence session, and this is also true for public health, prevention and the technology issues that you talked about—is how you ensure adoption at scale of beneficial change. Keith McNeil talked about how difficult it is to get everyone to do everything that is good. It is the same in public health. Sometimes we focus on big regulatory actions, as we did in smoking when we changed the legislation; sometimes it is about getting people to adopt best practice. One of the things I would like to do is think about how we can learn from the STPs, the 44 areas that are looking at prevention and having a sustainable system, and how they can learn from one another. Otherwise, the system ends up much too fragmented and does not adopt change at the scale that is needed to deliver beneficial change to everyone.

The Chairman: Thank you all for coming today; it has been very helpful. If, on reflection, you think that you might have forgotten to say something, please send it in as evidence.

Department of Health – Oral evidence (QQ 250-256)

Evidence Session No. 26

Heard in Public

Questions 250 - 256

Tuesday 6 December 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey, Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

Chris Wormald, Permanent Secretary, Department of Health; Professor Chris Whitty, Chief Scientific Adviser, Department of Health.

Q250 **The Chairman:** I am glad to see you both and thank you very much for coming to help with our inquiry. Before we start, we are live on the BBC parliamentary channel for the first session. Obviously you are popular, as the BBC has chosen you, or your evidence could be riveting to the nation, so you ought to be pleased about that. Before we start, would you mind introducing yourself for the record? If you want to make an opening statement, please do so. Of course, you will be sent a transcript of the proceedings to make any corrections, if you wish. Mr Wormald, can I start with you?

Chris Wormald: I am Chris Wormald. I am the Permanent Secretary to the Department of Health.

Professor Chris Whitty: I am Chris Whitty. I am the chief scientific adviser at the Department of Health and, in that role, also head of the NIHR. I should declare I am also professor of public and international health at the London School of Hygiene and Tropical Medicine and a consultant physician at UCLH.

The Chairman: Thank you very much. Do you have any opening statement?

Chris Wormald: I will say a few words by way of introduction. The first thing to say is that we, as a department, very much welcome the work that this Committee is doing, as the Chairman and I have discussed outside this Committee. These questions about the long-term health issues are, in our view, rather underdiscussed in public. It is of course completely unsurprising that the public debate focuses on the shorter-term questions in health, which I would say is completely understandable,

but it is also important that we discuss the questions that this Committee has been looking at.

I should also say a little about the department's approach to the short and the long term, because I know that has been an issue that the Committee has been interested in. Of course, as with any government department, our primary focus is on delivering the manifesto right now. Our focus is unashamedly on the next five years, delivering the five year forward view that I know you already know a lot about. That is the primary focus of our work for Ministers. However, we try to make this short-term policy and advise Ministers in the light of our understanding of the longer-term trends. The reason I am joined by Professor Whitty is that he is what we could describe as the conscience of the department on those longer-term issues. His job is to continually confront us as we make policy with what we know and what we do not know about the long term, so that we can build that into our immediate policy-making. We are not in the business of publishing long-term plans and future visions of the health service beyond the current Parliament, but we are in a continuous process of horizon scanning across those issues as they affect day-to-day policy. I am sure we will get into a number of those questions as we go through this discussion.

There are four key areas on which we do that. I am sure we could discuss any number of things, but the main things that we look at are: first, the demographics of health; secondly, technology; thirdly, workforce; and, fourthly—I am not quite sure how properly to describe this—the future of health, disease and illness, which is possibly the trickiest area. It is basically those four areas that we look at within the department and attempt to link the long term with the short term.

The thing that links all four, and the area that you and I have discussed before, Lord Chairman, that we feel is slightly underplayed in that debate—we may come on to it as we go through this hearing—is the demand side for health as opposed to the supply side. There was a lot of debate about the supply side, rightly, about how we build the future capacity for health. We think there also needs to be a debate about the demand side and particularly about what you might call inappropriate demand: the question of where are we using either the wrong part of the health service to deal with an issue or where there are issues that should not be coming to the health service at all. We believe—as I say, we have discussed this before—that that question is rather under debated, so we particularly welcome the light the Committee is bringing to that.

The final issue, which I am sure we will debate, is the question of where decisions are best made about the future in these systems. As you know, the 2012 Act is predicated upon moving decision-making power away from Whitehall desks and towards the professions themselves and decisions in local areas. There are clearly debates to be had about the right level of decision-making and type of decision, which I am sure we will also debate as we go through the hearing.

Q251 **The Chairman:** Thank you very much. That takes me immediately on to the first question. You focused on three or four areas that you are looking at long term, and it is good to have Professor Whitty here for the

demographic changes that are likely to occur by 2030. You said that you were looking in the long term at the impact of that on funding issues, on manpower issues, et cetera. You might also include the challenges that might produce for the social care side of health and social care. Could you give us a flavour of your thinking and the answers you are coming up with?

Chris Wormald: Perhaps Professor Whitty would like to say where our thinking is about the long-term demographics, and then I will come in.

Professor Chris Whitty: There are some things in the long-term demographics that are obvious and which everybody knows, and there are some things that are probably less obvious but are equally important. Then, of course, there is the issue of disease mix, which we might want to come to, because I think that is quite important for the future.

On the obvious one, it is probably worth noting that we know that the population is ageing, as it is in every country in Europe. To put some numbers on that, ONS data comparing 2019, which is the midpoint in the current system, and 2039, which is a forward view, would show 13.4 million people aged 45 to 59 now and exactly the same number at that later stage of 2039. For those 85 or over, it would be 1.7 million now and 3.6 million at that later stage. For those aged 75 and over, it would be 5.8 million now and 9.6 million in the future. Those changes are quite extreme, so the working age to age dependency ratio is going up the whole time. That clearly has some significant implications. I think this is obvious, but it is worth putting numbers on it.

Linked to that and an issue that you may wish to come back to later is the fact that the propensity to consume health services has steadily increased—it has gone up by 50%, according to the OBR—in those aged 75 and over. Not only do they naturally use more health services because ill-health tends to be clustered in older people, but that tendency has increased quite markedly in those over 75 and those over 85. That is an important driver.

There are some things about the demography that are often not recognised. I will highlight two, but we can go into others. The first is that because our cities and urban conurbations maintain their demographic structures—they import youth and they export early middle age, essentially—cities' demographic structures will look remarkably similar if you look forward 20 years from now. Therefore, inevitably, the rest of the country, the smallest towns, the semi-urban areas and the rural areas will get older a lot faster than you would predict. This has clear implications for service delivery. That is one thing that, as I say, I do not think has been fully picked up on.

Reading some of the evidence given to your Committee, it felt to me as if people thought that the UK was an island medically as well as geographically. Everyone around this Committee knows that is not true. If you look at the ageing of the rest of Europe, it is going to happen a lot more sharply than it is in the UK. Only France has a similar demographic profile to ours. For example, in Germany there will be a sudden fall off in people retiring in around 20 years, and then they will move into massive increases in healthcare use. That is important because there is a

competition—I do not mean it in a negative sense—for healthcare resources across the continent, as there is in the world. If you look at the rest of the world, again, India, China, Brazil and many of the middle income countries are rapidly getting older populations and getting wealthier, and their demand for healthcare will also increase. The positive side to that is that we will turn into a global market for healthcare goods, which will probably help to push down prices over the long term.

The Chairman: What will be the funding pressures on health and social care? What will be the pressures on the workforce?

Professor Chris Whitty: That very much depends on what kind of healthcare system we choose to have in 20 years' time. The Permanent Secretary will want to answer on this. I think there is often a misunderstanding that the NHS somehow at any given point in time is going to roll forward in an identical state. The healthcare system that we have now is totally different from what it was 20 years ago, and it will be different again in 20 years' time. It will change. The disease mix—I do not know whether you would like me to go on to that—will heavily influence that.

Chris Wormald: Shall I say something about policy in this area? There are obviously some immediate debates about social care that I know a number of people around this table contribute to, but I will stick to questions on the long term. As Chris has said, this is an issue that faces the whole of the western world, and no one is pretending that we know the exact answer to your question. This is a situation that we have not, of course, faced before. We build that back into immediate policy in two ways. One, as I think this Committee has picked up in its other hearings, is that we want to see considerably greater integration between health and social care. The Better Care Fund that we have introduced is the first time that we have, as it were, mandated integration. That is a big step, but we have a lot of learning to do from how all that works out about how you do integration well. Secondly, and vitally, out of what Chris says, in this area we will see different parts of the country developing differently with those very different demographics that Chris is describing. One of the few things that we can be definite about over this period is that we will not see a national one-size-fits-all solution to the question you are raising.

We are looking, and are already beginning to see evidence of this happening, for individual areas deciding the right answer to that question in that place. You have heard some of the individual examples; Manchester has a particularly far-advanced approach. Bluntly, and leading on from the demographics that Chris has quoted, the right solution for Manchester will not be the right solution for Dorset, Brighton or anywhere else in the country. We want to see places addressing that question and coming up with their own solution within the framework that we set out in the Better Care Fund. In the current STP process you can see a number of those STPs led by local authorities and building the local authority dimension into policy-making. It is that type of approach that we are promoting across the country, where we take the demographics that Chris is describing and try to build that kind of flexible policy response into what we are doing.

Q252 **Lord Kakkar:** I want to explore, if I may, the question of the OBR's assessment that health spending will need to grow by more than GDP in any of the scenarios that have been presented beyond 2020. Is there any calculation of what that additional funding might be for both the health and social care systems to achieve that sustainability? Is there an inclination that there should be a longer-term agreement with regard to central funding for the health and social care systems to enhance sustainability, if you think that longer-term agreement would indeed be beneficial in that regard, and how might that be provided for?

Chris Wormald: That is a remarkably complicated question and an extremely important one. I believe you have the chairman of the OBR before your Committee later today, so I am sure he will say with considerably more expertise and in greater detail some of the things that I will say. This is, of course, an issue that we discussed with the OBR, and it is very important to be clear what the OBR has done. They have done an incredibly professional job on this, but they are not attempting to make a recommendation of what they think the right answer is. I am sure Robert will explain this much better than I, but they are looking at previous trends, building into that what they know about changes in the economy and demography, and projecting those trends into the future and coming up with a number. As I say, they have done a very professional job, but it assumes that all other things are equal.

The question those OBR numbers raises is what the policy response of successive Governments will be over that period. How did they get to that number? If you simply observe—there is no calculation involved in this—the history of health spending both within the UK and across the western world, it grows as a percentage of GDP every decade. On average, it has grown 1% a decade since the foundation of the NHS. We see that across all western economies. That clearly presents a public policy choice for Governments. You can continue, as you have for the last 60 years, to accept and agree that it is right that an ever greater proportion of GDP is spent on health and prioritise accordingly—it is open for Governments to do that, and indeed that is what people have been doing across the western world—or you can decide that you wish to, in some way, seek to cap that growth. That gets you to the question I made in my opening statement about whether there is inappropriate demand in the system that one wishes to try and keep out of the system: too many people dealt with in acute care could be dealt with in primary care, too many people coming into primary care in the first place and public health being the major component of that question.

Turning to your question of whether there should be a long-term settlement of that issue, obviously there is a lot of politics in that. There are few more debated topics. My personal view is that there should probably not be. I do not see that you can deal with health spending either economically or in policy terms in isolation from the rest of government. That question of whether you want to invest a greater proportion of GDP as the economy expands is a question of how you prioritise health spending against other forms of public spending and wider economic activity. I am not sure that is a question you can have a long-term answer to. I think it is better settled by the Government of the

day arguing their case before the electorate. Personally, I would not go in that direction. I know others will not agree with me on that.

I would not do it in policy terms, because a huge number of the questions relating to the demand for health are not within the health system at all—I know lots of people around the Committee know this, but I will say it anyway—they are about the long-term drivers of health, which are to do with housing, transport, exercise, diet, smoking and all the things Chris is an expert in, although not personally obviously, that we can discuss further. I am slightly wary, therefore, of trying to treat the health budget itself as a unified thing that you take out of that wider discussion. All these points are debatable and, as I say, they are not really for me. It will be a set of political questions, but that is my take on it.

Lord Kakkar: Before Professor Whitty intervenes, I should remind the Committee of my interests as professor of surgery at UCL and at UCLH, because of Professor Whitty's connection there.

Lord Warner: Even if we accept your position on the political determination of the quantum of money for the NHS and social care, what is within the gift of the Department of Health—your department—is the way in which that quantum of money is distributed and invested. It would make sense to do the investment and distribution through a system that was likely to deliver the service delivery model that your long-term planning suggests you will need in 2030. So what work is going on in the Department of Health and what unit is working on a system that is more likely to distribute those resources in line with the service delivery needs of health and social care in 2030?

Chris Wormald: I could not point you to a specific unit, because in a way that is a question for the health system as a whole. As I said at the beginning, and Chris may want to say a bit more about this, we want a number of those decisions to be taken outside, not within, Whitehall. The key units within the department that looks at those sorts of questions would be our strategy unit and our economics unit, which reports to Chris Whitty, but all done within the context of what I said right at the beginning: that our primary aim is to deliver the Government's manifesto of the day and within the structures set out in the 2012 Act. Our focus is on how we use the current mechanisms to deliver what we want.

Lord Warner: Can I just press you on that? Are you telling me that that unit is working on the issues I have mentioned?

Chris Wormald: No. We are not designing an alternative health system, for the reasons that I have given.

Lord Warner: I am not talking about the health system; I am talking about the way the money that is granted to the Department of Health to deliver the service delivery model you want is invested and distributed. You are agnostic on that and there is no work going on. I want to be clear.

Chris Wormald: Yes. I partially misunderstood your question.

Lord Warner: Let us have another go at it, shall we, if it is not clear?

Professor Chris Whitty: Shall I have a go? I am going to approach this slightly obliquely, because this Committee is looking at 20 to 30 years ahead, not right now.

Lord Warner: We are looking at 2030.

Professor Chris Whitty: The first question is: what will be different that is predictable about health in that period? There are some very, very clear things that are predictable and there are a number of things that are uncertain, and they tend to be come about where technology is going to happen. The first big predictable change relates to cardiovascular disease, which over the last 40 years has had a complete transformation in this country. It has gone down, year on year, throughout the entire lifetimes of virtually everybody around this table—certainly the working lifetimes of everybody around this table—to the point where two weeks ago it was overtaken as the leading cause of mortality in the UK. That is an astonishing change. That is not just mortality; every year there is a 6% reduction in angina admissions to hospital. There are certain areas of health that are improving. Child mortality has fallen 64% over the last 30 years.

Lord Warner: I am sorry to interrupt you, but that does not answer the question. I am trying to get an answer to the question about what work is going on in the Department of Health now, or is being planned, to shape the distribution of resources from whatever quantum the political decision-making produces—and you have the five year forward view to give you a clue—that is likely to produce services delivered in the way that is needed in 2030. It is a simple question: is any work going on in the Department of Health on the distribution systems and the payment systems for 2030 or is it not? Yes or no?

Chris Wormald: That is basically the STP process. That is the process by which we take the resources that are allocated in this area, and individual local areas look at exactly the question you are asking. So, no, we are not trying to answer that question from Whitehall, but there is a process by which we try to answer that question in individual places.

The Chairman: Let us move on to Lord Kakkar and Lady Blackstone. A quick question and quick answer, and we will move on.

Lord Kakkar: Having an approach towards agreement for funding for health and social care into the long term would not have an impact on its sustainability. It is much better to be flexible, as you have described.

Chris Wormald: When we look across the world, if you leave out the outlier of the United States, most countries in the OECD and Europe spend roughly the same amount of GDP on health. I do not think that trying to fix that long-term quantum, either here or generally, will make that much difference to the question. The question is how you spend the percentage of GDP that you have, as opposed to an attempt to fix that percentage long term.

Baroness Blackstone: Given what you said earlier about one size not fitting all, with which it is very hard to disagree, I think you were implying that there is a need for some devolution from the centre—in fact, you more or less said it.

Chris Wormald: Yes.

Baroness Blackstone: Is it not rather important that somebody in central government, if not in the Department of Health, perhaps somewhere in the centre, ought to be thinking about how we get there and what the mechanisms are way beyond the STPs? Is local government going to play a very much different role, or is it going to be done in the Greater Manchester model? It seems a failure not to have some people who are prepared to think the unthinkable and come up with some ideas about how we can move from where we are now to where you are suggesting we probably ought to be.

Chris Wormald: I think that is debatable. As I say, we have a clear policy set of priorities at the moment and we are focused on delivering those. On a lot of the questions you are raising, the ideal answers come from both local areas and the professions themselves, as opposed to from desks in Whitehall. That is the better way of addressing this set of questions.

Of course, the department needs to think, and does think, about which framework those decisions are made in. Personally, I am not a fan of trying to answer every question from a desk in Whitehall in that way. I think there is a big role for the professions. It is not really my business. Chris, do you want to add anything?

Professor Chris Whitty: If you think about what drives the changes in the OBR figures, which Lord Kakkar mentioned earlier, the demographics are a relatively small part, and in sensitivity analysis it makes surprisingly little difference if you change them. The things that really drive it are increases in income, which is very heavily a part of their model, changes in productivity and changes in technology. Of those, some are more predictable than others. For example, although you can broadly say technology is going to lead to an increase in spending, that is likely largely because we find things to treat that we previously did not; it is not because they are necessarily more expensive. We do not know which bits of technology will make a difference, and trying to predict that now is a mug's game, as everyone around the table knows. I have heard multiple people over my career—I am sure you have heard even more—saying that this is going to change it and it never does, but when you look back 20 years you can see technologies that have been transformational, such as angioplasty. There is the opportunity to look at the bits that we can change; productivity is probably the most important, and the better use of technology is another. There are certain things, such as the propensity of richer people to use more healthcare, which we cannot change and which we simply have to use as a given, but those tend to move at a relatively predictable rate.

The Chairman: A quick question from Lord McColl, and a quick answer, please, and then I am going to move on to Lord Willis.

Lord McColl of Dulwich: I was fascinated by your statement that you wanted to reduce demand. What about reducing need? What would be your reaction—one Minister of Health is rather interested in this—if we were to recommend an all-out nationwide campaign involving everyone, the people, the media, politicians and so on, to reduce the real problem in

the NHS, which is the obesity epidemic, which is causing diabetes, cancer, dementia, joint replacement problems, heart disease, the whole caboose? How would you react to a nationwide campaign?

The Chairman: If you could make your answer short and crisp, that would be helpful.

Chris Wormald: On the straight public health questions I will ask Professor Whitty to comment, because he knows a lot more than me. You draw a very important distinction. I used the phrase “inappropriate demand”, which you could describe as need. We are not talking about demand reduction for its own sake; the question is inappropriate demand, as in: can we prevent people being ill, as opposed to reducing the demand on the health service by people who are ill? Chris, do you want to comment on the public health question?

Professor Chris Whitty: On the very specific question of obesity, Lord McColl raises a really important point, which is that in most areas of public health things are getting better, such as smoking. In obesity, clearly things are getting worse, and we have the worse situation in Europe at the moment. As Lord McColl and others around the table know, addressing obesity is not straightforward, because it requires multiple interventions, many of which are at an individual level. Moving up the ladder of intervention, there is a relatively limited number of things that government can do that would be acceptable that would have a direct impact. A lot of it is to do with things such as education, trying to change the amounts of sugars and fats in processed foods, and so on, all of which are small, incremental changes. There is no clear evidence this has worked well anywhere yet, whereas we know what works in smoking, let us say. We know certain things help a bit in obesity, such as reducing sugar in drinks, but across the board the evidence base is pretty weak. This is a really important issue.

Q253 **Lord Willis of Knaresborough:** After Lord Warner, I would like to be rather helpful here. The OBR’s analysis of how productivity has grown, particularly since 1997 to 2013, shows an average of 0.9%, which is incredibly small, despite unprecedented levels of spending on health for part of that period. I think both of you would agree that productivity—Professor Whitty just mentioned it in his previous answer—will be fundamental to balancing the books in what we spend and what we deliver. Why is it so low? What can be done to improve it? Why are there such variations in productivity around the healthcare system?

Chris Wormald: I will ask Professor Whitty to answer half that question, because half of that is about how the medical profession works. Why is it so low? It is a much-debated question and I will not try to give you a pat answer, because long treaties have been written on this subject. Clearly, key to it is the relationship between health and technology. As you know, what you see in most sectors of the economy is that technology is one of the biggest drivers of productivity and then reduced cost. Health has a very different relationship with technology. Most technologies, wonderfully, both prolong life and allow us to treat diseases that we have never been able to treat before, but they do not save money. That is probably the root cause as to why health is behind other sectors.

Lord Willis of Knaresborough: There are two things, if I might interrupt. First, all the healthcare providers over the period since 1997 have had access to the same technologies, yet their levels of productivity have varied enormously. The new dashboards are demonstrating that quite vividly.

Chris Wormald: I was going to come on to exactly those points. I was answering your strict question on why is it different from other sectors. Clearly, as set out in Lord Carter's report and elsewhere, a lot can be done on productivity in health, both to increase the absolute level and to deal with the variations that you refer to. I think you have already stolen my answer. The transparency of the data on the dashboards available is probably the single most important thing we can do in that area. We need to promote a culture in which health providers look at who is best in class and ask themselves, "What do they do?", in exactly the same way as you see in most sectors of the economy. A big component in this is about medical practice, which of course I cannot comment on, but Professor Whitty is.

Professor Chris Whitty: To make an obvious point, with masterly understatement the OBR says that measuring medical productivity is not straightforward, which is clearly true. I have to say that in this area the medical profession is its own worst enemy. There are many leaders of the medical profession around the table here. My firm plea to the medical profession would be that they should take this seriously, because currently they do not in reality. The incentives are not stacked up along trying to improve productivity in the system; they are stacked up along trying to prolong life, which is a very important thing to do, but the two need to be kept firmly in balance.

The Chairman: What are the barriers for the medical profession not taking it up? How would you break that barrier?

Professor Chris Whitty: It is quite interesting in the sense that I think the medical profession has walked itself into a place that is incredibly efficient in the single-disease management of conditions, which is what has led to many of the remarkable advances that we have seen. First, that does not deal very well with multimorbidity, which it is quite inefficient at dealing with as a result. The second problem is that the medical profession has got itself hung up, I think, on longevity rather than quality of life measures and longevity rather than efficiency measures. If you make those bits of the system as important in medical training all the way through the system, we could incrementally change it really quite a long way.

Lord Willis of Knaresborough: Can I press you there, Professor Whitty? I declare an interest as the chair of the Yorkshire and Humber CLAHRC. I would like to ask you, because you have not mentioned it in your answer, where the NIHR, the Medical Research Council and the charitable sector, of which you put huge amounts into research, will deliver those sorts of productivity developments. I would have thought you would have come out with that answer first.

Professor Chris Whitty: Thank you. I completely agree with that question and its implication, which is that in many of these areas we have far more data on which kind of stent to use, for example.

Lord Willis of Knaresborough: But are we using it?

Professor Chris Whitty: No. We have far more data on very narrow clinical questions than we do on questions about how you make the system more efficient. It is a responsibility of the academic community and of the NIHR, for which I now have responsibility as well, to take that a lot more seriously and to say, "If we wish to make the NHS sustainable there are broadly two ways in which you can do that". One approach is increase the amount of money going into a system. The other is whatever quantum is given by the public to make the system more efficient. The data to do that and the incentives to use that are currently missing. We have a responsibility to change that.

The Chairman: The word "data" has excited Lord Scriven.

Lord Scriven: It is not because of the data, Lord Chairman, it is because of the previous answer. I am still not clear. You have identified productivity as one of the three strands that really have to change in relation to future healthcare. I am not clear what you, at the centre, are going to change to ensure that productivity starts to increase, and in a systematic way, across health and social care. What work is going on and what is going to have to change?

Chris Wormald: Three things. The most specific, and I am quite happy to send you much more detail on this, is our work to implement the recommendations of Lord Carter, all of which are about productivity one way or another. That is the most specific thing the department is doing.

The second thing is what Lord Willis pointed to, which is making productivity questions much more transparent across the system so that we get an internal drive for productivity. Key to that will be the measures we are taking to link up the work that NHSI does on financial improvement with what the CQC does about quality, and see those as the same question, so that use of resource becomes an inspection question. That will change the incentives in the system. There is a whole set of things around incentives and transparency.

The third bit is what Professor Whitty just described, which is that you need to refocus research slightly so that it addresses both the system efficiency and productivity questions as well as pure research. I say that slightly hesitantly because, of course, our current model of research is the envy of the world, and we do not want to throw any babies out with any bathwater. It is basically those three categories.

Lord Scriven: When your decentralised system does not necessarily give a systematic improvement in productivity, where does the centre hold the ground, and what incentives and levers will you pull to ensure that productivity systematically improves? Decentralisation does not necessarily lead to more productivity; it can actually lead to places being less productive. That is what we are trying to find out: what is your role going to be in sustaining the NHS and ensuring that it systematically happens?

Chris Wormald: We are working on a model, and I agree exactly with your comments that you need three things to happen simultaneously to make that model work. You need the correct devolution, you need transparency, and you need an accountability framework that holds places to account about whether they are productive. That is why the changes to inspection and the work of NHSI in this area are so vital. This is true of any devolved system; there is nothing unique to health. Devolution of itself does not solve any questions; you need that level of transparency and the accountability framework that goes round it, and those three things need to work in tandem.

I was going to add to Professor Whitty's answer that this is something the health service has demonstrated it is capable of. A very dramatic productivity gain occurred as a result of the move to day surgery. That has completely transformed the number. I know that a number of people around the table were involved in that. So we should not get ourselves into the position of saying that the health service is incapable of making these big steps; the question—exactly as your question raises—is how you make that a systematic part of thinking as opposed to the sorts of one-off changes that lead to an improvement. Is that fair enough?

Professor Chris Whitty: Yes.

Q254 **Lord Warner:** The reason why day surgery improved productivity was competition and the bringing in of alternative providers, and I was personally responsible for that.

Dr Chris Wormald: I said that I know a number of people around the table were involved.

Lord Warner: My question, sadly, is to bring us back to this issue of longer-term planning. The Committee has been struck by the apparent lack of longer-term planning across the health and care systems. In your previous answers you suggested that was not the job of the Department of Health; it was the job for devolved health economies around the country. That, I think, strikes many of us as a pretty odd position for the headquarters of a £140 billion a year business, which is what you are. It is a bit like Marks & Spencer deciding to leave it to the local shops to carry on selling clothing even though no one is buying it. If the way I have described it is still your position, what should the Committee be saying about who can take responsibility for planning for the longer term, and who should be charged with ensuring that? We are going to have to say something about it, and if it is not the Department of Health and it is left to devolution and 1,000 flowers blooming, if I may put it that way, who else could play in that game of running this?

Chris Wormald: I am afraid I do not agree with the premise of your question. You have started from the presumption that the creation of a long-term plan is a given, and the question is who should carry it out. We are debating what model is best to create that long-term thinking, and we are setting out our position that we do not believe that a central body should be charged with answering that question. I appreciate that you and a number of other people may disagree with that and may recommend something different, and that is the value of the debate we are having.

Lord Warner: Sorry, but you seem to be shifting your position that you are doing some longer-term thinking.

Chris Wormald: My position is exactly as I set out in my opening statement. We do not do longer-term planning in the classic sense; we do horizon scanning. We are seeking—and, as I say, Chris leads this work and he has described how we build that into day to day policy—to identify those long-term trends and ask ourselves how we should build that into current policy. There is an alternative proposition to what you should do, which is to go beyond horizon scanning into a longer-term plan for the health service. I fully understand why people argue for that; I am just saying that is not what we currently do.

Lord Warner: What would you do if your longer-term thinking, your horizon scanning, shows that the five year forward view is heading in the wrong direction?

Chris Wormald: You will do what Governments always do, which is make policy corrections accordingly, and that is the purpose of horizon scanning. We are describing that sort of iterative process of policy-making between a constant scanning of the horizon and the translation into current policy as our answer to the very complex issues that we all face in this area. I acknowledge that there is an alternative way of doing that, which is more towards what you describe, but that is not what we are doing.

The Chairman: In your introductory remark you also mentioned workforce planning for the future.

Chris Wormald: Yes.

The Chairman: None of you, so far, has mentioned what workforce planning there is.

Chris Wormald: You have not asked us yet.

The Chairman: Very briefly then.

Chris Wormald: That is the area where, of course, we publish long-term things. The HEE is charged with thinking about the workforce, both in the short and the long term. The reason why we do that slightly differently is pretty obvious; it takes quite a long time to train a doctor, so you have to take a longer-term view. In that area we have published two things. You have had evidence from the Centre for Workforce Intelligence, which the department commissioned to look at the longer-term trends, and Health Education England published its 15-year forward look at the end of 2015. Because of the long lead times, that is the one area where we set out much more long-term thinking. The process of operationalising that is the same, however, in that we set out that long-term thinking and then it plays out in the year-by-year commissioning arrangements that HEE puts in. It is still not a long-term plan in the way some people have described it, but we are closer to that modelling workforce than we are in the other areas, for obvious reasons.

The Chairman: Baroness Redfern, you have a supplementary, and then I will ask you to move on to your question.

Baroness Redfern: Yes, I will. Following from Lord Willis's question, you

mentioned the 2012 Act and the 44 STPs, decisions being taken away from Whitehall and delivered locally.

Chris Wormald: Yes.

Baroness Redfern: How do you think the STPs can take that forward when there is concern about there being not a lot of collaboration with other local organisations as such?

Chris Wormald: For STPs to work well there has to be collaboration. This is, of course, the first time we have tried to run a system in this way, and there is a lot of learning to be done. I do not think anyone from either the department, NHSE, NHSI or elsewhere would say, “We think we have reached the finished product there”, but we do think that we have the right model of trying to draw people together to look at both the health needs of an area as a whole and the total resources available as a whole, and to take decisions accordingly. As you know, that is a very tough thing to do in an individual area, and it will take time, but we think we have taken the first step on the road to that form of decision-making.

Baroness Redfern: You said earlier that it would be down to data sharing and how important that is for STPs and long-term planning. My query is: do they understand how important that remit is, particularly for workforce planning?

Chris Wormald: I think it is an evolving picture. I do not know if you have taken evidence from people running STPs, but I think they would say the same: that some good first steps have been taken but there is an awful lot of debate, discussion and decision-making to be done before we get to the position where they are doing the kinds of things I described earlier. Some of that is about data, some is about working relationships and, of course, some is about these questions locally; they are tough and they are disputed. The process of arguing through to the right answer is part of how you build the kind of system you are describing.

Q255 **Baroness Redfern:** I will move on quickly to my question. What effect is the lack of a social care settlement having on the sustainability of social care and health systems? Is there an alternative funding model that you would consider more viable? Do you think Dilnot’s recommendation for a cap on social care costs can and should be delivered?

Chris Wormald: The lack of a social care settlement?

Baroness Redfern: That is right. On the sustainability of social care and health systems.

Chris Wormald: There is a social care settlement in that the Government have set out its resources.

Baroness Redfern: Is there an alternative funding model?

Chris Wormald: Social care is clearly an area—I do not think there is any dispute about this—that is under challenge and local authorities are taking a lot of tough decisions. A bit like Lord Willis’s question on hospitals, however, what jumps out from the data is the level of variability between different places. The financial challenge in social care is what it is, and we need to focus on whether everyone is adopting best

practice and whether they are moving towards integration in the way I described in answer to some earlier questions. That is our focus. I am not sure the funding model is relevant to that question.

Lord Scriven: Clearly, the issue of long-term sustainability for the NHS is absolutely vital to working more closely and to integration with social care. I think everyone has said it is a key element. Do you think, therefore, that there will have to be a different funding model for health and social care together to deliver this integration, or can it continue like that? Could you suggest any funding models that could help this path of integration in the future?

Chris Wormald: No, I do not think a different funding model is required. The best moves that we have seen towards integration—I pointed to some of them earlier—have been about the working relations at local level, not the funding model.

The Chairman: That comment has just excited several hands. We will have to be quick about it. Lord Bradley, Lord Warner and Lord Willis.

Lord Bradley: A number of issues have been wrapped up. You speak about devolution in Greater Manchester and the STPs being the drivers for change, and the locality plans are meant to recognise the demographic changes within each locality and bringing together the STP. But to suggest that the social care budget is “under challenge” is the understatement of the morning. We had Greater Manchester before us last week, and in terms of sustainability for the long term, which is what we are trying to get to, they see a crisis in the next financial year in social care. Unless they get extra resources into the funding and a redistribution, as Lord Warner has suggested, they will not be able to deliver the sustainability transformation that is absolutely critical to the long-term sustainability of health and social care. What action does the Department of Health take to try to support the devolution deal to ensure its success going forward? Otherwise, your mantra of “devolution at local level is the answer going forward” falls apart.

Chris Wormald: As you know, the Government do not agree with the starting point of your question. In terms of what we are doing, they are the things we have been describing. We are working closely with our partners in local government, from the Better Care Fund and elsewhere, to try to develop the models of integration that we want to see. I acknowledge that there are funding challenges. I am not going to use the same language that you do; as I say, the Government do not agree with your position.

Lord Warner: The Government do not appear to agree with the position of the CQC, which has made it very clear in *State of Care* that providers are leaving this sector at a growing rate. Is that on the Department of Health’s register of risks, or do you think it will also turn out happily at the end?

Chris Wormald: No. We monitor that and we see it as a risk.

Lord Willis of Knaresborough: Again, I am quite incredulous at that last answer. If you refer to the question I asked you earlier about productivity, if you go to any major hospital, or in fact any district

hospital across the country, you will see that they will have between 10 and 60 people there bed-blocking every day of the year. That has one of the most significant effects on productivity, yet you do not seem to flag that up as a major issue which the department needs to tackle.

Chris Wormald: No, we do think that is a major issue, and there are a number of things that we do on that subject. There is considerable variability across the country on that issue, and a considerable quantity of what is termed bed-blocking is about issues in the NHS, not between the NHS and local government. As I say, the funding settlement is what it is. We see very variable performance in different areas and we seek to address those variabilities.

The Chairman: Over and over again, lots of witnesses have commented on the need to find a settlement for social care and that if we do not find it the NHS will begin to suffer even more than it is now. There are around the table members who are associated with local authorities, and they are telling us the same things. Who do you think should address this issue of finding a settlement for social care?

Chris Wormald: And by “settlement” you mean—?

The Chairman: Financial settlement.

Chris Wormald: There is a financial settlement for local government that involves considerable new resources going into social care. As I say, the Government have made their position clear on this.

The Chairman: Do you think that is adequate?

Chris Wormald: As I said, there are clearly challenges in this sector, as there are in a number of public services, and we all know the reasons why. Yes, we acknowledge there is a challenge in this area. We believe that the variability in the system is an important component of that, and that is the issue we work on with local government and others. Clearly, the debate about the right level of funding in that sector will continue.

Lord Willis of Knaresborough: Chairman, the Permanent Secretary has not answered the question on Dilnot. Is that now dead?

Chris Wormald: The Government have set out their position on Dilnot, and that has not changed.

Lord Willis of Knaresborough: Is it dead? What is the position?

Dr Chris Wormald: No. As I say, we have said we are committed to Dilnot towards the end of this Parliament, but clearly that is for future decision.

The Chairman: Professor Whitty, what do your demographic figures suggest will happen to the demands of social care, looking ahead 15 years from now?

Professor Chris Whitty: It is very clear that the demand for social care in some form—I stress that—will go up. That is partly because of an ageing effect, partly because of multimorbidity, and partly because of the advantages we have had. For example, the incidence of stroke has gone down, which is fantastic, but that means that the number of people surviving with stroke is going up. The same is true for dementia. Clearly

more people will get dementia because other causes of mortality are going down. It is an inescapable fact that, viewed over a 20 to 30-year horizon, the need for social care will increase.

Lord Ribeiro: In the 1980s we had the Department of Health and Social Security, and that was separated into two areas. It seems to me that the Department of Health has lost sight of what social services do. Is it time, if we are thinking in the long term, as we are in this Committee, to bring those two units together so that DoH and social services will work together to try to work out some of the problems you have identified but do not seem to have the power to do anything about?

Chris Wormald: The social security bit of what used to be the DHSS was the benefits system. That is now the Department for Work and Pensions. I do not think it is that question. Policy responsibility for social care rests within the Department of Health. Financing questions are part of the local government settlement, which is part of the Department for Communities and Local Government. We work very closely with them on these questions. Personally, I do not think redrawing the map of Whitehall is normally the way to solve questions; indeed, most machinery of government changes create a new, rough edge somewhere, so I would much rather concentrate on how we work within the current system. There are very, very close working relationships between us and the Department for Communities and Local Government on these questions.

Lord Ribeiro: You mentioned clinicians having a responsibility and needing to change their practice. As an ex-clinician, one of the frustrations is knowing that you are carrying out procedures but you cannot get your patients out of hospital and into the community. For clinicians, it is not so much a change of practice as a matter of closing off the tap at one end and opening the door at the other.

Chris Wormald: Yes. We appreciate that.

Q256 **Baroness Blackstone:** What is your key single suggestion for change that the Committee ought to recommend to support the sustainability of the NHS?

Chris Wormald: I am not sure it is for me to say.

The Chairman: Go on. Be daring.

Baroness Blackstone: Be brave.

Professor Chris Whitty: I will take two then.

Dr Chris Wormald: No, I will give one answer, but you have your two.

Professor Chris Whitty: Clearly, it would be inappropriate for us to say what the Committee should say to Government, but I would say two things the Committee might want to say to other bits of the system. One is to the medical profession, because there are so many leaders around the table. We have to take seriously the way multimorbidity is heading our way, and we are not doing it at the moment. We have a disease model that is very mono-disease-based, with NICE guidelines and things, all of which are aiming in the wrong direction for where we are heading in

20 years. Some advice on that to the professions, not just the medical profession but the other professions, would be a very useful thing.

Lord Willis's point that this is an area that has been under-researched in terms of getting information to do things is absolutely right. That does not mean robbing Peter to pay Paul, but this in the long run is going to make the system a lot more efficient.

Chris Wormald: As I say, I will not give recommendations that you can make back to government, but I will finish where I started. I do think that the questions this Committee is raising, both about long-term supply—and I will adopt Lord McColl's words—long-term need for health are ones that need to be debated publicly more. Whether you agree with my version of how those debates should be had or the Committee's I think is irrelevant; the most important thing is that those things are properly publicly debated. Therefore, my encouragement to the Committee will be to recommend that those debates go on and on and are given the kind of light that we have seen today.

The Chairman: Can I thank you both for coming today? It has been most appreciated. It has been very interesting and challenging, no doubt, but, I have to assure you, a very helpful session. We appreciate you coming today. Thank you very much indeed.

NHS Improvement, Care Quality Commission, General medical Council and Nursing and Midwifery Council - Oral evidence (QQ257 – 264)

Evidence Session No. 27 Heard in Public Questions 257 - 264

Tuesday 6 December 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey, Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

Jim Mackey, Chief Executive, NHS Improvement; Professor Sir Mike Richards, Chief Inspector of Hospitals, CQC; Professor Terence Stephenson, Chair, GMC; and Jackie Smith, Chief Executive, NMC.

Q257 **The Chairman:** Good morning, lady and gentlemen. Thank you very much for coming to help us with this session. We are being broadcast. I do not know whether the BBC is carrying it live or not, but we are certainly on the parliamentary broadcast. If you would not mind, please introduce yourselves, from my left first and, if you want to make a short opening statement, feel free to do so. We will send you the transcript of the session subsequently. Feel free to correct it, but you are not allowed to change it. Can we start from the left first?

Jim Mackey: Good morning. I am Jim Mackey, chief executive of NHS Improvement.

Professor Sir Mike Richards: Good morning. I am Professor Sir Mike Richards. I am chief inspector of hospitals at the Care Quality Commission.

Professor Terence Stephenson: Good morning. I am Terence Stephenson. I am chair of the General Medical Council and I have been dean of a medical school, president of a royal college and I am still a practising doctor seeing emergencies every month.

Jackie Smith: Good morning. I am Jackie Smith. I am the chief executive of the Nursing and Midwifery Council. We are the largest regulator, regulating almost 700,000 nurses and midwives.

Q258 **The Chairman:** Thank you very much. I will kick off with the first

question, which relates to the model of health and social care that we need. The whole of the inquiry for this Committee is looking longer-term, to 2025, 2030 and beyond. What actions should be prioritised now, do you think, to prepare a system to deliver a model of care that will be fit for purpose in terms of funding, manpower and training of the workforce?

Jim Mackey: From my point of view, the priority should be integration organised around the needs of the people we are looking after. In the bit that I heard of the previous session, there was some discussion about the multiple morbidity problem that we have now and that will get worse over the next few years. In that context, it should be a real focus on joined-up services that are not as compartmentalised or as siloed as they are now.

Professor Sir Mike Richards: I would go along with that completely. I think it is all about integration between health and social care and also integration within the health service between primary care, community health services and acute hospitals, working more effectively together to keep people in the right place at the right time.

The Chairman: How do we get there? Are there barriers to it?

Professor Sir Mike Richards: I think it is beginning to happen. After a long period when it has not happened, I sense that the new models of care that people are talking about are beginning to take shape. We will have accountable care organisations which, effectively, cover all those bases. We see it probably the most closely in Northumbria, and Jim Mackey can talk about that in more detail, where you are seeing an acute trust already running community services and starting to manage aspects of primary care, a number of GP services and care homes—so it is beginning to happen and, with that, we will see efficiencies.

Professor Terence Stephenson: Perhaps I could say something about the medical workforce for 2030. My own professional life would indicate that it is fraught with difficulties trying to predict the kinds of doctors we might need in 2030. That would say to me that what we need is a group of doctors who are very flexible and adaptable. You have heard already that there will probably be more generalists and more people in primary care because we will have an older population with comorbidities. Over and above that, I think it would be rash to be training people today for a very fixed role in 2030. I think we need to train doctors in a flexible way, and the GMC is doing that with our flexibility review and our review of general professional competencies.

On training doctors, remember that most of the people working in the NHS in 2030 are already working there now. We are not starting to train them, they are there—people like me and people younger than me. We need to have the capacity to retrain and upskill them as health changes, which is very important. Finally, if you were Florence Nightingale walking around the NHS today, a third of our doctors were not trained in the United Kingdom and we need to maximise what we get from them in whatever kind of transition there is between now and the Brexit settlement. We need to make sure we maximise the use of the doctors we have and any who are coming to this country from abroad because, historically, we have been very dependent on overseas doctors.

The Chairman: So both your organisation and Jackie's organisation are

regulators of professionals, doctors and nurses. We have had evidence asking that a change be brought about and states that we train our doctors for too long, that the profession does not want to address this issue, that you, the regulators, can bring about that change but are not willing to do that, that there ought to be more of a skill mix and that others, who are not doctors, can be trained to provide some of the care and bring about efficiency and productivity. What would be your comments on that?

Jackie Smith: Yes, we find ourselves in the same position as the GMC. In fact, we are embarking on a radical review of our pre-registration nursing standards at the moment because we cannot just think about the workforce for today, we have to think about it in 10, 20 and 30 years' time. We are very keen to raise the bar so that employers can find themselves with nurses and midwives who can deliver the complexity of care that we have heard about.

The Chairman: The challenge is to you.

Professor Terence Stephenson: Let me take it in two parts. Over the last four or five years, I have been to 23 different countries to see how they train doctors. There is no country in the world that takes as long to train as us, but there is no country in the world that is so dependent on its trainees for delivering the service. In most countries, training is much more formalised and structured. We have to recognise that we have 55,000 trainees out of a workforce of 150,000 and that, for much of their time, their training is long because they are not being trained, they are just providing a service.

Lord Patel, you are an obstetrician and gynaecologist. There is nobody in the GMC today who could set out how you train an obstetrician. We are like a judge in a court; we are totally dependent on the experts telling us how long they think it takes to train and then we can make a judgment. Colleges have no monopoly. If anyone else were to come forward with an alternative training system—shorter, different, more flexible—we would look at that.

The Chairman: So, as a regulator, why do you not talk to institutions of higher education, the universities?

Professor Terence Stephenson: We would be very happy for anybody to bring forward any kind of training scheme. If the University of Dundee wanted to put forward how to train obstetricians and to do it in a shorter time, we would be very happy to look at that. No one has a monopoly on this. It is probably the start-up costs that deter people. We have a training system which has been running for decades. For anyone to break into that would take probably quite a big up-front investment and nobody yet has ever come forward with an alternative.

Q259 **Lord Kakkar:** I want to build on this discussion about what your organisations are doing on ensuring that regulation enables the workforce to adapt. What about your statutory regulatory responsibilities and the ability to provide flexibility for the workforce to adapt both in terms of addressing the sustainability of NHS care and social care? In particular, what do you consider are the greatest workforce threats to long-term

sustainability and what solutions do your organisations have to address those particular pressures?

In terms of the current workforce resource and how you see it going forward, what are you doing to address what is available and what might be available and the gap with regard to perceived patient needs?

In terms of the future requirements, do you believe that there is a mechanism in place to ensure that there is the capacity to make sustainable change over the medium term to ensure that the skills are available for the longer term?

I should declare my interest as a recently retired member of the General Medical Council who sat on the review that looked at the change in training.

Jackie Smith: At the risk of repeating myself, the responsibility we have is to set the appropriate standards to deliver care, as I say, not for today or tomorrow but for the next 10, 15 and 20 years, and we cannot do that in isolation. Regulators are famous in the past for working in isolation, but we need to understand what the demands are and we need to work with employers and providers across health and social care and universities to find the best way of delivering the standards required and to protect the public—because, at the end of the day, that is our job.

Lord Kakkar: Does that capacity currently exist to bring those different stakeholders together to have that type of discussion?

Jackie Smith: That is exactly what we have embarked on over the last 14 months; the radical review of the pre-registration standards for nursing has done just that. It will raise the bar and I fear it will scare some individuals at the same time, but that is the place we need to be in. We cannot just be saying, “This will work for now”; that is too short-term.

Professor Terence Stephenson: Probably the greatest threat to the workforce is, as Chris Whitty alluded to, that we continue to produce highly specialised clinicians, who are very highly trained but in a very narrow area, when the demographic is a population that is getting older, more obese and with multiple comorbidities. The Greenaway report, an independent report commissioned by the GMC, flagged up the idea of needing more generalists, both in primary and secondary care. And everything that has been said, including treating people closer to home, better social care and probably fewer larger elective centres – I agree with, because all the evidence is that the more you do of something the better you get. I think those are the threats.

In addressing the question of whether we have the capacity to change that, yes, I think we can work with the royal colleges to change the training to produce a cadre of generalists, and we are doing that. Second, there is a scope of practice where many, particularly trainee doctors, are spending a lot of time doing things that do not really need a doctor’s training. We may talk more about physician associates or other entrants to the workforce who would allow us to deploy the medical workforce to do what they are trained to do—to make diagnoses and embark people on

the treatment pathway—whereas others might be able to help to deliver that in a more efficient way.

Lord Kakkar: Do you believe that the Shape of Training review, the Greenaway review, has been implemented sufficiently quickly and robustly to be able to help address the longer-term sustainability needs of the NHS by radically changing the approach to workforce development?

Professor Terence Stephenson: It definitely has not been implemented yet; there is no question about that. We are in discussion with the Academy of Medical Royal Colleges and, in response to the recent industrial dispute, we are conducting a flexibility review so that trainees who start in one discipline and change their minds can move to something else more easily.

On this idea of generic competencies, whatever kind of doctor you are, there is a whole set of skills that everybody needs. If you change your training pathway or medicine changes so we need different care or we do not need cardiac surgeons anymore—and the amount of cardiac surgery has gone down hugely—then you have a group of people who already have those generic competencies, which is quite important.

Lord Kakkar: Do you believe that your current statutory framework for providing regulation allows you to be sufficiently flexible to address the questions that we are discussing?

Professor Terence Stephenson: No, we absolutely do not. Our legislation, as we are a creature of statute, is the 1983 Medical Act, which is now over 30 years old. We have been pressing for some time. First, there was the Law Commission Bill, and there will be a consultation, I hope, soon by all four Governments on the future of regulation and the reform of it. We would very much like enabling legislation which allowed us to reform our practices, protect the public, improve professional standards, change training and change the way that we deal with fitness to practise issues. We think it is overly prescriptive overregulation, but we need primary legislation by government to change that; we cannot change it without primary legislation.

The Chairman: Do you think a single regulator of healthcare professionals might be the answer to developing a workforce that has the appropriate skills and works together?

Jackie Smith: I am particularly interested in what the PSA said about this recently in relation to regulation rethought—in fact, they talk about a single portal and a single register. I do not think the benefits have necessarily been sufficiently articulated. It is absolutely true that the public want to be able to access a solution when they want it and an apology when they want it. Those things are not provided by the regulators, but by where it happened, the point of care, and we, as regulators, would encourage that. I am not clear what a single regulator does in terms of the overall benefits to the public. I do not think that has been sufficiently articulated.

Baroness Blackstone: My question was mainly asked by Lord Kakkar, but can I just pick up on the issue of regulation? A single regulator is possibly a step too far, but there is a question about how many different

regulators providers can cope with. I would be very interested to hear whether you think that at the moment providers are under too much pressure from a large number of different, external and quite interventionist regulatory systems?

The Chairman: The systems regulator might be able to answer that.

Professor Sir Mike Richards: Speaking first for the CQC, as you know, we brought in a new model of inspection and rating three years ago. We have now completed our first round of inspections of NHS trusts and foundation trusts, which includes ambulances, community health services and mental health trusts—and I think we have learned a great deal from that. We have seen the variation of quality that there is within the NHS from outstanding trusts through to those that are inadequate, where we have been working with NHS Improvement on the special measures regime and are seeing considerable improvements in that area. We have a much clearer picture and we are moving towards working together on developing an approach to assessing the use of resources and efficiency. We will be working as one on that so that we can give a balanced picture of quality and use of resources for every organisation and acute trust in the country.

Lord Warner: We have had a lot of evidence on the issues that particularly Terence Stephenson raised about whether you can get a bigger bang for your buck from your existing workforce by pushing things down to associates or assistants—call them what you will. What are the things that we should be saying in our report to make that happen? There are lots of good ideas out there, but there does not seem to be a coherent game plan for making it happen, so any thoughts you have on that would be very helpful.

Professor Terence Stephenson: I think nine regulators is possibly too many and one is too few—and too big. We had a huge throwing of the cards up in the air in 2011 and I am not sure that we need that right now when we are in a state of stress and crisis. For sure, if we are going to bring in new people who will do the kinds of things that doctors currently do, they do need to be regulated—so that is a double-edged sword. Perhaps we can streamline some of the current regulations, but that would not, for me, be an argument for bringing in physician associates as an unregulated group. I think most of the public would expect people who, after all, will be asking you intimate questions, laying hands on you, examining you, possibly sticking things inside your body, which are invasive procedures, to be part of a body that is regulated.

Lord Warner: Could you take that on though in your role?

Professor Terence Stephenson: We would be agnostic. If we were approached by the four Governments to look at that, we would be very happy to look at it. We are not looking for business. I think all the regulators are agreed that it is a group of people who should be regulated. If they are to fulfil their maximum function, they have to be able to do the kinds of things I have talked about, to make a diagnosis and start treatment, and, if they are going to do that, they should surely be regulated.

Jackie Smith: Of course, the Secretary of State has asked the NMC to take on the role of regulating nursing associates.

Lord Turnberg: First, let me apologise to you, Lord Chairman, and to the witnesses for missing the beginning. I have to express my interest as a past president of the Royal College of Physicians.

We have been talking for a very long time about the development of generalists. I remember the Royal College of Physicians way back talking about it and trying to develop a cadre of generalists. Does that necessarily mean a diminution in the number of specialists? Are we in danger of throwing the baby out with the bathwater, because people do need specialists? Is it that we need more or do we need to convert them?

The Chairman: Or does it matter if there is a diminution?

Professor Sir Mike Richards: Can I have a go at that, largely building on my previous work in the field of cancer? I think we need the right balance of specialists and generalists. Yes, we need more generalists, and I think we have seen that with acute medicine, for example, which has been a very valuable step forward. If you take surgery, and I realise that I am surrounded by surgeons, if you are going to have oesophageal surgery for cancer, you want it done by somebody who is highly specialist. Getting that balance right and being clear on what needs to be done by a specialist and what is best done by generalists is very important. At the same time, thinking about other skill-mix issues, when I was working in cancer, we pushed the idea of non-medical people doing endoscopy and becoming advanced practitioners, radiographers taking on extra roles and clinical nurse specialists taking on extra roles. It is not that we have not seen any of this happen, we have seen a lot of it happen, but it just needs to be pushed further.

The Chairman: Jim, you wanted to come in on the last question and this time, so cover both.

Jim Mackey: On the single recommendation, the key thing would be to allow local flexibility within a clear set of national guidelines and rules. Often, the innovations that Mike has just described are there in appetite, but it is very easy for somebody inadvertently to get in the way of that and the decision-making systems are very complex. In this next phase, we need to do things that encourage and enable local innovation. That is the first point.

Secondly, I agree with Terence on the regulation point. Physician associates are a good example where, if they are going to do the job, they need to be able to prescribe; if they are going to be really effective, they need to do that and, therefore, they need to be regulated. We need to allow them as much flexibility as possible to develop.

From my point of view, a lot of this is possible now, but it is difficult. It is more possible when there is more supply, and we are too constrained from a supply point of view. There is some value in some work on the economics of a small excess of supply versus the shortage of supply we have now, and I think this system can be, in my view, demonstrably more productive if we could deal with that. The problem is that these are very

long-term decisions and, if we make decisions now, it is a very long time before they feed through—but that should not mean we avoid them.

Lord Lipsey: Just on the supply question, I think we have experimented with that in Gordon Brown's Niagara of cash that hit the health service, and we know that a lot of it went into doctors' wages—which, although important, did not obviate the shortage of supply. How will you obviate the shortage of supply without the money you are trying to use for that purpose being used for other purposes which are less obviously a priority for the public?

Professor Terence Stephenson: Maybe I can say two things about generalism that relate to that. First, we should not lose sight of the fact that 90% of the people seen in the UK by the NHS are seen in primary care. We already have a large cadre of generalists. Our problem is that they are dissatisfied with the work and the pressure on them, so we need to attend to making general practice a popular option.

The second thing is that I do not think it is an either/or. Of course we need specialists, so we would welcome the 1,500 new medical students who will be entering training, provided they are an additional number of doctors for the UK, which is below the OECD average of doctors per 1,000 people. If they substitute for the third of doctors who currently come from outside the UK, we will not have any more net doctors and then more generalists would mean fewer specialists—which I am certain is not what the UK population is looking for.

Lord Bradley: Innovation and flexibility, under devolution, is the direction of travel for long-term sustainability. To get to that point, you need short-term investment in innovation. Does that mean that you can be flexible around current control totals to enable, for example, Greater Manchester to invest and innovate going forward?

Jim Mackey: We would not rule that out, but we would need to see a business case for it. We are having conversations across the country with providers and STP areas, which are trying to demonstrate a case that, if there were some short-term investment or flexibility, they could get a longer return. That is difficult because there is no headroom at all anywhere in the system financially, so, to create flexibility for somebody, it actually means that somebody else has to work harder, financially, but we will try within those constraints. I have not yet seen a business case that shows that we get our money back on any of these transformations, so, if anybody has one and I could see it today, I would be very grateful for it.

Q260 **Lord Willis of Knaresborough:** Lord Chairman, a great deal of what I wanted to say has been answered before, so I will concentrate on two areas. First, all the panel, and indeed every panel we have talked to, has talked about greater integration between health and social care and more generalists as well as more specialists, which always seems to be the case from medics. In reality, the question which Sir Andrew Cash, the chief executive of Sheffield, who was a witness a couple of weeks ago, brought up with us made it quite clear that, without a significant change to the regulatory framework, we could not, in fact, deliver the sorts of ambitions that people have. Earlier, Professor Stephenson, you mentioned exactly

that; that there needs to be new legislation to look at regulation that is fit for 2030 rather than 1930. What is your vision of what that legislation should say? What should we be recommending in our report as to what the new framework for regulation should be about? We have systems regulators and professional regulators, a lot of them, and simply saying that it is something between nine and one is not a sufficient answer to go forward.

Professor Terence Stephenson: There are two broad strands that we would be looking for. One is that we want to, if you like, upstream. We get 10,000 complaints a year about doctors, of which about 7,000 we close very quickly. With the other 3,000, we put people through the mill and eventually 80 to 90 people are struck off. We are dealing with legislation that was not designed for 10,000 complaints a year. Lord Walton, who just died, one of my predecessors, told me that he heard every complaint personally—about 350 a year, one a day. We have legislation now dealing with 10,000 a year. The first thing would be to allow us to upstream because many of those could be dealt with locally and those doctors do not really need to be taken out of practice; it is a hammer to crack a nut.

The second thing, hinted at earlier, would be that if we had new legislation we could have a more similar common code where if a nurse, a midwife, a doctor and a dentist all did the same wrong thing, they all got the same sanction or the same kind of evidence was brought to bear. At the moment we are all operating under rather ad hoc legislation which has grown up higgledy-piggledy over decades. It must seem strange to the public that, if they see a health professional who is found to have done something wrong, there are all these different ways of dealing with them. That is why I would push for an ability for us to act with a more common set of rules and an ability for us to keep stuff locally that does not need to be reported to a national body.

Jackie Smith: I would very much agree with that. Actually, I would say that our legislation is probably 15th century: it is that out of date. Consequently, we are in the business of pleasing no one because the public have an expectation that we will deliver a resolution and we cannot because of the constraints of our legislation. I very much agree with what Terence said; we need to work together better. The public want consistency of decision-making across the regulators and they need to understand what we are doing. Because I hold a hearing and then Terence might do something later in a different way, the public are confused, so we need change to our legislation to make sense and to provide a better service.

Lord Willis of Knaresborough: I have to declare an interest as a consultant for the Nursing and Midwifery Council. So much of the evidence we hear about regulators is that they are part of the problem. How do we shift that to actually make regulators part of a solution to a modern healthcare system moving forward?

Jackie Smith: I would say first that we need to be honest about what we can do. We are fundamentally here to protect the public, but we are also here to set the right standards, and we need to work in partnership, not

in isolation, and be clear about what can be achieved. That is the first point.

The second, and I keep coming back to this, is that we need to think about the workforce in the future and how we are setting the right standards to deliver care in 10 or 20 years' time.

The Chairman: Are you doing that?

Jackie Smith: I believe we are. As I say, the review that we are doing now in relation to pre-registration nursing is radical.

Lord Willis of Knaresborough: What about Jim Mackey and Mike Richards?

The Chairman: Jim, you wanted to come in.

Jim Mackey: On the question about what should be in the legislation—

Lord Willis of Knaresborough: Do you agree that there should be legislation?

Jim Mackey: Possibly. I think we are all a bit fatigued with change and we have not recovered yet from the last changes. If there is a need, what I would like to see enshrined in the legislation is a duty on regulators to guarantee minimum overlap and minimum duplication and to collaborate on consistency, which people are trying to do, but to make sure it is a core commitment.

A fundamental principle is that we should look at regulation as a kind of safety net, but not a guarantee of success. The service runs by people taking control locally and making their own decisions. In this last period, that has all got a bit confused and there is far too much focus on the regulatory system and far too little focus on how people, such as Manchester and others, take more local control of their circumstance. I think the regulatory system needs to support that.

Professor Sir Mike Richards: I am not sure that legislation is what is needed at this instant from a systems regulator point of view—I cannot speak for the professional regulators. We are already working much more closely with NHS Improvement, NHS England and CCGs. I co-chair the National Quality Board with Sir Bruce Keogh and one of the things we are doing is looking at how we can best align all our requests for information on quality, or efficiency for that matter, so that trusts are only being asked once rather than multiple times in slightly different ways. We are also working, as the organisation representing the trusts, with NHS providers to say, "Tell us where we are not working well together so that we can understand that and put it right".

One of the specific objectives we have set out in our new strategy for the CQC is to have a shared view of quality. We base that around our current five key questions and we are adding in questions on the use of resources. What we are finding is that trusts are already using this model for their own internal quality assurance and quality improvement. If you go to a trust such as Frimley Health, it is already using it for its own internal insurance—and it does it at a much more granular level than we would do. It will look at cardiology, respiratory medicine and gastroenterology, whereas we might just look at medicine combined. It is

finding it very valuable and also using it when it is trying to drive up improvement—and other places such as Oxford are doing the same.

Q261 Lord Warner: The thing which keeps coming back to us from witness after witness, particularly those in the operational field, is a sense of conflicting demands being made on them by a group of people called “regulators”, and they do not always distinguish between whether they are professional or systems regulators. You guys and gal are actually in the frame, as far as I can see, for many of the operational people. What would you like us to say to help you get, if I may put it this way, a better press from the operational people—not from us, not from the politicians but from the people whom you are regulating?

Jim Mackey: I do not think there is much you can do. We need to help ourselves with that and, as Mike has described, we are doing an enormous amount of joint work to try to minimise the interactions with providers, and it is absolutely work in progress. One example would be that we have a bit of joint work about to kick off with a major provider to look at safety in ED, and we are doing that together rather than as separate interventions and separate support. We need to do much more of that. If you start saying positive things, unless it is borne out by experience, it will actually not do anything. Often, people use the word “regulator” when they just mean somebody else in the system. It is often the commissioning system where a lot of the interactions happen and then we can absolutely ask for similar things, so we have lots of work going on trying to simplify that. Simon Stevens and I are working, as part of the STP process, on whether there is a way of us devolving as much local responsibility for all that resource to STP leaders or devo leaders to make sense of it in the current context.

Professor Sir Mike Richards: You mentioned the negative press we may get, and we have all said that we need to work better together to reduce the burden. On the other side, we do survey the providers that we regulate. In adult social care, 93% are positive about the benefits and impacts of our inspections, in independent health it is 92% and in NHS trusts it is 86%. You may not hear about the good press that we also get.

Lord Willis of Knaresborough: They dare not say anything else.

The Chairman: Exactly.

Professor Terence Stephenson: I was preparing for my annual appraisal after midnight last night, so this is quite close to my heart. Almost all of what I am doing is not required by the GMC. The vast majority of it is mandatory training required by my employer and some of it is dictated by the royal colleges. So I think we have to reflect a huge societal change. I qualified as a doctor in 1983. Nobody was expecting me at midnight to do online training on different colours of fire extinguishers. Now, it is mandatory training. Nobody was expecting me to do training on back lifting. You can argue whether that is right or wrong, but society has changed hugely. The burden of regulation across society and what we expect of people is vastly different. Just look at the change in the driving test.

The Chairman: The comments we have had suggest that sometimes,

both for systems and professional regulators, the regulatory regime that you require us to follow is not proportionate.

Professor Terence Stephenson: There is a huge risk with that; that is what I am trying to say. It is a cri de coeur. Most of what I have to do is not mandated by the General Medical Council. What the General Medical Council asks for is actually quite modest, which I have to do. I have revalidated—along with 155,000 other doctors, so it is doable—but a huge amount of what I do is dictated by other people.

The Chairman: I will not invite comments around the table about revalidation.

Baroness Blackstone: One of the criticisms that is made of the systems regulators, in particular, is that they are too driven by processes and procedures rather than by outcomes. Is that a criticism that you think is valid and one of the areas that you want to work on to improve?

Jim Mackey: I think that has been fair in the past. It is probably a work in progress, I would say, certainly from an NHSI point of view, as we are in transition from a regulatory system that was created at a point in time and the world has changed and we are trying to adapt and be flexible for now and for the future. There will, over time, be more outcomes, focused and orientated. Frankly, a lot of clinical practice is absent of outcome measures, so we need the profession to help with that. There is really strong evidence that the CQC has moved a long way from the first inspections and is much more outcome-focused. I do not think any of us are happy that we are there yet, but we have started and we are trying.

Professor Sir Mike Richards: I am very happy to move in the direction of outcomes, particularly when people can measure them and provide them to us. For example, with all the national clinical audits, we are working with them, they do give outcome measures, and we are working with the leaders of those audits to say, "Tell us which are the five key questions in your 80-question audit which matter most and we will then incorporate those into our inspection programme"—so we are doing that.

When we look at processes, those are processes which an organisation such as NICE has said are closely linked to outcomes. I think there are times when we will have to look at processes because they are the best proxy and, at least, they are going on right now, whereas, sometimes in outcomes, you have to wait a year or even five years to know what the outcome really was.

Q262 **Lord McColl of Dulwich:** Staying with the regulation business, could the burden of regulation be reduced without damage to service consistency and patient safety? In particular, we have heard quite a lot of criticism of the CQC in general practice, where it seems to be much more interested in ticking boxes than in listening to outcomes and the views of the patients in the general practice that serves them.

Professor Sir Mike Richards: As you know, I am not the chief inspector for primary medical services, but we take the views of patients into account there. The GP patient survey is a very important element of the inspection programme.

The other thing I would say—and this is not only for general practice but for hospitals as well—is that we are now in a very different position from where we were three years ago. We are either completing our first round, or have completed it, and we have a much better picture of quality, which I think will allow us to be much more targeted in how we inspect in the future. Coming back to hospitals, if we have been to a hospital that is outstanding, it could be Northumbria, Frimley Health or whatever, do we need the same intensity of inspection at a hospital that we know is outstanding as in one that we know is really struggling? We will be developing a completely new approach to looking at our previous experience with their inspection, any new data that has come in from national data sets, our local relationship with that trust, knowing what is going on there, any concerns that have been raised by staff or patients, and we will take all that into account and say, “This is the specific service that we need to go into” and not necessarily do a comprehensive inspection.

Professor Terence Stephenson: I would agree with Lord McColl’s premise that the regulation burden can be reduced without impairing patient safety. That is why we need legislation. Modern regulation should be targeted, proportionate, data-driven and intelligent. It should not be a blunderbuss. Whether it is the way we inspect medical schools or the way we deal with complaints, we should be focusing our attention on where we need to and not labouring under very old legislation where one amendment can take two years.

Jim Mackey: I would agree with all of that.

The Chairman: I do not know if you have been following our evidence sessions. If you have, you have probably read or heard some of the comments we have had, particularly from well-recognised foundation trusts, about the bureaucracy that systems regulation imposes and the conflicting requirements that both of you ask for independently rather than working together, which not only produces more cost for them but disrupts their working.

Jim Mackey: I recognise that. It is not much more than a year since I was out there doing that, and I completely recognise that. It is not a new thing. I was thinking earlier on about one of the questions. It would be over 10 years ago when we got to a Thursday morning and we had seven regulatory interventions that week—and that was before a lot of this architecture was built, so it has always probably been a bit of an issue in health.

As Mike has described, between our two organisations we are seriously rationalising our work to share intelligence, support and intervention and to manage the noise as much as possible and simplify that. It is a work in progress. We have started now, between NHS England and NHSI in an STP context, working on how we do that. There are lots of points of entry into providers.

A lot of the people you have heard evidence from are high performers. On the proportionate point, we should not have a lot to do with the high performers; we should be allowing them to get on with things. We also have a large number of organisations that, frankly, need our support and

we need to help prop them up and get them into a more stable position. So I would agree strongly with the proportionality point and that we all have a duty to stand back occasionally and minimise duplication. One of the things we say within NHSI, which is a new organisation, is that often the right thing to do is nothing. If we are dealing with a provider and there is a lot of noise going on, probably what we should do is talk to the people who are generating the noise and allow them to get on with what they need to do. That is a very hard judgment to make when an organisation is in trouble.

Lord McColl of Dulwich: Could we do something about the CQC inspection of general practice because it really is a shambles—and that is the view of one of the Ministers?

The Chairman: You wanted to come in first on the last question.

Professor Sir Mike Richards: I was going to add on the high performers that, in a number of instances, we have found individual services where they have taken their eye off the ball and they have acknowledged that afterwards and where the spotlight that we have been able to shine by doing a comprehensive inspection has led to improvement. I am quite sure that those high performers, because they have good leadership, will put those things right—so we need to pay particular attention to the ones that are struggling.

Coming back to Lord McColl's point, even among general practitioners, going back to the question of whether we get good or bad press, 57% of them say that it has been beneficial and had a good impact, so it is not all that you may hear. What we will do at the end of our first round is look at the whole process of how we do general practice inspection. We have set out our new strategy overall for the CQC, which includes having a more targeted and tailored approach. As you will know, a large proportion of GP practices have come out as good or outstanding, so we will consider what we need to do with the reinspection of those, and we will be reconsulting on that in the spring.

Lord Scriven: I have been listening very carefully. A lot of the discussion in this session has been about small steps and what we are doing now to change. Can I take us forward to 2030? There is a lot of evidence coming to us which is talking about a more devolved system of health and social care: much more integration, much more generalist in terms of staff. Going forward to that system, what is the role of regulation and how would regulation change to sustain that very different model from what we are talking about today? Can you give us your views about that? It is quite important, not just in terms of numbers but in terms of what the role is, how it would work and how it would be different, because I think it will be a very different system and I have not heard that come out from what you have said.

Professor Sir Mike Richards: First, I think we will still need regulation. As Jim was saying, it is absolutely vital in ensuring that patients are getting safe services, so we need to adapt as the health and social care services are changed, and we are doing that. We are working very closely with those who are developing new models of care.

Lord Scriven: It is not a criticism. I want you to crystal ball-gaze a bit

into what is needed.

Professor Sir Mike Richards: To crystal ball-gaze, we will still be needed, we will need to be lighter on our feet and we will need to target those places where the problems are greatest, but we will adapt so that we can inspect and regulate new models of care. With those new models of care, we are saying, "Please tell us what you are planning so that we can plan the regulation with you". For example, I am meeting with 13 of the acute care vanguards on Thursday of this week to discuss that very issue.

The Chairman: Is there not an issue where you inspect and Jim improves? Should part of the inspection regime not be to help to improve the delivery of service?

Professor Sir Mike Richards: Absolutely.

The Chairman: So why do you not do it together?

Professor Sir Mike Richards: We inspect and rate and we therefore shine a spotlight on what is working very well and what is working less well. It is very important that we do not also do the improving or are not overseeing that—otherwise, we would be marking our own homework. There is a real danger then that we would say, "Oh yes, it is all better" because we all want it to be so. So I think the separation of inspection from improvement is a very valuable one.

Q263 **Lord Warner:** We have heard a lot of concern expressed about unwarranted levels of variation in the quality of services, safety and, indeed, productivity. You are also moving to a system now, increasingly, and the STPs take you down this route, where you are talking about what is happening in a health economy rather than just what is happening in a particular institution. Following up on the Chairman's question, how do you need to change, given that there will be health economies which often determine the performance of some of the entities within them? How will the systems regulators in particular change in that world and concentrate more on productivity and performance?

Professor Sir Mike Richards: Of course, one of the points is that the level of unwarranted variation is something we have helped to point out by shining that spotlight, so that is an important point. At present we do not regulate the commissioning side; that is the responsibility of NHS England. As we move to accountable care organisations, that changes because, in effect, a lot of the current commissioning tasks will be performed by the accountable care organisations. What is vital to us is to know who is accountable and what they are accountable for. David Behan, my chief executive, has a slide picture of a coroner's court. Who is the person who gets called to the coroner's court when something goes wrong—who is the controlling mind, if you like? As long as we can be clear about that, we can then design the regulation around it—but it will change as the balance between commissioning and provision changes.

Lord Scriven: I think where Lord Warner was going was that healthcare in the future might be around a health economy rather than individual organisations. What does that mean in terms of your regulation? A lot of the evidence we have heard is about this move, basically. Therefore, the

role of regulation in holding to account a very different type of beast has to change. We are trying to get your thinking on where you fit in there and how you can help improve the sustainability of the NHS and social care moving forward in that new model.

Professor Terence Stephenson: Our view, as a professional regulator, would be that the devolution that you describe, and that localisation, needs to be matched by the regulator. We now have an employer liaison service, and we are out on the pitch, we have a regional liaison service and we have offices in London, Manchester, Edinburgh, Belfast and Cardiff. Moving away from the idea of the regulator just sitting in an ivory tower in London and waiting for stuff to come to it to being out on the pitch, talking to people and helping stop problems getting escalated to a national central regulator, we should continue that march forward to match that devolution in terms of regulation.

Lord Warner: Chairman, can I follow up Mike Richards' answer, which I thought was a very good answer? What it actually poses is an issue for this Committee about the 2012 Act because, if you are going to create new bodies to run health economies, call them what you will, and you can adapt the regulators to regulate accordingly, you then are posed with this problem of who is in charge. What you have is a very rigid system of legislation now which has made, and we can be kind, an interesting approach to who is in charge. But does it inevitably follow from where we are heading for the regulator that, if you do not change the accountability to clarify it, you have a problem with regulation?

Jim Mackey: I think there is still a lot more we can do. A lot of what Mike has described with the development of acute care organisations or systems is slightly constrained by the law, but those organisations and how we work with them can change and adapt a very long way from where we are now. We apply a similar thing to David Behan with a kind of "Who goes to jail?" test, so we can help with the design. We will be doing this with STP processes, governance mechanisms and accountability mechanisms to make sure that it is clear and legal that the right people are in charge and you can actually point to somebody who is in charge and who the controlling mind is. So we can go a long way further than we are now without changing the law.

When we have done that, we will hit upon where the law needs to change—but we are not at that point yet and we can still do a lot more by collaborating, being flexible and helping people navigate what is possible within the law and what is not.

Jackie Smith: Can I make three points? We need the flexibility of our legislation to remove the most dangerous practitioners quickly and we need to continue to challenge ourselves about the right standards and outcomes, but then I think we need to be much more data-savvy. All the regulators have masses of data—we are rich with data—but I do not think we are very smart at saying to ourselves, "How best can we use it?"—and we will have to do that. We should have done it years ago.

Lord Willis of Knaresborough: How do you pull all this together? It is very interesting listening to your step-by-steps and Jackie Smith's very interesting point about the use of data and different organisations using

data, which has come up in a lot of our evidence. Who is going to do this? It comes back to Lord Warner's constant question throughout our inquiry, which is so interesting, about who is going to be in charge. I do not want them in the coroner's court, but I want to know who is going to lead this revolution because at the moment we do not know.

Lord Warner: It is not the Permanent Secretary at the Department of Health.

Lord Willis of Knaresborough: Do not start that.

Jim Mackey: My view is that the last thing the NHS needs now is a big nationally led reorganisation. We are all too busy.

Lord Willis of Knaresborough: You are avoiding the issue.

Jim Mackey: No, I am not. I will try to answer your question. We are at the point with the STP process, whether this works or not, where some of the STPs are coming to us and saying, "Sort this out, rationalise it. Help us get from where we are now". Manchester has pushed it, Sheffield is pushing it, and Frimley is. Simon and I, David Behan and others are encouraging that process where they set out what they think they need and want from us and we will have a conversation about it. The arm's-length body chief execs had a session yesterday to briefly agree that, in principle, what we should do is try to get to the point where we support and agree rather than find obstacles and we need some examples where we can challenge ourselves on it. That will mean, I think, that we agree, which we do now, shared posts, shared intelligence, shared intervention and support, and we all have a duty to massively rationalise our overhead. We are spending a lot of public money when we do this and, when money is tight, we need to maximise the amount of money free and available for public use.

The Chairman: You keep saying, which we have heard before, that we do not need any further major reorganisation. On the other hand, we do get reorganisation. Manchester is an example with devolution; the STPs are a major reorganisation without legislation. If you are going to make the health service sustainable in the long term, and we are talking about 2030 onwards, there has to be some reorganisation, surely. The primary care model may not be appropriate.

Jim Mackey: I think that is all happening and people are out there and doing it. Our job, as regulators, is to try to find a way of facilitating and supporting that in a safe way rather than being obstacles to it. I have lived through lots of NHS reorganisations. The last one was very painful, very long and very expensive and I do not think that any of the people you have seen have said, "We want to do that again". I do not know anybody who wants to do that again. Everybody wants to get the best value and the best use out of what we have now. When we have done that, there might be a point when something very material requires a change in the law.

Lord Willis of Knaresborough: We really need to press you on this. If you take Manchester as an example, you have a group of organisations coming together under one umbrella. Do they create their own governance structure and then present it to somebody so that there is

somebody in charge of it? Is that the model you are talking about?

Jim Mackey: Yes. They are in the process of developing and agreeing a kind of subsidiarity agreement where they agree that some decisions are made as a collective and each board agrees that and cedes control of that decision-making to the collective body. The institutions still exist. Mike Deegan, for example, who is the chief exec of Central Manchester, is still the accounting officer for the Central Manchester Foundation Trust. If something goes terribly wrong, he is accountable, but he does it within a framework of that broader decision-making. People are doing that now and it is starting to work, but it is still early days.

The Chairman: What is the governance mechanism of STPs?

Jim Mackey: That is an interesting point. It is very early days.

The Chairman: You mean there is none?

Jim Mackey: No, it is a development and planning process currently. A small number of them will want to move to a process where it becomes more of a governance mechanism, and it will be similar to the Manchester model, I think, for some. Most of them will see it as a joint planning and development exercise, a strategic forum, rather than a governance entity, a structural change—but there are 44 and there is huge variation among them.

The Chairman: Here is your chance now, Lady Blackstone.

Q264 **Baroness Blackstone:** What is your single key suggestion for change that the Committee ought to recommend to promote the sustainability of the NHS—just one single change?

The Chairman: Looking ahead to 2030 onwards.

Professor Sir Mike Richards: We have all said that we want integration and efficiency. To get that, I think we need to put greater emphasis on leadership. We need to build the cadre of leaders, both clinical and non-clinical. Where we see good leadership and things are happening already, we need to put people working alongside those very good leaders so that they can learn from them.

Professor Terence Stephenson: We are an independent regulator answerable to Parliament, not to the Government. We need Parliament to give us legislation fit for 2030, not fit for 1983.

Jackie Smith: I will say the same thing as Terence. If we are going to be agile, flexible and current, we need change to our legislation immediately.

Jim Mackey: Support integration and do only the things in a regulatory system that need to be done in a regulatory system and allow as much local flexibility as humanly possible.

The Chairman: Thank you very much, all of you. We appreciate very much your coming today and giving us evidence. It has been most interesting. You will get a transcript, as I said, and you can correct it for accuracy but not correct its content. Thank you very much.

Baroness Cavendish of Little Venice, Lord Darzi of Denham and Sir Cyril Chantler – Oral evidence (QQ265-271)

Evidence Session No. 28 Heard in Public Questions 265 -271

Tuesday 6 December 2016

[Watch](#) the meeting

Members present: Lord Patel (Chairman); Viscount Bridgeman; Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

In attendance: Viscount Bridgeman

Examination of witnesses

Baroness Cavendish of Little Venice, Lord Darzi and Sir Cyril Chantler.

Q265 **The Chairman:** Good afternoon, lady and gentlemen, lords and ladies, and sir. Thank you for coming today. Your evidence is crucial. Camilla, I know some of the health issues may not be directly pertinent to you, but you have a wide experience of the health service, particularly training for social care workers; we will be very interested to hear about that. Thank you all for coming today. It would be helpful for the record if—Sir Cyril, starting with you—you could introduce yourselves. If you want to make a brief opening statement, please feel free to do so.

Sir Cyril Chantler: I am Cyril Chantler. I am a retired paediatrician. I have in my time been the general manager of a large hospital, dean of a medical school, chairman of Great Ormond Street, and I was the founding chairman of UCL Partners. Everything I can think of saying I have already written down for you.

Baroness Cavendish of Little Venice: I am not a clinician and it was very kind of you to invite me. I would like to make some comments about the NHS, if you do not mind, as well as social care. My background is partly as a journalist. I first became interested in the complexity of the NHS and wrote quite a lot about it. I did a report for the Department of Health on the support workforce in health and social care, and I then sat on the board of the CQC for two years. If that is of any use, I would be delighted to share my thoughts with you.

Lord Darzi of Denham: Ara Darzi. I am part of this place. I am a surgeon and at some stage in my life I was involved in policy-making. I was the author of *High Quality Care For All*.

Q266 **The Chairman:** Thank you very much. Perhaps I may start with the first question. We are looking at the long-term sustainability of healthcare, so we are looking to 2025, 2030 and beyond. The question is threefold.

By the way, before I start, I should say that Lord Bridgeman has joined the Committee, although he is not a Committee member, because he is particularly interested to hear this session. Welcome, Lord Bridgeman. I should have introduced you.

I shall start again. We are looking at the long term. The question is: what do you think we need? What would a fit-for-purpose health and social care service look like in 2030? What are the barriers, and what is the greatest threat to its long-term sustainability? How should we prioritise to get there?

Lord Darzi of Denham: This has been the question around the NHS since its birth in 1948. It is interesting that we are still asking this question. It needs a vision; it needs a strategy. The principles of the NHS are set in stone, and we know them. Looking at what is happening at the moment, I do not think the NHS is malleable or proactive enough in addressing the big challenges facing society, including the change in both the burden and the nature of disease. Our delivery mechanisms are based on the last century in many ways. You have touched on a few of these elements, such as the integration of care, whether that is primary, secondary or social care. It needs to be properly funded and society needs to decide what that funding envelope is. I think it should have a major focus, as it did back in 2008. Quality should be the organising principle of the NHS. It needs to have a fairly strong public health and preventive strategy, which I think it has always struggled to deliver. I could go on. Quality is a moving target; historically, the NHS has not kept up with that around innovation and the exploitation of technology. I heard some of you talking about information technology. We have lived through a data revolution, and we are now going through a digital revolution. You do not see signs of that impacting healthcare delivery in terms of improving quality, dealing with the productivity challenges facing us, and better utility of the workforce. You have heard this before. It is nothing new.

The Chairman: We have heard it, but how do we deal with it all to make the NHS sustainable by 2030 and beyond?

Lord Darzi of Denham: I think devolution is one way, because local change has to happen at a local level. I am very excited to hear about Manchester. I tried to do the same in London. The most recent piece of work I did was the London Health Commission for the then Mayor, Boris Johnson. More integration at a local level, pooling of budgets was another area; joint accountability in delivery of services was again a way forward. The accountability side of things and who these joint structures report to need to be managed. That, I think, is still unresolved. What is the mayoral role in all of this? It is interesting that at a local level the mayor

is as high as the Secretary of State would be in the NHS. There are a lot of tensions at that level too. All of this needs to be resolved.

You cannot do that without having the funding and the finances sorted out as well, and money coming with reform. You have to remember that we have been through this cycle before. This debate happened when the NHS was 50 years old, and there was a massive injection of cash. At the top of the envelope it said, "This money comes with reform". I think there was a reasonable amount of reform, but not the type of reform that would have been self-sustaining, where an organisation is resilient enough to keep up with the changes and the challenges that it faces.

The Chairman: Why do you think the ideas in your report about London were not implemented?

Lord Darzi of Denham: I think it happened in some areas. There was a change of leadership, mayoral change, and there were all sorts of other challenges. In some parts of London it is happening. If you look at north-west London, there is an integration. STPs present another opportunity, but how many of them have the big vision, the bold changes, and the political cover to make those changes happen? Let us not forget that the organisation is as good as the neighbouring organisation it is working with, so it is back to the local health economy. What changes are happening at the local health economy level? We all know. I could tell you there are too many hospitals in north-west London; there have been historically. We said that in 2007. Cyril was a partner of mine when we did the first London piece of work, called *A Framework for Action*. We have not really acted in changing those services. We need strong primary and community services, not the old general practice run by one or two general practitioners. There is the idea of—the dreaded word—polyclinics, and I did so many Parliamentary Questions on polyclinics at the time. We have invested in a few but we need to expand them more, because ultimately the delivery mechanism has to be at a primary and community level. Looking at the burden of disease, that is where you put your money in—it is cheaper, more cost effective, with better quality and a better patient experience. Let us not call them polyclinics; let us call them hospitals. Whatever you call them, that is where the injection of talent, leadership and money should go.

The Chairman: Camilla, in policy terms, you are on record as saying in 2011 that the Health and Social Care Bill should have been put out of its misery.

Baroness Cavendish of Little Venice: I may well have done. Briefly, if you want to ask what a fit-for-purpose healthcare system looks like in 2030, one of the main things has to be far less variation in outcomes. If you came down from Mars and looked at the NHS, irrespective of structures, what is utterly shocking, I think, is that we still have so much variation. We have excellence in almost every part of the NHS; somewhere someone is doing something absolutely superb. The problem with the NHS, it seems to me, is that the rest of the system cannot learn from that. There is a sort of silo culture—others will know better than I do why that still exists—and a belief that each individual area is different. I go round the NHS and talk to people and I say, "Do you know what is

happening at Salford?”, and they say, “Well, we’re different”. I think that that is fundamental to the cultural issue.

Obviously, we have to align incentives to allow things to happen, and that has to happen from the centre, but when you ask what the barriers to change are, the first barrier is political. Unless we address that, we are not going to get anywhere. The first barrier is the fact that, although there is a great deal of cross-party agreement in private about what needs to be done to the NHS, including reconfiguration, as Lord Darzi mentioned, no one is prepared to say that in public. Politicians are still using the NHS as a political football, and the public are rightly very sceptical about closing hospitals. How many years did it take to reconfigure the stroke unit system in London? That has saved an enormous number of lives but the reason it took so long was partly that people are very sceptical about the idea that distance no longer matters. There is a huge challenge there about the language that we use.

Similarly, you were talking about technology. Our strategy at the moment is entirely based on getting people out of hospital. Most normal people think that hospital is the safest place to be, where they know they might see a doctor, and they are extremely sceptical about what happens out of hospital or in the community. We have not explained to people what that means. Apart from all the delayed transfers of care, which we might come on to later, clinicians are also very reluctant, frankly, to discharge people from hospital into what they see as a kind of chaos. I think there is something there about language, politics and culture.

I have been around the country in my previous job and looked at a number of areas. Manchester is, I am afraid, unique. I do not believe there is any other part of this country which has the same constellation of talent in terms of the NHS and local authorities. I do not believe there is anywhere else with the same political impetus, because it is essentially a political construct. At the moment we are basing our aspirations for STPs upon a hope that politicians in local areas will be able to come together in the way they are doing in Manchester. I think it would be very foolish to expect anywhere else to adopt the Manchester model. If you look at all these places, they have been working on this stuff for 10 or 15 years; this was not invented a year ago. The same is true in north-west London, where they are doing good work, but, again, we are seeing too much double-running. We are not seeing an integrated system anywhere.

I suppose my concern would be that, although we have in our sights some potential models of what the system should look like, we are perhaps too optimistic about proceeding on quite such a voluntary basis, with a great political reluctance at the centre to impose any models.

The Chairman: Cyril, with all your experience, what model should there be for long-term sustainability in 2030 and beyond?

Sir Cyril Chantler: I think the fundamental model of the NHS is right. It should be funded through central taxation. It is one of the things that creates equity, which is the fundamental value of the British National Health Service, and it is one the British people absolutely support and those of us who work in it are passionate about. As I pointed out in the evidence I have written for you, it comes at a price, and the price is that

political accountability is necessarily upwards to the Secretary of State. Systems which are more flexible, such as social insurance systems or locally funded systems, have some advantages. The much-maligned 2012 Act created a means of getting local accountability, and maybe Manchester is exploiting that.

We are certainly exploiting it in Newham, where I currently spend a day a week. People tell you that the health and well-being boards have not achieved anything, but there is more to the doing than bidding it be done, as Charles I is said to have said. But it is beginning to happen. In Newham the mayor is about to sign a memorandum of understanding, I was assured yesterday, to invest in 35 general practices, working with federations of general practice, and build four community hubs—which is the word that Ara and I did not dream up 10 years ago but wish we had. They will achieve, I hope, the co-ordination which is necessary to bring the specialist from the hospitals, like I used to be, to work in the community with the general practitioners.

Over the years since the 1960s, when we closed small hospitals, many of which I worked in and other people here remember very well, we have had a gap between general practice and specialist practice. We moved to district general hospitals for populations of 300,000 people. We now commission services on populations of a million or more. I have recently been the vice-chairman of the National Maternity Review, and we recognised that we had to commission services for maternity on a population base of between 500,000 and over a million, depending on the part of the country. That is fine for specialist services, for secondary services, but it is not fine for the management of people with chronic illnesses, because that involves a co-ordination of social care and healthcare, and social care is the responsibility democratically of local government, so local government and health services have to work together. STPs or local maternity systems are fine for commissioning large-scale services, hospital services, but if we are going to solve the problem of looking after the 70% of NHS expenditure spent on people like me with multiple chronic illnesses, we have to give that responsibility to local government alongside the National Health Service. That could well have the advantage of taking some of the top-down pressure off the service, so we do not have to have so much fear in the system, so much top-down accountability, so much regulation, and we can at that point begin to promote back the professionalism and the need for local systems which deliver services which are directed to local patients.

I heard the evidence about regulation. It is a fact that Denmark, in 2015, abolished their institute of quality because they thought accreditation had gone far enough and they now needed to get back to getting local people working together to improve the services for patients.

Q267 Lord Warner: Can I come back to your brilliant report, Ara, *High Quality Care For All*? The interesting question is: why was it not implemented? It was not just a question of money. Can you give us a bit more detail about why you think that did not happen? You had worked very hard to get the NHS to buy into this. They could not say that this was dreamt up in Richmond House and imposed upon them. Why did it not happen? The background to my question is that we are beginning to see a sense

coming out of much of the evidence that people do not feel they can change this institution. There is a learned helplessness coming out of a lot of the evidence being put to us. We need to understand why a credible report, which had been negotiated with them, did not happen.

Lord Darzi of Denham: Let me acknowledge first that a lot of good things did happen—stroke services have been mentioned—both in London and nationally. That has become a Harvard Business School case study; people talk about that around the world. Trauma centres are another example. There is now an understanding that primary and community services need a better infrastructure to address the issue of health security. Patients did not feel secure in the community when they had to go up to an attic to see a primary care physician alone. That did not build confidence. So I think that a lot of good things happened.

As to why the rest did not happen, I do not believe in conspiracy theories, so I think it was mostly incompetence. It was published in 2008, as you may remember. In 2010 we had a general election, and then we became completely preoccupied with the biggest change the NHS had seen—the CEO described it as so big that you could actually see it from space. That kept the whole system busy. Ultimately, everyone was looking at what these changes meant. It was the most destructive change, and that again completely switched off the clinicians.

It took me a year. I met 65,000 people out there—engaging them, listening to them. Part of it was therapeutic but part was strategic; understanding their local needs, because I was very anxious that this was not London repeating itself in the rest of the country. We have done all that. It was very energising, very engaging. They took the ownership of change, which has to be local; it cannot be national. The system was ready with the local plans, and then change happened, and that stopped the whole thing.

Now we have a landscape which is a bit complicated. As we have heard, no one wants to see change again. The emphasis became more on regulation. If you open *Hansard* in 2008, when I took the Bill through, and you will see that I do not believe that regulation improves quality. It is ludicrous to suggest that regulation is the way to improve quality. Regulation is there as a minimum core standard so that we can all sleep at night and know that we do not have some fraudulent doctor working without a licence in a hospital setting. It is the local culture, local leadership, the culture of quality, safety and innovation that will drive that change. We lost that between 2011 and 2012—whenever the Bill went through—to be fair. There was a gap for about a year, and that is how we lost our way.

What is also interesting is that, at the time, in 2008—I still remember this—the big financial crises were happening globally but the NHS was in the unique position whereby the tsunami would not be hitting the shores until about 2012. I dream of running a business in which I know a tsunami is coming but it will hit me in three or four years' time so I can get ready to address and deal with it.

As I said, all of that was destructive, with structural change and leadership change, which I am sure was unintended. This was not

intended. No one woke up in the morning and said, "I want to stop high-quality care for all". To be fair, despite all that, throughout the period post 2010, quality has remained in the language of the NHS, in the political language, as the organising principle of the NHS. The emphasis on quality and safety still exists, and I am very gratified by that. Pre-2007, in the Government that you and I served in, it was mostly about the quantity; it was about the targets, not quality. I remember when I published *High Quality Care For All*, a couple of people said before they read it, "This is a damp squib. What does this mean? It does not have a deliverable called a target." We have moved from that, but quality has remained in the narrative, and I am happy to see that. You need to re-switch the system, go back and focus on that, free up the system. We need light regulation. We need to use data. We can know what the terrorism activities are and where the pockets are by using data, yet we cannot even figure out where the "never events" are around the country in the NHS.

Baroness Cavendish of Little Venice: Can I make one tiny point on that? Hinchingsbrooke Hospital is surely an example which undermines your point. I sat on the CQC board when we got into hot water over Hinchingsbrooke. The truth was that all of the data suggested that Hinchingsbrooke was excellent, and if we had not had inspectors, I am afraid, going in and making qualitative judgments, we would not have uncovered what we found. That is the point I want to make. There is a role for some form of qualitative inspection.

Lord Darzi of Denham: I agree, but not to the depth and severity we are going to. That is what I am saying.

Chairman: It should be proportionate.

Lord Warner: How do we get back? The issue for this Committee is how we get back on track for 2030. What is coming up to us is a sense that the NHS on its own cannot make these changes. It is sitting there looking incapable of going fast enough in the direction of a sustainable health service in 2030.

Lord Darzi of Denham: Let us look at the narrative again. It is the only narrative I know that unites everyone, whether you are a politician, a health service manager, a doctor in the front line or a nurse or a community worker. Get that narrative back in, empower people to make that change happen at a local level, give them permission to fail, give them permission to make some of the big changes and provide them with the cover. Also, settle with some form of a financial envelope to help them to do it. That is essentially it. It is not rocket science.

Lord Kakkar: To come back to this question of how the situation is recovered, what would be the best approach to re-engaging with clinicians to bring them to the situation prior to 2012 or thereabouts that would reignite that enthusiasm and commitment? Am I right in understanding from the comments made that it is that type of commitment and enthusiasm that is ultimately an important determinant of the sustainability of the NHS?

Lord Darzi of Denham: How do we engage them? We have these STPs. First, I would change the name—I do not know what an STP is; it sounds like a disease. Engage the local clinicians; give them the opportunity to

write the prescription, because they know what the prescription is—this is not a new discovery of a novel drug; and support them in implementing that within the local structures. I could not agree more: Manchester was a local leadership issue that came together and drove that, but we need to drive more of that at a local level. I think the vehicle is there; the narrative needs to change; the vision needs to be clearer; empower them to make that change; and provide them with cover. That is all. I provided a lot of cover at the time.

The Chairman: Camilla, do you wish to comment from your policy experience.

Baroness Cavendish of Little Venice: I understand entirely why you are suggesting we need to reignite enthusiasm, and there is a morale problem in the NHS. However, what I saw in No. 10 for the first time ever—and I have had meetings with Shelford for many years in different capacities—was a bunch of really talented people, clinicians and chief executives, who for the first time seemed to be genuinely determined to change things, and I think that is because there is a burning platform. On the one hand, you have people who are extremely concerned—the financial situation is dire, people are in deficit, there is a concern that deficit will become normalised—and on the other hand there is a group of people who want to grab the opportunity to change. The gap is that we have not provided a sufficiently clear template to them for what to do, and there are some very bright people out there who are very busy, and they do not want to have to reinvent the entire wheel again in their patch.

Lord Kakkar: What mechanism should be mobilised now to provide that template? Many people would agree it needs to happen now, to ensure that we can move forward and meet that sustainability objective of 2030. I do not know, Cyril, whether you have a view?

Sir Cyril Chantler: I think you need to concentrate on the local. There is a lot of, if not waste, inefficiency in the organisation and the provision of community services—voluntary, social, nursing and so forth. I see that in the stuff I do at the moment. That needs to be organised locally. Manchester, which is where I come from, is not the same as Newham, where I work, but there are obviously similarities. There is an organisation in local government that is capable of doing this, in partnership with the National Health Service.

If we can get better care for people with chronic illnesses, we will take the pressure off the hospitals. You cannot, I submit, run hospitals safely at over 90% bed occupancy. Other countries have seen that and we have seen that. As long as we are running the present system, where people default to hospital and then cannot get out of hospital, the hospitals are under pressure and things begin to do wrong.

The first thing is to look at the political change which is necessary to understand the importance of local government in taking us forward. There are other changes that I think need to take place. They are not enormous. I think a professional change is to relook at the contracts and replace them with a more professional relationship, as has happened at the Virginia Mason Hospital in Seattle, where they have introduced compacts, which is essentially engaging with the profession in a common

aim to deliver better outcomes for patients, value outcomes per pound spent.

Finally, I think some administration change is probably necessary. I do not think you want to radically reorganise the National Health Service, but when you plant a garden, sometimes it is worth while going round and looking at it.

The Chairman: I only look at it so it does not matter.

Baroness Cavendish of Little Venice: Briefly on your point, I think there are too many alternative models of care. In the *Five Year Forward View* I think Simon Stevens was right not to be too prescriptive but to say, "Let's have a couple of thousand flowers bloom and see what happens". I think it is time now—not waiting for 10 years, because these things are far too slow—to say there are one or two models of care here and you can pick. From an IT point of view in particular, there is a lot of money being invested in developing different models of IT in different places. Salford has one that is excellent. Let us just take it and let us leave it for the nation. Those are things I think we should do, which is the spine; provide the backbone from which people can innovate.

The Chairman: My pleas are not often listened to but I make a plea again for short questions, short answers; otherwise we will not get through the agenda.

Lord Ribeiro: I am very happy to hear Ara talking about the quality agenda and the move away from targets and quality outcomes—and here I declare an interest as chairman of the Independent Reconfiguration Panel—because in many of the cases we have looked at, and north-west London was a case in point, we were able to call on the changes in London to trauma, to stroke, as an indication of how quality had impacted on patients and how change needs to happen. That may not be relevant in rural communities; it may be far more important within the urban situation. The fly in the ointment, if you are going to achieve the 50,000 to 100,000 target of community work for GPs, seems to be their private contracts. GPs are the only private practitioners we have in the NHS who can make those changes in the hospital sector. How are we going to do it in general practice?

Lord Darzi of Denham: Finance is a means to an end. It should not be the difficulty or the challenge here. What we got wrong in the original polyclinic—and I will blame Cyril for this—is that we described what this looked like, a federation, but we never really looked at the business model. In the NHS we are not good at business model innovation. We look at technological process innovation, but there are many business models that you can use to ignite the interest in primary care, whether they are partnership or employment models. We have to understand that the primary care community and leadership are also very divided; we can stratify them into those who would like employment contracts and those who would like to build partnerships. So I do not see that as an issue. I never saw the mode of employment or the mode of contractual arrangement as an issue. I think we need to mature up and say, "This is the best model for this region; this is what we need to commission", and to do that you need strong commissioning.

Baroness Redfern: Lord Darzi mentioned the need for digital revolution and data sharing. What incentives do you think are needed to move that on? Just financial ones? That helps of course, but I think something needs to be enhanced to move this on quickly for 2030.

Lord Darzi of Denham: First, you need to remove the obstacles before you talk about the finances. There are many obstacles but, thanks to Fiona Caldicott and the review being done on privacy, data security, and data sharing, they are starting to be removed. The quicker we roll that out and win the public confidence on those very sensitive matters, which are extremely important, the quicker we will start investing. You talk about innovation and the NHS being slow but I have noticed a number of junior doctors coming through who are absolutely engaged with the whole digital era in every way possible—for example, the use of simple digital technology such as WhatsApp to deal with patients and improve things. That generation wants this to happen, and there are many vendors out there. We are not talking about a £15 billion—

Baroness Redfern: It is not about wanting it to happen but making it happen.

Lord Darzi of Denham: It is making it happen, absolutely. There are a lot of people, a lot of vendors, out there who are trying to redesign pathways of care using digital platforms. In terms of handing over care; one of the big safety gaps in healthcare at the moment is the transition of care between teams in the hospital, between primary and secondary. Digital will sort this out.

Baroness Redfern: Why can we not make it happen quicker?

Baroness Blackstone: I wanted to pick up the fact that all of you have said that there are some very talented people out there and they need to be empowered and they need more autonomy. Cyril, you said that there was a climate of fear. Could you talk a bit more about that and how we liberate those people from something which I recognise too when you talk about a climate of fear? What are the specific things that this Committee ought to recommend to get rid of that, so that we can have far more local decision-making and can give people with ideas, who are capable of promoting innovation and implementing it, the power to get on with it?

Sir Cyril Chantler: As I have suggested, I think it comes from the nature of the top-down organisation of a healthcare system funded through taxation, which is what Beveridge and Bevan put in place. It is the right model but with it comes a responsibility upwards which leads to downward control. That is what the two groups that Ara commissioned to look at the NHS in 2007-08 said. My submission is that the way round that is to have more localisation and more democratic accountability locally, as they have in Scandinavian countries, which will free up the system. At the same time, we need to go back to a model of employment of healthcare professionals where they are encouraged more to work for love but to high professional standards.

I do not think there is one simple solution, but there are solutions. The digital thing is happening wonderfully well. In the practice I chair in outer north-east London, in a year we had a system running with a digital care plan, a contemporary record, and sharing it across other healthcare

workers. We are getting there, and I think we can move faster if we concentrate on doing it locally rather than just centrally.

Q268 **Lord Willis of Knaresborough:** Perhaps I may address most of my questions to Camilla. We hear constantly about the need for change, the need to integrate health and social care and the increasing demand for social care by 2030 and beyond, yet for the 1.3 million social care staff currently working in our care homes, in the community and, indeed, in hospital settings, their levels of training and career development are pathetic compared with what we are offering medics. Camilla, in your report you recommended the care certificate. Do you feel that that has made an impact? Do you feel the steps beyond that are being put in place so that we have a social care workforce that is capable of delivering the very care that every expert we have had before us says needs to be delivered?

Baroness Cavendish of Little Venice: You and I have talked about this many times, and thank you for all your work on the same subject. It is probably for other people on the front line to judge whether the care certificate is working or not. I have had some very encouraging feedback, and I have had a lot of feedback from individuals on the front line saying this is raising the status of workers, which was one of the objectives, but it is also training people better. I do not think we will know whether that is the case until we see whether employers are accepting that certificate and not doing what they have previously done, which is retraining people themselves. If people accept that training, and if the practice is sufficiently observed so that it is not a tick-box exercise, I think we can judge it as working. I know 90,000 social care workers have taken the care certificate. I do not know what that means in practice, but I am quite encouraged by it.

You rightly ask about the next steps. Just to remind you, one of the things I recommended which I felt very strongly about was that we should be training health and social care workers in the same way, because of course we will really need one workforce to underpin the system we are talking about. We all know that the lines are blurring. Ten years ago people who are now in care homes would have been in hospitals. Where we draw the line between health and social care is increasingly difficult, is it not? We all know about the overlap, and one of the things I discovered and was very surprised about was the fact that nurses were finding it very difficult even to manage healthcare assistants, because their training was entirely different. We are finding exactly the same thing with district nurses, so you are going into someone's home as a social care worker and you find the district nurse has left a note. We all know this is a chaotic system where there is an enormous amount of duplication. We absolutely need to have that workforce speaking the same language. That is as important as acquiring the knowledge. It is speaking in the same way about that knowledge, as well as filling in the gaps about lifting and handling or whatever it may be.

I think that is beginning to happen but I would like to see more training on site of those different workforces together, and I would also like to see us offering volunteers that training, because I believe that volunteers are playing an important part and they should be able to access that training

as well—why on earth not? There are people looking after their own spouses who are already doing those things that we require other people to be qualified to do. We need to treat all these people as one in some way. We need to go to the next step, and, as I understand it, that next step is being developed, that advanced care certificate that you and I talked about.

The other thing that I think is quite encouraging is that we are beginning to put in some career ladders for people. Again, I think there was an announcement about nurse apprentices the other day but that is also very important. If people in this profession, particularly in social care, do not see this as a career, or cannot see any way to move forward, their morale will be low and we will have the kind of turnover we have seen before. There is absolutely no reason, in my view, why some of those people, who are excellent, should not be able to move up in their own system or even into the health service, but I think there is a lot more work to be done on that.

Lord Willis of Knaresborough: One of the big barriers, as I see it, moving forward in this new world in which localism will rule, is that the Health and Social Care Act, whatever we think of it, has created a whole set of different organisations out there, each with their own authority, which in some ways militates against having those common standards, where somebody who has done a phlebotomy course in Manchester will be accepted when they go to Newham.

Baroness Cavendish of Little Venice: Yes. That is one of the reasons why I recommended that certificate. It was not the ideal; we would not have started from where we started. You have to have common standards, from the point of view not only of patients and users but of employers. Otherwise, as I said earlier, if hospital trusts or care providers do not have faith in the training and the standards, they will simply go on and duplicate those things. The measure of success will be if that entire sort of cowboy industry of training providers has disappeared in a few years' time. Then we will know that it worked.

Lord Lipsey: I agree with everything you have said about the problems in this field but there is an elephant in the room, which is pay, particularly as we move forward with Brexit and stricter immigration control. You cannot go on saying you are respecting people, providing career ladders and all that, but they are only paid peanuts and the reason is that local authority can only pay peanuts for the care it is buying for its people.

Baroness Cavendish of Little Venice: Yes. Equally, care providers would say that our introduction of the national living wage has ruined their margins. I was very proud to be part of the Government that introduced the national living wage, not least because of the impact for some of those people, and it will help those people, but we need to accept that the impact on providers is significant. I totally agree. You come back to the financial question, which is a much bigger one. I do not know if you want to address that separately.

The Chairman: Please go ahead, with your recent experience of the policy unit.

Baroness Cavendish of Little Venice: I am not going to say anything that people in this room do not already know. Obviously, unless you can find some way of quantifying the money that you save by reducing delayed discharge into the NHS, you can never cycle it back into social care. That is what the Better Care Fund was about. The fact that we have hospital deficits means that the STP money is ending up being funnelled into that and not into innovation. There is a danger, as we know, of leakage from the BCF. This is the perennial problem that has dogged government for quite a long time.

I do not think there is a lack of concern at the centre of government about this. Lots of great people in government are trying to solve this problem. Lord Patel, the other day, was raising the question of insurance. I think we need to be much clearer with the public about what is a disease and what is not a disease. It is arguable that dementia is a disease and we should classify it as a disease. If we did that, suddenly, lo and behold, we discover that the NHS is going to have to pay for that. There is a real question about whether we are up to date in terms of defining what is a disease which needs to be paid for by the NHS and which people are entitled to have for free, and what is not, and what kind of provision they should make for their old age. Also, do not forget about adults with learning disabilities, which is a growing part of the challenge here. At the moment, partly because this has all happened quite quickly, partly because of the politics of this, we are stuck; we have a growing ageing population and an enormous demand on funds and we have not been honest with the public about what they can expect in their old age. We are not seeing people making provision for that. Make of that what you will but we have to do something about it.

Q269 **Lord Scriven:** All three of you have touched on the STPs, which are seen as quite an important future way of working in the health service and social care. What contribution do you think the STPs will make to longer-term NHS sustainability? Do you see any issues that arise? Two of you have mentioned some things that have not been mentioned before and I would like to explore them. Camilla, you talked about local leadership in Manchester being unique. I would like you to unpick that or explain more about that, because I think that is quite important. It backs up a recent report from the Treasury and DCLG, about three years ago, which talked about collaborative leadership not being at a local level. Cyril, you talked about the STPs going way beyond acute hospitals and much more about the 70% with chronic disease. Could you explore those, please?

Sir Cyril Chantler: I think STPs are an important development. They recognise the need to commission certain services on a larger population than we have done heretofore, but they are not the solution to the total problem. The fundamental problem of sustainability is that medicine has changed and the demography of our nation has changed but the National Health Service has not changed adequately to reflect that. We need to recognise the need to bring health and social care together and the need for health and social care workers to learn together, and that is one of the things they can do in the community hubs, as we now hope to call them. All these things have to change, but my notion is that that has to be done from the bottom up, with co-ordination from the top down. You cannot

have a hundred different systems and lots of different people competing to produce different digital systems. You need a combination of these things. It was sort of expressed in our report when we said centralise where necessary and localise where possible, and that is the process.

Baroness Cavendish of Little Venice: I sometimes try to unpick these things for myself by going round and looking at things and talking to people on the ground. I have done quite a lot of that. What I meant about Manchester was simply that you have an extraordinary set of characters there who are able to rise above their own political party allegiances or their own fiefdoms. You have two major hospital trust chief executives and a really great constellation of political leaders who have come together, as I said before, over very many years. The point is that these are voluntary contracts.

Part of my view is I spent five years running a public-private sector partnership regenerating a part of London. I sat in a lot of those committees and I know that the bigger the committee gets, the harder it is to make decisions, and I know how much time those committees take. There are a lot of committees around London where marvellous people are spending a lot of time sitting around tables, trying to figure out from scratch in their own area how we work together, what kind of IT system we will have. I just do not think that is rational. It is marvellous until you realise it is taking energy away from the front line. There are some fantastic clinicians who are now caught up in quangos, sitting on local committees. There is so much energy in there. I totally agree with what Sir Cyril said: we ought to be able to be much clearer about what we centralise and give these people something to cling on to. At the moment I feel it is much too voluntary. A lot of people do not want to spend time reinventing the wheel; they would like to hear about what someone else did and maybe have it provided prescriptively. That is all I meant. I have been to a lot of places where there is great energy and great ideas, but I do not see enough harnessing of that at the centre in a way which can help all the other people who are still stuck at the table.

Lord Warner: Is there not a problem that we have never, under successive Governments, got the NHS to understand that a key part of this solution is a properly funded and sustained funding of social care which at the very least is equivalent to the increases in the NHS? That is a political failure as much as anything else. If we do not tackle that issue, we will not get anywhere. Is there not an inherent political reluctance to take that step with local government over a long time?

Baroness Cavendish of Little Venice: Yes.

Lord Warner: I wanted someone to say that.

Baroness Cavendish of Little Venice: You know better than anyone; you have been there.

Lord Warner: But it is not what the NHS is saying. They are saying give more money. We have had people in front of us arguing that they should take over care homes—people in the Shelford group, because they would do a better job.

Lord Darzi of Denham: I can see where they are coming from. The cost per bed occupied is significantly greater. In fact they could even make money on top of it. They are the clever ones. The answer to your question is absolutely, yes. Is the NHS asking for it? Yes, it is. Simon Stevens is on the record as asking for the money to be given to them. But a long-term sustainable settlement for social care is an important one, and it is getting more and more difficult as the social care needs are getting greater and greater. If there was a political reluctance, it is getting worse. I can see why they would do it. It is a Pandora's Box.

Q270 **Lord Kakkar:** This question was about a lasting social care settlement but I think much of that has already been rehearsed. I want to ask two specific questions. What kind of model might provide for that longer-term social care settlement? Secondly, if such a model were available, what might that contribute to improved productivity across the entire system?

Sir Cyril Chantler: I cannot deal with the first one; that is beyond my pay grade. I can deal with the second one. I have been surprised by the redundancy in the organisation of community services and the number of things which are done as tasks without any proper appraisal of what the client's needs are. I have on my iPad something UCL Partners did looking at services available in the community in outer north-east London, and they are simply duplicated and not connected. There is a lot of efficiency that can be gained from that. I quote the Buurtzorg model. They have increased their efficiency of delivery of home nursing by 40% on the appraisal by Ernst & Young. Proper organisation locally of whatever means of providing a proper long-term settlement is to me the way forward, and I think that that is where we should concentrate. If we do not get that right our hospitals will always struggle and we will not be able to introduce the new technology which is so important to improve the outcomes. These things are co-ordinated and linked.

The Chairman: To the first part of the question, Camilla or Ara.

Baroness Cavendish of Little Venice: I think there is a big question, as I said earlier, about where you draw the line as to what social care is, but let us say that we have done that—

Lord Kakkar: You have identified it; how should it be funded?

Baroness Cavendish of Little Venice: I think there is a very strong argument for some kind of insurance system, because we are seeing virtually limitless demand here. Where are we going to draw the line? It is extremely difficult. Other countries have developed various types of insurance systems. I think that, politically, an insurance system for the NHS is absolutely impossible. I believe very strongly, as you said, in an NHS that is free at the point of use. I think this Committee should certainly look at something like that.

Productivity is an interesting question. It is arguable that the social care industry is a cottage industry and that some form of consolidation will be needed in that sort of industry. I cannot think of the right analogy, but it is very fragmented. Some local authorities have hundreds of small domiciliary care agencies, and the travel time—it is what you are saying.

There are deep-rooted inefficiencies in there which do not make an awful lot of sense.

One thing that could be done from the centre which is very simple, which I am always going on about, is to reduce bureaucracy. The amount of paperwork and pressure put on the front line by central government and the whole of this landscape of quangos is utterly unacceptable. I find that people in the centre of government or in the quangos have no understanding of that, have no overview of how the amount of data they require overlaps with the amount of data other people require. Other people have recommended endlessly that we need one single data set that should be required by all of these public agencies from all of these providers, whether they are in health or social care. I am not saying that that is the answer but I think you would find productivity would increase dramatically.

Sir Cyril Chantler: Can I second that, and whatever else I can do to support it? I am not against regulation; regulation is important. There are just too many of them all trying to do the same thing. There are too many agencies as part of the central system of the National Health Service now. I do not want them reorganised but a bit of rationalisation would be quite useful.

The Chairman: Ara, do you have any comment?

Lord Darzi of Denham: I think it needs some form of a settlement with society in identifying the best business model to do social care funding. It could be insurance, it could be a combination of the two, whatever it is, and I would ask the clever people who do these types of things to come up with three options.

Lord Willis of Knaresborough: You did not mention Dilnot. Is that dead now?

Lord Darzi of Denham: I have not heard his name mentioned for a while, yes.

Baroness Cavendish of Little Venice: If you have talked to Dilnot lately—maybe you should ask him, because I think you might be interested by what he says.

Q271 **Baroness Blackstone:** This is a “Today” programme question. What is your single key suggestion for change that you think this Committee should recommend to support the sustainability of the NHS?

Sir Cyril Chantler: Local reorganisation. As I have suggested, to me, it is absolutely key.

Baroness Cavendish of Little Venice: A three-year freeze on all central government directives and a single data set to be required from providers.

Lord Darzi of Denham: Those two would be on top. Giving people the permission to go ahead and make the changes happen based on their local needs. Support the STPs. You have to remember—we did not cover this—STPs have filled a gap at a local level, and they should be there in

continuity. It is not just one element of it. Just give the permission to make the change happen.

The Chairman: Thank you all very much. We could have gone on for longer with you but we have run out of time. Thank you very much indeed for coming.

Office for Budget Responsibility (QQ272-277)

Evidence Session No. 29 Heard in Public Questions 272 - 277

Tuesday 6 December 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

I

Examination of witness

Robert Chote, Chair, Office for Budget Responsibility.

Q272 **The Chairman:** Good afternoon, Mr Chote. Thank you very much for coming today to help with our inquiry. You are the most important witness we have had, because we would like to hear about financing the health service and social care. It would be helpful for the record if you say who you are, and if you want to say anything to start with do so, otherwise we will go on to questions.

Robert Chote: I am Robert Chote. I am chairman of the Office for Budget Responsibility. The most sensible thing, by way of introduction, would be to explain the relatively limited engagement with this topic we have as a result of the remit we have been given. As you will be aware, our primary task is to produce forecasts and projections for the outlook for the public finances for the UK, which therefore requires us to look at forecasts and projections for revenues and spending. In doing that, we are instructed by Parliament to look at projections only on the basis of current government policy, in the best way that can be defined. We are not allowed to look at different policy options, we are not allowed to give advice and we are not allowed to give recommendations.

In producing the medium-term forecast, like those we produced for the Autumn Statement, most recently, and at Budget time, areas such as health expenditure, for most of that period, are laid down in clear plans that the Government have set out in spending reviews over a three to four year time horizon. We plug those in and we make a judgment about the degree to which spending across the whole range of public services will undershoot or overshoot the limits that the Treasury has set. When it comes to producing longer-term projections, which we do currently once a year—we will be moving to doing it only once every two years—we, again, have to make assumptions about how much will be spent on health, education, transport, defence, et cetera, over that horizon. Clearly, at that horizon, the Government have not set a policy statement of what

they want expenditure to be, so our legislation requires us to make a judgment and explain that as transparently as we can.

In most areas of expenditure our starting point for public services and capital spending is to assume that it remains constant as a share of GDP. One wrinkle to that over a 50-year horizon is that we adjust for demographic trends. In a sense, if the representative member of the population gets older over that period we assume that the expenditure that older people consume more of rises as a share of GDP, so for things such as health and social care you would expect to see that rise as a share of GDP as a result of the ageing population.

We are conscious in doing this that, obviously, looking back, there has been a trend in health expenditure, although not in the most recent years, for it to rise as a share of GDP, not just in the UK but in other countries as well, which casts doubt for us on whether assuming a constant share of GDP adjusted for demographics is a sensible definition or interpretation of unchanged government policy when government policy is not defined. In past reports we have looked at what would happen to health expenditure if you made an adjustment for the perceived differences in productivity growth in health and the rest of the economy. In a paper which, I think, some of you will have seen relatively recently, we have gone back to that and said, "Do we need to revisit that set of assumptions by looking more broadly at the role of demographics, non-cost pressures and the relationship between demand for healthcare and changes in income?"

I would come back to the limitations we have. We are doing this to produce a line for health expenditure to go into a forecast for the public finances. My colleagues and I make no claim to be health specialists. It is not our job to say what should be spent and it is not our job to say whether what is being spent is being well spent; it is to come up with some relatively transparent assumptions about what unchanged government policy could imply, given the pressures on healthcare, and to forecast the public finances accordingly.

The Chairman: That is very helpful. I hope most of our questions are related to the finance side and not the health side. I will kick off first with your latest analysis of public spending on health. This Committee is looking longer term; it is looking at 10 to 15 years from now, 2025-2030 and beyond. On that basis, what are the key factors that you think will drive those pressures? What will the pressures be? What impact will those funding pressures have on the long-term fiscal sustainability of the NHS? What possible figures might we be talking about?

Robert Chote: I will deal with the second part of your question first. I think it is important to make the point that one has to be careful in saying that any given category of expenditure is, in its own right, fiscally unsustainable or sustainable. Clearly, if there is an area of expenditure which, over time, is going to rise inexorably to 100% of GDP, wiping out everything else you could possibly spend, that is clearly unsustainable. However, with smaller increases, the judgment about sustainability is one for the public finances as a whole. If you want to spend more on health as a share of GDP your choices are to borrow more, to spend less on something else or to tax more to do that. In a sense, sustainability has to

be thought of in the constellation of decisions you want to make about other elements of tax policy and spending policy rather than saying that any particular element of it is, by definition, unsustainable or sustainable because it is rising or falling as a share of GDP.

In terms of the drivers, there are three main elements that most of the studies, internationally and in the UK, have looked at, one of which is the relationship between expenditure, or the demand for healthcare, and income. Do you expect, as people's incomes rise, that their desired expenditure, or the amount that society will want or end up spending on health, will rise more or less quickly than that? There is an argument that says that as societies get richer not only will they want to spend a larger amount of cash on health but they will also want to spend a larger proportion of national income on that. Clearly, if you assume that ad infinitum it would rise up and up and would be unsustainable. The assumption we have made, which is not an untypical one—others have made different choices, higher or lower—is to assume that, basically, it will rise in line with income. There is no specific pressure, either upward or downward, on health expenditure as a share of GDP simply as a result of societies getting wealthier. That is one issue.

The second issue, as I say, is a demographic one. Health expenditure tends to be higher on people who are older. That is not the whole story. Obviously, quite a lot of health expenditure is higher proximate to death, which will show up as a relationship with age—but there is more to it than that. In the past we have focused on the demographic pressures. It struck us, looking at other studies that people have done in different countries, that there seems to be a growing belief that pure demographic effects are not, perhaps, the major driver of the increases in healthcare spending as a share of GDP that one has seen, and therefore that it would be a source of upward pressure but not necessarily the main source of upward pressure going forward.

We base our projections on projections of the size and structure of the population done by the Office for National Statistics. We have to choose, among those, for example, to have a particular measure of net inward migration that seems sensible, given policy and economic developments, but those are implying, over the 50-year horizon that we look at, a significant ageing of the population. The proportion of 85 year-olds and above was about 0.8% in 1970 and is about 2.4% now; it will be 7.3% in 2070. The ONS projections assume that the number of centenarians is around 14,000 now but will be 450,000 in 2070. There is obviously a lot of uncertainty around these things but that is one driver element.

The third one is a catch-all term for "other cost pressures", which are partly things such as new techniques, new drugs and new treatments that become available that may be more expensive. There is also the paradox that some treatments that are cheaper can end up putting upward pressure on healthcare spending because they can be used more widely. A good example of that is the use of stents as an alternative to heart surgery. Again, I am going well on to thin ice in terms of my medical knowledge here. As I understand it, around 30% of the use of stents is on people who would otherwise have much more expensive heart surgery, but 70% of it is being used to treat people who would not have received

heart surgery and, therefore, that is still putting upward pressure on spending even though stents are a lot less expensive than cracking someone's chest open. You have those issues.

A related cost pressure which can show up in the numbers is the perception that healthcare, and perhaps, in particular, social care, is more labour intensive and therefore less able to deliver improvements in productivity—the amount of output per hour worked—than in the rest of the economy. Having said that, the rest of the economy is not doing terribly well in delivering productivity growth at the moment. Leaving that to one side, you have estimates that hospital budgets are about 70% labour cost, and that has been rising. If you assume that productivity growth in healthcare, on most studies, rises by about 1% a year, we have in the past been used to productivity growth in the rest of the economy of about 2% to 2.5% a year. If you therefore want the output of healthcare to rise in line with the output of the rest of the economy, you have to make good that productivity gap and spend continuously more. That will be another element of the cost pressure story.

The relative importance of these appears to differ quite a lot from study to study. Some have the share of other cost pressures as low as 25%, and some have it as high as 75% of the explanation. I suspect that the numbers you end up with may be, in part, a function of which of these you try to estimate first and, therefore, which one is left to soak up all the things you have not managed to explain with the other two assumptions. How much weight you should put on the precise relative importance of those would be doubtful, but the conventional wisdom is that the major source of upward pressure is the other cost pressures and less, perhaps, the demographics that people would have focused on earlier.

The Chairman: Thank you very much.

Q273 **Lord Kakkar:** Lord Chairman, thank you very much. I would like to further explore how the Government might accommodate a growth in health spending because of these upward pressures beyond the assumptions of an increase in wealth in society. How might this growth in expenditure be used to provide for health? Is it reasonable to consider more and more cuts to other areas of public spending to accommodate increased requirements and expectations in health? Or do we need to consider raising taxes or, indeed, as you have mentioned, borrowing much more to support health?

Robert Chote: As I say, those are the options and it is not for us to say which of those should be pursued. If you look at the way in which the budget deficit as it stands now is being dealt with on existing plans, cuts to public expenditure as a share of GDP and, in particular, cuts in current spending, as distinct from capital spending, so the day-to-day running costs of public services and welfare spending in the form of cash transfers, are delivering quite a lot of the, roughly, 3% of GDP improvement in the structural budget deficit projected over the next few years. A lot of that is coming out of other relatively unprotected public services. As you know, if you look at what has been happening on health and you look at what the current plans imply over the next four years, there is an increase in real spending, so spending is going up faster than

inflation across the economy. However, that is not keeping pace with the growth in population. Real spending per capita will shrink by about 1% on current plans over the next four years, and there will be a further fall in expenditure as a share of GDP. On our estimates you would be at about 6.8% of GDP spent on health by 2019-20, which is down from about 7.6% at its peak in the wake of the financial crisis.

You are also seeing welfare spending—cash transfers—being cut in generosity, in particular. That is focused very much on things such as incapacity and disability benefits and tax credits. The state pension is conspicuously less affected by that and is, in a sense, an upward pressure, so that is an area that remains relatively protected. The other choice, of course, would be to raise more in tax. The Government have chosen, at the Autumn Statement, to have a less ambitious programme of deficit reduction than they inherited from the Cameron-Osborne Government regime that preceded them. There has been a shift there. The Government have used up some of that but have put the money into additional capital spending plans. We have soaked some of it up by having a more pessimistic forecast for the outlook for the public finances as well. You do, in the end, come back to a choice, and Governments historically have been reluctant to go for a significant rise in the tax to GDP ratio. So far it has been cuts in other elements. How far that goes on, as I say, is a constellation of choices. It seems to me, in thinking about what one should be telling the healthcare sector are its prospects for the 10 or 20 years coming up, you cannot do that in isolation; you have to say, “What does this imply for what we might want to spend on defence or transport?”—or whatever else it might be.

Lord Kakkar: For how long is the current trajectory we are on, the 7.6% to 6.8% by 2019, sustainable in terms of what you see as the broader determinants of demand in this particular part of the economy?

Robert Chote: As I say, over that sort of time horizon this is ultimately a political choice. If you want a greater or lesser quality and quantity of publicly provided healthcare than is implied by that, you have to make your own choices. Clearly, healthcare is a squeaky wheel that can be relatively confident of being greased relative to some other areas of public services. That would be the historical record.

Lord Kakkar: I am now on very tenuous ground as I know nothing about economics and productivity, but I ask this question: how much of this shrinking proportion of GDP might be met by an increase in productivity to bring productivity of the healthcare workforce closer to general productivity?

Robert Chote: Measuring output in the health sector is not straightforward. In a relatively broad-brush way it can be done as the number of interventions, roughly speaking, which obviously begs a whole series of questions about value for money and whether you are reflecting quality in that or not, et cetera. As I say, historically speaking, recent studies suggest productivity growth in healthcare of about 1% a year. Over a longer time horizon we have been used to the rest of the economy delivering 2% to 2.5%, although it has not been delivering anything like that recently. It may be that rather than healthcare improving its

productivity performance to match the rest of the economy, the rest of the economy is worsening in order to match that of health.

Lord Kakkar: Another question that has been put is whether there is any evidence that spending on healthcare has an overall impact on broader economic growth as a potential justification for this being an area that, in terms of sustainability of the NHS, should be more targeted and more protected.

Robert Chote: It is not an aggregate relationship that we have explored or attempted to explore. We do not look at what the Government are intending to spend on health and then take a judgment from that back into what we are assuming about the underlying growth potential of the economy—although I am sure some people must have done studies that do that. There are obviously elements of the delivery and effectiveness of healthcare, broadly defined, that would have an impact, not least the age at which it is realistic to expect people to continue to work. Do the improvements in life expectancy, and the changes in morbidity that come out of that, mean you are extending people's effective working lives by the same degree? We are struck, looking, interestingly, within the welfare budget, by what the Department for Work and Pensions is having to spend on things such as disability living allowance, and by the degree to which mental illness is an important factor. Part of it is, obviously, dementia for relatively old people, but it is increasingly striking younger people as well, and that would have a feed-through to economic performance and the health and material well-being of the individuals concerned.

Lord Kakkar: One last, very short question on hypothecated tax for healthcare expenditure. What are the pros and cons of that, in your opinion?

Robert Chote: When I was running the Institute for Fiscal Studies I would have given you chapter and verse on this, which is now outside my remit. If I was still at the Institute for Fiscal Studies, I suspect that they would, in the great Treasury tradition, broadly defined, be wary of hypothecation, rhetorical or mechanical, on the grounds that money is fungible. When you link expenditure to particular receipt streams, when that receipt stream starts to dry up for some unexpected reason, do you want to reduce the amount of spending in that area? It is easy to set these things up; it is harder to deal with those things when they come out. As I say, I could not possibly comment on that subject. I suspect, if you asked my IFS colleagues, they would say something similar.

Lord Warner: The coalition Government made some rather bold claims about driving up productivity, but on closer inspection it looked as though the driving up of productivity was more to do with pay restraint than anything else. What assumptions do you make about wages and pay in these labour-intensive industries in terms of productivity over the longer term?

Robert Chote: For the projections we make, we are obviously looking at the wage and productivity picture economy-wide rather than building it up sector by sector. One point which is worth bearing in mind is that in the efforts that have been made to measure productivity in healthcare—and

the Office for National Statistics has had a programme of work over this period for some time—there is an inevitable link between measured productivity and the swings of relative boom and bust in the generosity of spending at any given moment. Disentangling that cyclical effect from any long-term underlying improvement is not straightforward.

When you saw public spending in public services growing rapidly in the Brown chancellorship era, somewhat inevitably quite a lot of the productivity numbers did not look as good because you were shovelling in a lot more input and getting relatively less output. The argument could be made, “Well, that is an inevitable short-term consequence”. What you hope it will do is deliver for you a longer-term improvement that will show up later on, but by that stage the spending cycle may have moved in the other direction and you can sometimes get the productivity numbers to look quite good by pulling input out, and the system manages to keep going—as Wile E Coyote manages to keep walking as he goes over the edge of the cliff before falling down. I am not an expert on the way in which that is measured, but I think you have to be wary of the short-term interactions when you are shovelling more money in, be it to wages or other elements of input, and the timescale by which that leads to underlying changes in productivity.

Lord Turnberg: Can you help me with this productivity business and how we measure it? It seems to me that if we cure someone of a disease with some expensive treatment, they go back to work and they are productive and pay taxes for longer, and that will accrue to the Treasury but not to the Department of Health. Does that get into the productivity measurement?

Robert Chote: As I understand it, the productivity measurement tends to be a more mechanical number of treatments of a particular type. Over time you can do it in a more sophisticated way by chopping it up and trying to reflect the quality of those things in a more granular fashion. It is not quite as stark as in education where it is the number of pupils taught. If you make cuts in education and implement them in a way that does not involve not educating anyone whose name ends after M in the alphabet, you get a perverse effect on measured productivity. I do not think it is as extreme in healthcare. It is the number of hips replaced, not the number of days of useful working life restored.

Lord Turnberg: That is a shame, is it not? Productivity should be in terms of recouped costs to the community at large, not just to the health service.

Robert Chote: We are talking here about the way in which these things are measured for national accounts. One would hope that in the corridors of power decisions are made on a richer evidence base.

Lord Turnberg: Thank you—wherever they are.

Q274 **The Chairman:** You mentioned the “boom and bust” phase and that is how currently the NHS is financed; there are years of plenty and then there are years of not plenty. The trajectory seems to be going down now, ending up at 6.8% in 2019, as you mentioned. What is your suggestion for how to get rid of that, and what would be the effect if you

had a level playing field and increasing inflation?

Robert Chote: As I say, the commitment of relative protection, as I understand it, has amounted to, "We will ensure that real spending goes up", and there are a lot of sectors in public services where that is not the case. If people in health think they are hard done by, look at parts of the criminal justice system where the squeeze will be considerably tighter. As I say, protection is a relative term. You have spending rising in real terms, projected over the next four years, but that does not keep pace with the population, and as a share of the economy it would fall—but if you were not taking roughly 1% of GDP out of healthcare over this period you would have to be taking it out of somewhere else, taxing more or borrowing more than you otherwise would have done.

Clearly, I presume, there is a strategic choice that the Government, as a whole, have to make, which is to say, "Do we want to approach this in a top-down fashion or a bottom-up fashion?" The top-down fashion would be, given what we think people are willing to pay in tax and what we can get out of them, logistically, and given all the variety of other challenges that we have to address in areas such as education and defence, et cetera, you come up with a view of what health ought to be getting as a share of GDP. GDP can move around a lot, so that is quite an awkward thing to plan for, and obviously over time that normally translates into cash settlements. Do you then tell the NHS, "That's your money, plan within it. Don't come and tell us that you've suddenly discovered that winters are cold. That's the budget you've been given"? Or do you do it on the basis of, "Health needs this"—and each year they will come back and say it needs a bit more and then you have to go away and make decisions about what is elsewhere?

In part, I presume it is a decision about how clear a top-down signal you send the sector. Do you say, "Like it or not, that is the share of GDP you've got, given all the other challenges we have; deliver the best healthcare system you can within that"? Or do you say, "This looks a particularly bad winter, there are pressures here, there and everywhere"? That is well above my pay grade. As I say, it comes back to this point that, even with fiscal sustainability, you can look at demands and cost pressures—but there are different sorts of pressures in all sorts of other parts of the public sector and choices to be made about how much people are willing and able to pay in tax. At some level you have to make big decisions that bring all those things together; not just looking at the drivers in each particular sector.

The Chairman: Lord Warner, I pinched half your question.

Lord Warner: Can I pursue the impact of boom and bust on forecasting? Some of us have had a look at what has happened over the last 25 years to health and social care expenditure. It has been extremely volatile, on both of them, year on year, with spikes all over the place. There has also been no synchronisation, even though the demography is pretty similar, between what has been allocated year on year to social care compared with health. Indeed, in some years social care has done better than health, so it has been a rollercoaster for both these services. Given that that has happened over the last 25 years, how does that rollercoaster approach to funding these services affect your forecasts over the next 25,

30 or 40 years? Would smoothing those things out change your forecast of future expenditure? Is it likely to?

Robert Chote: Certainly over the much longer time horizon we are, effectively, smoothing by making broad-brush judgments about the share of GDP. To date there has been some adjustment purely for the demographic effect and presenting a representative implication of weaker productivity growth. As I say, we explore in this paper whether we should take a somewhat less pessimistic view of the pressures from morbidity and a somewhat more pessimistic view of other cost pressures.

The implications for our forecast are that over the five-year horizon we produce the forecast on the basis of government policy as it is stated. The Treasury sets what are called departmental expenditure limits, or DELs, and we look at the overall size of that DEL envelope for public services as a whole, informed by whether there is obvious evidence of particular pressures in particular sectors. Relative to other countries, the Treasury is powerful, relative to spending departments, in the management of public expenditure. We do not produce a bottom-up forecast department by department because we know that the Treasury has a sufficiently firm grip at the top so that it is very rare that the aggregate envelope for all these services is overspent, even if they have to take some money out of one and stick it into another.

One element of those departmental expenditure limits is the grants that the Government provide to local authorities. Local authorities also raise their own money and some local authorities are more exposed to social care costs than others. That is an area of complexity that goes beyond the way in which we look at it. Of all the many difficult things we have to forecast, forecasting local authority expenditure in aggregate is not a straightforward one. We had assumed for years, as the cuts were tightening, that local authorities were going to start running down their reserves in order to keep expenditure going. What has, in fact, happened is that they have ended up, perhaps until very recently, shovelling more money into reserves. Tony Travers at the LSE famously says that local authority finance officers share genetic material with squirrels; when confronted by any uncertainty their instinct is to put the hazelnuts away for a rainy day. It has certainly been a source of error in our forecasts.

As I say, we do not go into a sufficiently disaggregated look. There are clearly the local authority experts we would talk to, to say that there are different pressures facing local authorities for whom social care is a significant part of their budget versus those for whom it is less so. The fact that the Government are explicitly allowing authorities to raise more council tax to address some of this is obviously a recognition of that. I read, as others do, about the potential benefits of thinking about social care and health expenditure more holistically, which I am sure is a very important topic but is not one that is core to the forecasting job we do.

Q275 **The Chairman:** The OBR does a superb job on the independent analysis of spending in health and gives an important insight into the sustainability of healthcare funding. Given the pressures on the health and social care systems, do you think further independent analysis and oversight of the funding, the workforce and impact on the healthcare system based on

demography and medical advances would be helpful? If so, who might do this and how could it be implemented?

Robert Chote: The fact that you are all taking an interest in this with this inquiry indicates there is a level of knowledge. I do not think, certainly relative to sectors such as education, that health is particularly under-think-tanked. For a lot of people, in some cases, the sound of a grinding axe can be heard in the distance, and in some cases not. In a sense, some of the most interesting work is done by people such as the OECD who are able to look across countries and pick up things you would not necessarily look at, or interesting patterns that you would not get confined to analysis there. There have been exercises in the past—including the Wanless review—looking at definitions of particular need and how that could be done, and I am sure there would be many researchers who would very happily accept funding for doing this sort of analysis.

The Chairman: The difference is that you were set up by the then Chancellor to be an independent body to give this independent advice. The think tanks do a good job but they are not listened to because they are not set up by the Government. If we had an independent body that does in-depth analysis that you do not or cannot do, and then says, "Based on these findings we think this is what the funding settlement should be; this is what the workforce should be", et cetera, would that not be better?

Robert Chote: Again, I am not close enough to the sector to know. As I understand it, Wanless was relatively highly regarded as a proper piece of work. Presumably, that could have been given an ongoing life in the way in which we have mechanisms, for example, for the periodic review of the minimum wage or the state pension age. You do not necessarily have to have a large organisation that does it all itself; you could have a body such as the Low Pay Commission. Their working model is that they are able to commission research but come back to it and review in on a regular basis, and obviously they have a formal role in putting in commitments.

We now have the National Infrastructure Commission, which is supposed to be coming up with an overall approach to infrastructure spending, although I think it was the Chancellor's announcement in the Autumn Statement that there is a top-down approach there of saying, "This is the amount of money you have to play with; within the limits, go off and think about how that ought to be done". If you were setting up a body in health in this area, again, you have that choice between saying, "Do you want them to go away and work out what we need?" or do you want to say, "Health can have 9% of GDP to spend in 20 years' time. What can you deliver for that?" It could be approached in either or, indeed, both of those ways, if you wanted to. I would have thought models such as the Low Pay Commission or the National Infrastructure Commission would be possible ways of going at this. The fact that Wanless did what it did showed that a one-off exercise in that sector could get quite wide appreciation and purchase.

The Chairman: In the Autumn Statement the Chancellor said this about you: "Let me turn now to the forecast. Since 2010 the Office for Budget Responsibility has provided an independent economic and fiscal forecast

to which the Government must respond. Gone are the days when the Chancellor could mark his own homework, and I thank Robert Chote and his team for their hard work". My question, therefore, is: should a body be established to ensure that the Health Secretary does not mark his own homework?

Robert Chote: Again, you are taking me into areas of sectoral institutions. Does Monitor have any role in the performance element? Is this about whether the Health Secretary or the health department are delivering what they can with the money they have been given, or is it something you are tasking us with, saying, "How much money should these people be given"? Are you doing the top-down or the bottom-up? The advantage we have is that while we have a broad job our remit is very tightly defined. It is a great help that I can say, "I'm awfully sorry; I'd love to give policy advice or to shoot my mouth off over whether this is a silly or sensible reform to stamp duty or capital gains tax but that's not my job." There are other people at the Institute for Fiscal Studies, for example, who can do that. Having a deep but narrow remit makes our life a lot easier because it is just as important to be able to say, "That's not a question I can answer", as opposed to—pleasurable as it is—turning up here and offering my unfocused, uninformed thoughts on a whole variety of things. That is one of the choices you have to make about setting up this body, if you want to go down that route. Can you give it a mandate that does not leave it having to produce airy-fairy reports about, "Wouldn't it be lovely if we had 15% of GDP to spend on healthcare"? Wouldn't it—but there are other things to spend it on elsewhere.

Lord Warner: Can you say a little bit about how long it took you to get yourselves set up to do this, be effective and get accepted? Can you give us a feel for that?

Robert Chote: We were set up in 2010. The major advantage that we had was that, effectively, the Government chose to outsource a function that already existed in the Treasury. When we were created, the bulk of our staff were simply the people who were responsible for doing the main macroeconomic forecasts and the main revenue and spending forecasts in the Treasury who were, not quite physically, lifted out of the organisation, put into a quango, had myself and two deputies, like the figures on a cake, stuck on top and charged with making the decision. I inherited people who had been doing this work, mechanically, for many years and with established relationships between us and, in particular, Revenue and Customs and the Department for Work and Pensions that had been there for ages. We were able to get up and running very quickly. We have expanded in number, we have expanded in the remit somewhat, but the core bit of the machine was taking out a bit of the Treasury, moving it into a quango and bolstering its independence and transparency—and away we went.

If you are creating something new and trying to establish its reputation—which is more, for example, what is happening with the National Infrastructure Commission—there is a whole series of choices about the model you want. We have a large staff/small council model; the infrastructure commission has more commissioners and staff but the ratio is different. It was easier for us because the Government was outsourcing

a task that they had already undertaken rather than creating a new one or duplicating an existing function.

Lord Warner: That is very helpful, thank you.

Q276 **Lord Willis of Knaresborough:** Can I come back to your initial remit about forecasts and projections on current government policy? That is what you said as you started. Could you tell us, for interest, what you regard as the current Government's policy on the social care settlement? In fiscal terms, what is the settlement? What do you understand to be the settlement? My second question is going to be: can you project that through to 2020 and beyond?

Robert Chote: On social care, as with healthcare more broadly, over the longer time horizon you are looking at a constant share of GDP adjusted for demography. For social care there is a more sophisticated analysis that can be done, but on the amounts of money involved the scale of difference is that much less.

Lord Willis of Knaresborough: You are saying that it is linked to GDP and demography? The figures do not seem to indicate that because it is going in the opposite direction.

Robert Chote: I can give you more detail on that. Obviously, I was focused on health for the purposes of the invitation.

Lord Willis of Knaresborough: It is tied in to the same thing, is it not?

Robert Chote: Yes. The greater complexity there, as well, is what has been agreed in terms of local authorities' spending and their ability to raise revenue.

Lord Willis of Knaresborough: Can I try and help you here? I deliberately went back to forecasts and projections based on current government policy. Current government policy is, in fact, to integrate health and social care, and to do it from now, not in five or ten years' time. Are you saying you do not do any work at all on projecting what that overall cost of health and social care will be?

Robert Chote: We do the projections on the basis of the Government's stated decisions about the amount they are spending in particular elements of departmental expenditure limits, some of which will include estimates of the grants that they provide to local authorities.

Lord Willis of Knaresborough: The answer is no, is it not? The answer is no, you are not.

Robert Chote: I am sorry?

Lord Willis of Knaresborough: The answer is no. You are not aggregating those two on the basis of current government policy to project expenditure.

Robert Chote: Explicitly a combined health and social care budget?

Lord Willis of Knaresborough: Yes.

Robert Chote: No.

Lord Willis of Knaresborough: Do you not think that is a mistake and

perhaps something you should be doing without having government Ministers asking you to do it, as an independent body?

Robert Chote: At the end of the day, remember, the job we have been given by Parliament is to get an estimate of what this implies for the public finances, hence the aim of looking at the total expenditure. From our point of view it would be irrelevant whether you spent what is defined as social care versus health.

Lord Willis of Knaresborough: I understand all that. What I am trying to get you to say is that there is a job to be done by your organisation to look at current government policy and its projection in terms of finance, linking together government policy on combined health and social care.

Robert Chote: Whether that would get you to a better answer on the aggregate expenditure, I would be very interested to see. If you think there are particular ways in which we could slice this cake that would be more effective, I would be very happy to look at that.

Lord Willis of Knaresborough: The cake, at the moment, is being sliced, as you have said, quite rightly, so that there is a notional increase in spending on health, as agreed with the NHS, up until 2020 and the five-year plan. There is not the same settlement for social care, despite the fact that the two are interlinked in the form of government policy. All I am trying to get you to say is, "Yes, Lord Willis, this is a deficiency which I will take away and start working on tomorrow".

Robert Chote: I am not going to say that. As I say, we are producing the different elements of what the Government are spending both directly in central government and the allocations they make to local authorities. We make judgments on the ability of local authorities, for example, to raise their own revenue and then we have to make judgments about the degree to which they spend the money they raise or whether they add some of it to reserves or subtract some of it. At the end, we get to an overall set of forecasts for revenue and expenditure which drives our public finance forecast.

As I say, I am very happy to look at whether we are picking up the financial consequences of the various flows implied by statements of government policy as effectively as we can.

Lord Willis of Knaresborough: I think this Committee would be very interested if, in fact, that were the case. A simpler question to finish my section with is: Dilnot is current government policy. Have you factored that in to future spending requirements for social care, to your knowledge?

Robert Chote: To be honest, I cannot remember the current timing on Dilnot. It is not going to show up very much in the course of the five-year forecast that we are producing, for which plans are set out. We have responded as the timetable for that has moved out.

Lord Willis of Knaresborough: You did also say in your opening remarks that, in addition to the five years, you were forecasting beyond that, based on government policy.

Robert Chote: We do projections beyond that, yes.

Lord Willis of Knaresborough: Dilnot is not part of that?

Robert Chote: I think at that stage it is part of that, but it does not show up much in the five-year forecast.

Lord Lipsey: I would like your view as an economist as well as the head of the OBR. We have heard a lot of arguments in this Committee which say, spend a bit more on public health and people will give up diabetes and save the health service £4 billion a year, and they will stop dying of smoking and save the health service £8 billion a year—I am sorry, those are imaginary figures. Members of the Committee are slightly concerned about, “If I do not die from smoking today, am I not going to die, perhaps even more expensively, from dementia in five years’ time?” Have you looked at those kinds of putative savings at all? How do you think the logic of that pans out?

Robert Chote: We have looked at some of the studies, in particular, about the issues of morbidity, and the degree to which the extension in life expectancy results in an increase in healthy life expectancy and how much not. Some of the work that we cite, looking at the other cost pressures, would note, for example, the chronic diseases that you are likely to see, partly as a result of ageing but not just as a result of ageing, as chronic diseases become more important as a source of illness. Then there is the issue of co-morbidity. If that is a greater issue then the chances of other potentially expensive, complicated things happening at the same time is greater as well. They are subsumed in different ways into parts of the analyses people do on other cost pressures. Dementia, obviously, stands out as a particular issue. As I say, there is a broader mental health issue that is showing up in a way that we have not—and people had not—anticipated in the welfare budget, and at younger ages as well as older ones.

Lord Turnberg: If we are going to cure Alzheimer’s, how do you calculate that?

Robert Chote: I do not think we will be making explicit adjustment for that. The question then is: if you cure that, presumably, what else are people going to have instead, and is it going to be cheaper or more expensive over the longer term? If you are not killing people off with something else more quickly and they are ill for longer in such a way that is expensive but yet has an overall improvement in quality-adjusted life years, what choice does society make about whether it wants to spend a lot of money in that sort of area?

Lord Warner: Can I take us back to make sure I have understood your answers to Lord Willis? I do not want to go too much into the detail. As I understood what you were saying, the problem for you in forecasting ahead for social care is the fact that finding out precisely what the local authorities are doing on their bit of the budget is extremely difficult because you have to make a set of assumptions about what they may or may not spend. Is that a correct interpretation of what you are saying?

Robert Chote: That is the overall issue in terms of our forecast for local authority spending as a whole. Again, this is not an area where we are producing bottom-up forecasts authority by authority; we are looking at the overall amount of money, essentially, that local authorities are given

in grant. Then there is the amount of money that local authorities raise for themselves and then there is a judgment about the degree to which they add or subtract from their reserves to do that. We are conscious that, in talking to local authority experts about the anecdotal evidence, you might hear, "Oh, there are particular pressures in this sector and these are an important driver", and there may then be explicit permissions for authorities to raise more council tax to spend more money in these particular areas. That can be a factor.

Lord Warner: We only find out at the end of each year. Effectively, we only find out at the end of the process, do we not?

Robert Chote: The issue for both the NHS and healthcare, at central government level, and for local authorities, is that it takes some considerable months before we know exactly what local authorities have spent and exactly what the NHS has spent. That can be some months after the end of the fiscal year.

Lord Warner: That is very clear.

Robert Chote: I would have boned up more on the social care forecast if I had known you were going in that direction.

The Chairman: Based on your analysis, are you able to say what you think the share of GDP would have to be in 2030-31 for health?

Robert Chote: We tend to look over a 50-year horizon. You could probably chop it off at the relevant bit and divide the number accordingly. The most recently updated set of long-term forecasts we did had health spending rising to 8.8% of GDP by 2060-65, compared to 6.8% at the end of the medium-term forecast for 2019-20. That was a bit higher than we had forecast previously, partly because since we did the previous set of long-term projections the Government have decided to spend more in total on public services and more on health at the starting point, so there is more healthcare for the demographic pressures to bite on over the subsequent years, and there have been changes in the population projections.

In addition, if you look at our standard, "Let's adjust this for lower productivity growth and let us assume that you spend sufficiently more on health to deliver the same increase in output year in, year out, as you get in the rest of the economy", that would get you up to about 13.5% by the end—an additional 5% or so. A couple of projections that we look at in this paper would be, "Let's assume that the other, i.e. non-demographic, costs are rising at the sort of rate we have seen recently and they continue to do so throughout that 50-year horizon". That would get you up to something over 18% of GDP. If you make what most forecasters in this area would regard as, perhaps, a more sensible judgment, as the Congressional Budget Office does in the United States, of saying, "Let's assume that this additional cost pressure moves to about 1% a year rather than remaining as high as it has been more recently", that gets you to about 15% of GDP.

The other area where our forecast looks relatively pessimistic is on the assumptions we make about morbidity. Most other projections will be more optimistic on that, so you could take, maybe, 0.5% to 1% of GDP

off that. You can see that there are very wide variations between these, depending on exactly what sets of assumptions you make about them.

Lord Turnberg: That is health and not social care?

Robert Chote: That is health. With social care, as I recall it, again, you obviously have a demographic pressure, but the starting number is much smaller, so its impact on the public finances is much less important. Proportionately. I suspect it may be even larger than it is for health but the fiscal consequences of it are much less.

Q277 **Baroness Redfern:** Local authorities can raise social care to 2% each year, as such. It is disappointing there is less on social care. My question, Robert, is: what is your key suggestion for a change this Committee could recommend which would support the long-term sustainability of the NHS?

Robert Chote: As I say, it is you, collectively, as in Parliament, who told us not to offer policy suggestions. This is an issue of striking the right balance between thinking about and planning healthcare spending on a bottom-up basis and living in a world in which the NHS can come back, the wheel can squeak and more grease can be applied as and when asked for, versus a more top-down assessment of the choices about healthcare spending along with a whole lot of other choices about what we want our criminal justice system to look like, what we think our defence needs and diplomatic needs are going to be, et cetera, and to provide a more overarching sense of the share of GDP that health should reasonably be thinking of. We should not be ignoring that element of it to the degree that as a complete amateur and outsider one gets the sense of health being thought of in isolation—not in isolation from social care but from the rest of it. My suggestion would be thinking about what longer-term signals you want to be sending to the sector—not just because of a variety of exciting studies on drug price pressures but what are we going to want to spend on defence in 15 to 20 years' time?

The Chairman: Thank you very much, indeed, Robert, for coming today. It has been most helpful. We appreciate what a busy person you are.

Robert Chote: Thank you very much for the invitation. I hope it has been useful.

The Chairman: It has been extremely useful. You might want to know that the Government are to reveal a Brexit plan before the EU exit begins.

Robert Chote: Very good. The pleasure of an hour not talking about Brexit is not to be underestimated.

The Chairman: That is why I told you, because you told me you did not want to talk about Brexit.

NHS England – Oral evidence (QQ278-285)

Evidence Session No. 30 Heard in Public Questions 278 - 285

Tuesday 13 December 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Bishop of Carlisle; Baroness Blackstone, Lord Bradley; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witness

Simon Stevens, Chair, NHS England

Q278 **The Chairman:** Good morning, Simon. Thank you for coming to help us with our inquiry into the long-term sustainability of health and social care. We are looking long term, 2025-30, and beyond. This session is being broadcast on parliamentlive.tv and on the BBC parliamentary. You are popular, obviously. We will let you have the transcript, and you know the rules. Welcome, and thank you. For those of us who have not seen you for a while, it is you, despite the beard.

Simon Stevens: I have come in disguise, Lord Chairman, given that it is the distinguished end of the corridor.

The Chairman: We all know you, but if you would not mind please introduce yourself for the record, and if you have any statement to make, please feel free to do so.

Simon Stevens: Thank you. I am Simon Stevens and I am the chief executive of NHS England. Given the number of distinguished witnesses you have had before you already and no doubt the roster of questions you have, I suggest we just go straight into it.

The Chairman: I will start off. Now in healthcare it seems that a problem develops, you resolve it and the problem develops again. Looking ahead to 2025-30, what do we have to do to make healthcare sustainable year on year? What is stopping us?

Simon Stevens: When you say 2030, that sounds a long way off, but it is 14 years away, so I thought it was instructive to think about what the NHS was working on 14 years ago and whether we got those judgments right. Fourteen years ago we were in effect trying to solve a different set of problems than the problems now confronting the National Health Service. We were trying to convert our substantial extra money into improved speed of care, in particular cutting long waits for routine surgery. We put a set of ways of doing that in place, and as a result, as

everybody knows, the wait for routine operations has come down from 18 months to less than 18 weeks for most people, which is a dramatic change. I started work in the National Health Service in 1988, and in that year there were 220,000 people waiting more than a year for their operation. Now it is under 1,600. We put a set of solutions in place 14 years ago to deal with the problems of the 2000s, and frankly I think you can say that the NHS was successful in that. Net public satisfaction doubled as a result.

However, 14 years later we are dealing with a different set of situations. So the question looking 14 years out is: to what extent will the problem set in front of us now have been dealt with, and to what extent will new issues emerge? My view is that the right way of thinking about that is to identify the things that are directly under our control that we can therefore take action on to future-proof what we think the health service needs to look like, and the way care is organised and integrated between different parts of the health service. Indeed, the social care system would fall into that category, as would decisions that we have to make about the workforce.

The second category is changes that are outside our direct control but that we can nevertheless predict: changes in longevity, demography and the disease burden that we are likely to be facing. Thirdly, there is a set of things that are outside our control and are uncertain, so we cannot directly plan for those but we need to make some “no regrets” moves and some big bets and place down some markers on the board for things that we think might pay off but which we are not sure of. As we think about the actions we need to take, we need to get some serious changes layered in around the organisation of care and workforce in our control and we need to be responsive to what we can see coming down the pipe in the way of demography and epidemiology.

For the things that are outside our control and which potentially have the most fundamental impact—I would put two into that category—we have to think about different scenarios. The two most fundamental things that I think will shape what the National Health Service looks like in 14 or 15 years’ time will be the performance of the UK economy, given that for a tax-funded health service that is fundamental, and changes in medical innovation and technology.

The Chairman: As the chief executive, what would you be hoping for?

Simon Stevens: As in?

The Chairman: Strategy beyond 2020.

Simon Stevens: I think we have to marshal our forces on various timelines. As you know, we have a set of changes that we are looking to implement now through 2020. Some of those will be accomplished on that timeframe and some are more profound changes that will take longer. In three months’ time, I intend to publish the delivery plan for what the National Health Service will look like for the rest of the Parliament. Probably going into 2018, given that it is important that the strategic questions that this Committee is addressing are out there for public debate, I intend that NHS England will publish a set of proposals, a manifesto if you like, for what going into the next Parliament in should

look like over the medium term: the kind of timeframe that this Committee is debating.

Q279 Lord Kakkar: Simon, I would like to explore funding models with regard to both health and social care systems and what you consider those funding models need to look like to ensure sustainability into the long term. Then beyond that, if I may, I would like to explore three other issues. First, we have heard evidence that the variability in funding year on year makes it very difficult to plan in a meaningful way to achieve that medium and longer-term approach, and that there might be merit in having settlements that last for five or 10 years rather than the short timeframes that we have experienced so far.

Since the current funding settlement is at the lower end of what had been suggested was going to be required, how do you think that current funding settlement and the changes in social care funding are going to impact on longer-term sustainability? We heard from the Office for Budget Responsibility its assessment that health spending will need to grow by more than GDP growth beyond 2020. What do you think the implications of those projections are?

Simon Stevens: I think you can argue that a tax-funded National Health Service as a funding mechanism has served this country well since 1948. It has produced a steadily improving and expanding National Health Service and has done so in an equitable way that is highly valued by the people of this country. There is no evidence that the support that the people of this country show for that as the core funding principle of our health service is in any way diminishing.

However, there are some consequences. The interesting question that you are posing is whether there is a way of having our cake and eating it—to use what I understand is a popular phrase these days—by which I mean: could we keep the benefits of a tax-funded health system but do something to overcome the lumpiness of our funding settlements that, over the course of the history of the National Health Service, has meant that even though the average spending growth may have been reasonable, we bounce off the banks between feast and famine, sugar highs and starvation, when it comes to the funding of the National Health Service, which in the end produces poorer quality of care and a less efficient use of resources.

My reading of history is that all the existential crises in the National Health Service over its history have arisen about once a decade and have been due not to anything happening in the NHS itself but to some form of economic crisis in the UK economy. Is there a way of smoothing out those bumps? If we were able to do that, I believe we would get more health bangs for our buck.

Lord Kakkar: You very carefully suggested that that would be a sensible thing to do. Is that achievable, in your experience of the National Health Service since 1988, with all the commitment there has been from successive Governments towards the NHS? Why do you think that has not been achieved? What action might be taken to try to achieve that more sustainable and secure long-term funding approach?

Simon Stevens: It is partly that health funding settlements have largely been pro-cyclical to the performance of the UK economy for the reasons I discussed. It has partly been because the squeeze is ultimately understood to have gone too far, and it produces a backlash through the democratic process that says, “We now need to sort ourselves out”. In the same way, the Wanless approach in the early 2000s looked back and said that we had spent £220 billion less than the European average over 15 years and we needed a catch-up period. That is one of the issues.

A related issue is that we are not connecting the public’s willingness to fund the health service with the mechanisms that transparently bring that about. I know that other witnesses before you have talked about the pros and cons of greater connection—the “H” word for hypothecation of various sorts. There are pluses and minuses to that, but something that smoothed the funding increases, gave longer-term predictability and, more transparently for the public, connected what was being invested with the results they were getting in the NHS would be a great addition.

Lord Kakkar: If I may, I will come back to the two short supplementary questions. One relates to the current funding settlement being at the lower end of what you had requested. How will that impact, beyond this period, into the 2020s and 2030s? The second relates to the observation of the Office for Budget Responsibility that health spending will need to grow more than GDP after 2020.

Simon Stevens: On the first question, I would say that the reforms, which we may come on to talk about, to the way workforce training is financed are helping to untie or unconstrain the connection between the availability of funds in any given year and the numbers of new nurses or doctors going through the system. In that sense, that will help, again, to produce less lumpiness and short-termism in some of the workforce expansion that we clearly need.

On other elements of the future-proofing that are implied by the constraints that we are under right now, I think the main question will be whether, at some point during this Parliament, it is possible to liberate more capital expenditure in the National Health Service that would help investment in some of the new service models that we can see are part of what the future needs to look like. I hope we will have a chance to talk about some of those, because that is a profound redesign of the way clinical care works in the National Health Service, which will put us in good stead not just now through to 2020 but in the five and 10 years beyond.

Lord Kakkar: Do I understand correctly that if that type of capital investment for driving forward new models of care that you think will have a big impact on future sustainability is not made available in this Parliament, for whatever reason, that will have a serious detrimental impact on future potential sustainability?

Simon Stevens: You are perhaps gilding the lily in the way I framed it. I simply say that there is an opportunity to ensure that we drive productivity through well-targeted capital investment and lever in some of the wider service changes. In particular, we have this historic fragmentation between the way GP services work and hospital services

work, and that is hardwired back not even to the 1946 Act but, I would argue, at least to 1911. The result, as the famous commentator and historian Roy Porter said, was that, “The founding deal in the National Health Service was that the consultants got the hospitals and the GPs got the patients”. We have evolved a model where we have general practice as a cottage industry and hospitals as factories, and we and every other industrialised country can see that that needs to change. In order to do that we have a set of things we have to get right, but some of that is also going to require capex.

The Chairman: Lord Warner, Lord Scriven and Lord Lipsey all have supplementaries.

Simon Stevens: I am sorry, my Lord Chairman. This would otherwise have been Lord Kakkar’s third attempt to ask me the question about the income elasticity of demand post-2020. Yes, my view is that it is likely to be a positive income elasticity above one. In other words, as countries get wealthier they want to spend a higher share of their national income on health services. That is the revealed preference of all industrialised countries in the post-war period. Although one might step off that escalator for short periods of time, there is no particular reason to think that that would be the revealed preference of the British people in perpetuity.

Lord Warner: Simon, can we come back to this issue of lumpiness? The evidence that the Committee has heard is that it is more than lumpiness; there are extraordinary variations and no consistency even between health and social care in that lumpiness. I assume that when you talk about smoothing mechanisms you are applying that to social care as well as to health. Is that a correct assumption, before I ask my question?

Simon Stevens: Yes, I think that would make sense, although obviously, as you know much better than me, the funding sources of social care are more mixed than they are in the National Health Service. A combination of central government grant, local authorities raising their own funds, personal contributions to social care, elements of the benefits system transfers and the contribution the National Health Service also goes into what are defined as social care services. There are at least five different funding streams going into social care financing in a way that to some extent offsets some of that lumpiness but not completely, seen through the lens of the central government grant.

Lord Warner: My main point is this. You mention that from time to time there is a crisis, and in the standard British way we reach for a commission to see if they can sort out the crisis and make a recommendation. At the moment, the cry has gone up for a royal commission. Is there not something so systemically flawed in this system of allocating resources, which would enable you to invest for the longer term, that we need a commission but we also need something that is standing and that helps the people with day-to-day responsibilities to concentrate on those and not get drawn from the longer term by the preoccupations of the moment? If we look at what happened in the Treasury, the OBR was set up to give the Government some kind of independent view, because the public were fed up with Chancellors giving optimistic economic forecasts that suited them politically. Given the size

of health and care in public expenditure amounts, should we be thinking about some kind of independent body that keeps an eye on the longer term rather than reach for a commission every time there is a crisis?

Simon Stevens: It is an idea that in some respects has its attractions. With other countries' systems, which are financed with universal coverage, you get less lumpiness as a by-product of the funding mechanism in its own right. Beveridge systems are more prone to lumpiness, so the question arises: can you overlay the sort of mechanism that you describe? I do not think it is a particularly useful model, but in the US there is a group called the Medicare trustees, who have to report to Congress on the solvency of Medicare, the publicly-funded part of the US healthcare system, which in turn drives political debate about whether or not, on a medium to long-term prospect, Medicare is being properly managed. There are virtual models like that, if you like.

The alternative view, I suppose, is the one that I interpreted Robert Chote as putting before you last week, which was that it is legitimate for elected Governments to make these kinds of trade-off over time rather than pre-empting the decisions as between different elements of public spending. Certainly NHS England has sought—we did this in 2014 with the *NHS Five Year Forward View*—by default anyway, to play some of that role, prior to the last election, in explicitly setting out the NHS stall and saying, "Here are some of the choices facing the country". That was the first time the NHS had done that.

Lord Scriven: Thank you, Mr Stevens. In one of your answers you said that we have to get best bang for the buck. Clearly, there is the global amount that is given. I want to talk about going forward with the global sum, whatever it is, on productivity and variation of care, on which, the Committee has heard, the NHS has a pretty poor record. To make the NHS more sustainable in the future with the amount it gets, what strategic and systematic changes will have to be made so that we get the best bang for the buck, both in productivity and in dealing with the variation of intervention?

Simon Stevens: I think the NHS has a spectacularly good record on productivity and efficiency, certainly as judged against any other major industrialised country. Three things can be true at the same time. First, we are, in macro terms, a very efficient health system. Secondly, there are nevertheless still significant opportunities to remove waste and reduce clinical practice variation. Thirdly, despite those two things, if we are to continue to have the kind of health service that the people of this country want, it is likely that the NHS will need further investment in years to come. I do not think there is any inconsistency between those three things.

Lord Scriven: That is your personal view. Other witnesses have had a different view. As chief executive of NHS England, in order to get best bang for the buck and to deal with the productivity and variation issue, what strategic and systematic changes are you looking to make, or which will have to be made, in the long term to make sure that we get even better and deal with the inconsistencies?

Simon Stevens: I would underline the evidence that you have had from some of the previous witnesses that we are obviously aiming to drive about £14 billion of productivity differences out of the provider sector between now and 2020. When Jim Mackey was before you he laid out many of the measures that have been taken through reducing the waste identified by Lord Carter, by driving out some of the other practice variations that people such as Professor Toverim Briggs and Professor Tim Evans have identified in clinical practice surgery and medicine, and by dealing with some of the differences that exist in the configuration of services, which in turn means that we have different usage of expensive parts of the hospital system depending on where you happen to be in different parts of the country. I do not think anybody disputes that the NHS has a huge efficiency programme in front of it, which it is mobilising for, and that comes on the heels of £20 billion worth of efficiency that we delivered over the previous five years.

Lord Scriven: Can I ask one further question, very quickly? Looking forward, not dealing with where we are now—you talked about the three things that are predictable and that you can manage and plan on—are there any long-term strategic or systematic changes that the NHS will have to make, which it has not started now, to deal with the productivity and the variation issues that have been identified by the Committee? Can you think of any levers, any management changes—not necessarily structural changes—that you think will have to come in to make the NHS more sustainable to deal with getting more bang for the buck?

Simon Stevens: Yes, I think there are a number. The first is changes to the way the workforce in the NHS is supported and deployed. For example, in the case of nursing—and Lord Willis probably knows more about this than anybody else in the room—a major programme of reform in nursing is under way involving changes to the way support is given to people to move from care-assistant roles to nursing associates, and nursing associates to graduate nurses, and changes in the skills mix between different disciplines in different areas that we have to improve on. We know that we have bottlenecks on the early diagnosis of cancer, so we need more nurse endoscopists to go alongside gastroenterologists, for example. We know that we need to be more directive in some respects about the disciplines in which our new doctors are practising. If anybody had said 10 years ago that looking out in the decade to today we were going to expand the number of hospital consultants three times faster than the number of GPs, they would have said that that was probably the wrong answer, but that is what has happened. We have a range of changes that we need as to how we deploy our workforce.

More fundamentally, the fact is that many of us believe that the changes to medical practice that are going to be layered in over a 30 or 40-year medical or nursing career mean that it is quite important that as new practitioners are trained they are trained not just for the state of knowledge today but to be highly flexible over the course of their careers. That is not a new phenomenon, but it is something we have to accelerate.

Lord Lipsey: You cited economic growth as an important determinant of the future of the NHS. Is there not an important stabiliser there in so far as 70-odd per cent of your main costs are pay, and that generally

speaking, over the long term, pay will rise in line with GDP, so if GDP is slower you will have slower pay rises, which will help to compensate for the lesser tax funding that you would expect to get?

Simon Stevens: Yes. Offset against that is obviously the Baumol effect in labour-intensive services, probably more so in social care than even the NHS.

Lord Lipsey: To follow that up, one of the other major factors that I would be worrying about if I was in your shoes—which, thank God, I am not—is the combined potential effect of Brexit and a clampdown on immigration from the rest of the world. You are very dependent for labour force on the rest of the world, and if you cannot recruit from there you will have to pay Brits more to do it. Is that not likely to be a very serious inflationary element in the future course of the costs of the NHS?

Simon Stevens: It will certainly be important to get this right. We have perhaps 135,000 staff from the rest of the European Union working in the NHS and the social care system, and about a quarter of our 150,000 or so NHS doctors across the country are from overseas—36% qualified abroad. We have traditionally, like a number of other countries, relied on supplementing UK-trained staff with internationally trained staff. It is important that we also expand domestic supply, and I think that is why the Government decided to expand medical school places by 1,500 beginning in 2018—a 25% increase. Obviously that will take time to layer into the system, but that is one positive sign. Taking the cap off nurse training places, so that we move away from the ridiculous situation where we have more people wanting to be nurses than we train at a time when we want more nurses, will also help.

Lord Turnberg: When you were answering the Chairman you were talking about unknown unknowns and known unknowns, and those sorts of things.

Simon Stevens: I do not associate myself with the author of that particular epithet.

Lord Turnberg: I interpreted it that way. Among the known unknowns are the advances in medical technology and how far they are going to take us. I have two questions about that.

One is that traditionally we are very slow in taking up technologies. How long will it be before we are able to take full advantage of what are remarkable advances in treatment, which will cure many diseases we cannot cure now, and certainly help to prevent deterioration in them? How do we encourage a more rapid uptake?

The second is that they are likely to be expensive; all new therapies and inventions are going to be expensive, at least initially. The NHS bears the brunt of that, but the benefit of increased productivity goes to the Treasury. How do we sort that out?

Simon Stevens: Goodness. Over the course not only over our history but that of other industrialised countries, as countries have become better off we have been able to afford more of the good new things that are represented by medical advance. I would use a data point to illustrate this from the other side of the Atlantic. In 1900, Americans were spending

twice as much on funerals as they were on medicines; now they are spending 10 times more on medicines than they are on funerals. You can argue whether 10x is the right ratio on their drug prices, but the fact is that that represents the kind of transition that countries can afford as they become better off.

You heard from previous witnesses that part of the reason why new technology in healthcare does not always reduce costs—often it increases it—is partly because more people can get benefits. It is not all in that direction. I have brought one example here this morning, an ECG machine that straps on the back of my iPhone. It is going to be available on the NHS from April and costs less than £100. It is going to be deployed in this country for people with atrial fibrillation, of whom perhaps 500,000 do not know they have it, and it causes more than a fifth of strokes. Some innovations, particularly the spillover effect of what are called general purpose technologies into healthcare, could bring us some cost relief rather than simply layering in additional cost.

Lord Turnberg: Some.

Simon Stevens: Some, but there are others where frankly we are going to have to create headroom to be able to afford the innovation that represents, and we do that in a measured and managed way. Even in the last 20 or 30 years, I recall it being said that solid organ transplantation, new joint replacements or HIV antiretrovirals were going to bankrupt the NHS. The truth is we take a measured approach to these. We have done the same with new hepatitis C drugs, somewhat controversially, over the last year. Rather than saying, “We’re going to spend a couple of billion in one big bang”, we are layering these in based on clinical need. It is also a two-way street; it depends on the prices at which we can secure these new advances from the life sciences industry. I think we have an opportunity, coming up to and post-Brexit, to strike a new social contract with the life sciences industry, which we want, that would get us innovation and create the headroom to afford that and to ensure that the NHS and the country continue to be a vibrant and stimulating place for life sciences research. That is the sweet spot that we have to aim for.

Lord Warner: Can we come back to this issue of productivity and efficiency? We have heard a lot of scepticism in the evidence about the NHS’s capacity to drive the kind of numbers being envisaged for productivity improvement. They seem to be much higher than the British economy generally, let alone in the health service. You mentioned £14 billion in the next few years. What happens in the next few years in our view has quite a lot of impact on what happens in 2030. My question is: is some of this realistic? If Lord Carter provides £5 billion, give or take, in efficiencies, where does this other £9 billion come from? What is coming to us from the people having to deliver this is great scepticism about the kind of annual increases in productivity that are being sought? How confident are you that this is not just a remainder figure that the Government have decided on, and how real is continuing progress of over 2% a year productivity increase?

Simon Stevens: A lot has to come right to deliver those kinds of numbers. It is worth reminding ourselves that this is about creating headroom for other things that the health service wants to do over and

above the funding increases that we are getting. This is not taking money out of the health service; it is freeing up from our current cost base. I doubt that, over the timeframe the Committee is inquiring about—from 2020 to 2030—those kinds of compound rates are sustainable. The argument that the econometricians have put together, looking at the variation data, is that 2% efficiency comprised of the annual 1%-ish that the health service has traditionally been capable of delivering and that medical improvements and technology help you get, together with 1%-ish of catch-up, recognising you have this big spread between performance, gets you to this kind of opportunity for the next several years, but I do not think it would be a safe assumption, looking out over 10, 15, 20 years, to think that 2%- plus productivity, which is probably higher than the UK economy as a whole has delivered in recent times, is a safe basis on which to plan.

Q280 Lord Willis of Knaresborough: I was interested, when you opened your remarks today on sustainability going forward, that you mentioned two things. One was GDP growing, which would get more money in, and the other was new technologies. But you did not mention the workforce as being one of the three pillars of sustainability. You have gone over some of the ground with Lord Scriven. I was interested in what you said on page 30 of your *Five Year Forward View*: “We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money”.

Currently, we have a shortage of about 6% of clinical places in the NHS, we are losing around 9% of our nurses every year, and we are spending about £3.3 billion on agency staff. It is two years since that was written. If that continues, we will never be able to deliver the sorts of improvements that you certainly want and which we as a Committee want. We have not got workforce planning right at the moment. How do you see there being a step change in the future, so that we have an effective, flexible and sustainable workforce? How do we get the skills mix right within it? This Committee has heard lots of examples of where the skills mix clearly is not right in the NHS; there are far too many silos and there is far too much protectionism. I would argue with the royal colleges, but you might not feel that you can agree. What can we do to have good leadership? It requires significant leadership, which I suspect we do not have at the moment. There are three challenges.

Simon Stevens: To go back to your first comment, I said that technology and the UK economy fell into the category of things that were not in the direct control of the National Health Service. I certainly talked about the importance of workforce, but I said that that was in our control so it is our responsibility to get that right. I absolutely agree with you that that is one of the central pillars for future-proofing the NHS.

Obviously we are seeing continued growth in the number of health professionals in the NHS, notwithstanding the important points you have made. It is clear that we have had a period of public sector pay constraint while the economy overall has been in the position it has been. Looking out over five, 10, 15 years, we are going to need to see more flexibility in the NHS as an employer and in the combination of pay and benefits on

offer to staff. Frankly, some of that is the reason why there has been this spike in agency costs and temporary working over the last several years.

As it happens, I think we are making good progress this year in cutting the agency bill. Rather than the £3.3 billion or so that you mentioned, I think we are going to be substantially below £3 billion this year, and the figure is coming down. That shows that frankly there has been a gap, in my judgment anyway, in strategic workforce planning and implementation that has been distributed between decisions about future training requirements through HEE, decisions about pay made by the Department of Health and, on their behalf, by NHS Employers, and the action that individual trusts as employers take when we need more collective action, certainly at the regional level. There is a recognition of that fact, and in recent times the NHS has probably been less than the sum of its parts on some of those questions.

Lord Willis of Knaresborough: In terms of training staff for tomorrow, we have a tradition of training staff for yesterday and what we needed before, so how do we make a quantum leap to get the right sort of doctors coming through? We have heard time after time in this inquiry that we do not have the right mix of doctors, or medics; nor do we have the right mix of nurses and care assistants to deliver the sort of healthcare system that we all envisage for 2030.

Simon Stevens: Some of that is at the margin. If you start with nursing, roughly speaking we have about one million care assistants in health and social care and about half a million nurses. We need to find ways of creating career ladders for those who want to move from care assistants into nursing, and that is what the new nursing associate role will do. If we get that right, that will also produce a benefit for the sustainability of home care and care homes as well as for hospitals and the NHS as an employer of nurses. I hesitate to offer a view, given the distinguished nature of the Committee's membership, when it comes to the future of medicine.

Lord Willis of Knaresborough: They are looking to change their ways.

The Chairman: It was a long time ago.

Simon Stevens: Looking at Lord McColl, Lord Ribeiro and, indeed, Lord Turnberg—distinguished physicians and surgeons—over their long and brilliant careers there were massive changes in surgical practice, and surgery accommodated those successfully. This would be a good example of how changes in clinical practice have generated productivity benefits for the NHS. If you think about the combined effect of short-acting anaesthetics with minimally invasive surgery, with drugs that in some cases have displaced what would have been surgical procedures, the NHS and the surgical disciplines have adapted to that. I do not think we should throw the baby out with the bathwater here.

Lord Willis of Knaresborough: It is still taking six or seven years to train a doctor. Can we not do that a lot quicker? They are certainly doing that in other places right around the world. Why are we taking so long to get these people up and active?

Simon Stevens: There is an interesting question about how much people need to have under their belts at the point they get registration and how much on-the-job experience and training they should receive subsequently. Obviously, this has ebbed and flowed and differs between specialties. It looks quite different for a neurosurgeon than it does for a GP, say. I think we have some of those flexibilities.

Lord Ribeiro: One of the things you mentioned early was this question of the 1,500 new medical students, which was announced in October. As Lord Willis has said, the time to independent practice is probably about 10 years. One of the big problem areas is general practice, where recruitment is poor, 50% of the entrants are female and we know that many of them want to work part-time and not take partnerships but take salaries. One of things that came out in your five-year forward view was the primary and acute care systems.

Simon Stevens: Yes.

Lord Ribeiro: The challenge here is how you look at general practice. In your forward view, you say, "Is this model sustainable in the long term?" You have some great challenges in here. You say, "In urban areas where general practice is perhaps not as well sustained, you might give an opportunity for hospitals to take over". I can think of chief executives, such as Len Fenwick and Robert Naylor, who would have grasped that opportunity. Is it not time to start putting that into practice?

Simon Stevens: In places, yes. I think we need a mixed model. My philosophy on how the NHS should change, coming to this job, is that we should take account of three things. First, we should focus more on outcome improvement than on administrative reorganisations. Secondly, we should recognise that although in some senses we are small country, we are quite large and diverse when it comes to our populations and the way the health service is operating, so we should allow different evolutionary paths in different parts of the country. The third point, which is the corollary of the other two, is that we should therefore be willing to back energy, leadership and clinical engagement wherever we find it, rather than trying to create neat lines on a map and saying, "Right. You, you and you, you're it."

That is the precursor to the answer to your question, which is that, yes, we are going to see a mixed model in the way primary care develops. My reading is that GPs are not crying wolf and that they have been systematically undersupported and underinvested in, relative to the rising workloads and demands that we are placing on them, and that because, frankly, their backs are against the wall, they are now willing to contemplate some quite radical changes to the way in which general practice operates, while nevertheless maintaining the best features of it, including list-based continuity of care for populations and the personal relationship for patients who want it.

In a nutshell, I would say that general practice is a flotilla, not an aircraft carrier, so it will develop and move in different ways in different parts of the country, some of which you have described. In other places, such as Birmingham, you will see that the GPs themselves are coming together at scale, either with a very deep redesign of what primary and community

services look like, such as in Sandwell and west Birmingham with a partnership called Modality, or a looser aggregation of GPs in central and east Birmingham, with an organisation called Our Health Partnership, which covers about 280,000 patients. The trust in Wolverhampton is now running 11 of the GP practices in the area, and as a result it has redesigned the hand-offs between primary care and hospital services and says that it has cut emergency admissions for those 52,000 patients by up to 20%. So it is a mixed model.

Lord Ribeiro: Again, your mantra has been “let a thousand flowers bloom”, and no one size fits all. How are you going to achieve the leadership to see this happening? That question about the lack of leadership was raised early on. It should not come from the top. Who is going to drive this at ground level?

Simon Stevens: I would not say a thousand flowers; I would say horses for courses. That is an important distinction, because I think it will be fewer than a thousand, and some of them will not turn out to be flowers. In the examples I have described, in the two GP groupings it is the GPs who are driving that, together with the community nurses. In the case of Wolverhampton, it is the trust. In some parts of the country, such as what we are doing in Greater Manchester, frankly it is the local authority that has given strong leadership to the changes we want to see. Without being anything other than supportive, there are some parts of the country where you would not want to place all your bets with one or other of those groups, whoever it happened to be. You have to back energy and leadership where you find it.

Baroness Redfern: Following up on Lord Willis’s question on the retention of nurses, to cut to the chase and going to agencies as such, do you think it is a lack of management? Are they going for pay, for more flexibility, or leaving the NHS because of poor career progression for managers?

Simon Stevens: I think it is a combination. We are reversing the tide. We are now seeing a substantial switchback.

Baroness Redfern: I understand that. I am trying to take the lumps out.

Simon Stevens: Absolutely. The question is what did not work and what is working now that is turning the tide. You have had individual hospitals that have been very rigid in the shifts they have offered staff; they have said, “You do this length of shift and here are your off-duties, like it or lump it”, and nurses are perfectly entitled to say, “Lump it”. Some of that has been happening. In some cases there has been a ratchet effect on the rates agencies are paying, and frankly some of that ratchet has been captured by the agencies themselves, which is why I have, somewhat demotically, described them as “ripping off the NHS”, which I think in many respects they have been. We can, in a sense, get the best of both worlds if we can offer more flexible opportunities and make sure the banks are working relative to agencies. We have made real strides on nursing. The next group we have to apply equivalent attention to is medical locums. We are still being exposed to very high charges for medical locums in many parts of the country, and the NHS has to exercise some collective downward pressure on the market clearing rate.

The Chairman: A quick question from Lord Scriven and Lord Warner.

Lord Scriven: Lord Willis's first question was about how to support a flexible and sustainable workforce for the future, 2030. Your whole answer has been about the NHS, which is understandable. The blurring of social care and NHS means that the workforce planning, delivery and funding is going to be very different. Can you share your thinking about how the planning, the delivery and the funding will be in this much more blurred workforce between social care and health? A lot of witnesses have said that it is going to be absolutely key in looking at pathways of care and sustainability.

Simon Stevens: Yes, absolutely. We would have to say that the NHS focused planning for nursing numbers, for example, has probably not served the social care sector well. I do not know whether this is something you discussed when HEE were here, but I think it would accept that its gaze or remit needs to be more all-encompassing to deal with the total demand for nurses. On the discussion we have just had, as you know we obviously have more budget pooling between health and social care in Sheffield than we have in many other parts of the country. In places such as Tameside, Greater Manchester, social care staff have been transferred over to the employment of the hospital.

Lord Scriven: I am sorry; I do not want to cut you off. Strategically, what will have to change, rather than these pockets, in the planning and delivery of a unified workforce? What will have to happen or change in the national leadership, or the NHS leadership, to get these good practices being delivered elsewhere?

Simon Stevens: The two principal workforce groups for social care, by number anyway, are care assistants and nurses. It will be important that HEE, in thinking about the future requirement for nurses, factors in the requirement from the care sector. In the case of care assistants, as I said earlier, I think it is vital that we create these new career ladders so that people can, through apprenticeships, have training on the job, and become either nursing associates or, in due time, full graduate nurses. That will help with the recruitment or retention of well-motivated care assistants in the care sector.

Lord Warner: We had some very powerful evidence from Terence Stephenson from the GMC about the rigidities in professional regulation and the extent to which that was stopping them progressing the handing down of duties to physician assistants of some kind or the other, pointing to the fact they could only operate within statute and that the statute was from 1983; it was very out of date. How do you, as a user of a product of that system, see this as a barrier to doing the kinds of things you want to do in the NHS in skills mix terms?

Simon Stevens: There is a case, obviously, for legislation to clear the path for this, and I know that a Bill will be before you and the House of Commons at some point when time permits. What we must not do is use that as an excuse for not making some of the other changes that we know are needed right now. I can give you two very practical examples of things we have to do over the next several years. The first is that in beefing up general practice we want to put about 1,500 clinical

pharmacists alongside GPs to do medication reviews and run their own clinics. We are going to fund those directly, and we are in this fortunate position on some estimates of even having a surplus availability of pharmacists. That will produce a skills mix change in primary care. Similarly, as we want to expand access to mental health services, we are looking for

another 3,000 mental health therapists who we want embedded in general practice. That will be quite a big shift in the skills mix in primary care, alongside core GP-ing. Yes, there is a regulatory element to this, but I do not believe that is the principal driver or inhibitor of change.

The Chairman: When you talk about physicians' assistants, there is no regulation, from the GMC point of view, because if they are not doctors, anybody can train them. The hospitals can train them.

Simon Stevens: I think the question is how they will be regulated in their subsequent clinical practice, and that is an issue the HCPC has been looking at, among others.

Lord Warner: There is a safety issue, I think

Baroness Blackstone: Is there a regulatory element in relation to the deployment of nurses? Subsequent to the Francis report, there is now a huge emphasis in hospital trusts on safe nursing, which I think makes it much more difficult for inventive and innovatory thinking about the use of healthcare assistants doing some of the work that is currently done by nurses which they could easily do?

Simon Stevens: I think this was a necessary correction to what had been discovered to be the case in Mid Staffordshire. You can argue that at a time when the health service is under pressure it is good to have some sort of countervailing backing in the system to ensure that we continue to ensure that staffing levels are appropriate. That is obviously one of the things the CQC is also involved in looking at. That said, not every hospital is as creative and brilliant as Great Ormond Street. Where there are institutions that are capable of exercising that sort of flexibility, obviously it would be good to enable that to come about.

The Chairman: You could get a job in diplomacy.

Baroness Blackstone: I was thinking that.

Lord Kakkar: To come back on this regulation question, if you look at the totality of professional regulation systems of finance and so on, do you think that regulation increasing at this pace and complexity will impact longer-term sustainability?

Simon Stevens: My starting assumption is that most staff working in the health service do a good job and want to do a good job, so the question is how we support them to get that right as against a sort of rear-view mirror assessment and then going around administering beatings with a stick. We need as much emphasis on improvement support as we do on the transparency and the core safety measures. That said—and this is an imperfect example—when I fly on a plane I am pleased that the CAA has made sure that the engines are being maintained and that a basic level of safety in aviation is hardwired into the system. All the lessons from

aviation are that that by itself is not what produces a safety culture and the kind of improvement that we want. I think it is about how you calibrate it correctly so there are minimum levels of safety and quality through the system, but you do not rely on that as your principal method for driving improvement.

Q281 **Bishop of Carlisle:** I would like to return to the whole issue of social care, if I may. You have mentioned it several times and we know how important you feel it is. We are also aware of the huge pressure that a lack of a proper settlement for social care is placing on the NHS. According to recent press reports at any rate, that seems to be getting worse rather than better with the closure of many care homes. You said right at the beginning that social care is perhaps one of the things that is under our control, rather than not under our control.

I would like to ask two questions. The first has to do with the integration of health and social care. Almost all our witnesses have said that they see this as important. We have heard about particular areas where it is improving, but what do you think are the main obstacles overall at the moment to that happening? The second question has to do with the funding. You talked a moment ago about places where there is more budget pooling. Do you have any ideas for an alternative funding model for social care? You mentioned earlier all the different ways in which social care is funded. Is there something that would be more effective that would enable the longer-term sustainability both of the NHS and of social care? That is rather a convoluted question.

Simon Stevens: No, it is very apposite and timely. If you go back to where we began, thinking about the big things the NHS has to get right, my position has been that rather than what I have described as a triple fragmentation we need a triple integration, and the triple integration is between primary care and hospital specialist services; between physical and mental health services and between health and social care. However, there are various blind alleys and false paths on offer in the health-social care integration debate.

To cut to the chase, in my opinion anyway, there are three sets of things that it would be sensible to do ranging out in time. First, I am not making a new statement, but as you know I have previously said that if there were to be any extra money available any time soon, social care should be at the front of the queue because it is quite obvious that the knock-on consequences of a deteriorating social care offer not only for vulnerable people but in hospitals are now unarguable. You do not have to redesign Beveridge to produce some immediate support for social care services. That would be the first step.

Secondly, there are things that we ought to do to integrate health and social care locally, but those solutions are best designed between consenting adults locally rather than mandated nationally, because the relationships and the right way of doing it will differ between Plymouth and Sheffield or any other part of the country you may care to mention. We have to distinguish the budget pooling from the integration of the way care is delivered. In particular, I do not believe that the simple act of pooling budgets is in itself sufficient to ensure that there is enough

funding on either side of the equation. I think I said on my first day back in this job nearly three years ago that simply putting together two leaky buckets does not produce a watertight care solution.

There is a set of things that can be done practically in Salford, Plymouth, Sheffield and Tameside on the health and social care integration front, but I do not think that is the whole answer.

The third of the steps, it seems to me, is that we need to think more broadly about public funding streams for older people, for retirees, in this country. We need to go beyond just thinking about health and social care funding and think about what is happening in the benefits system, the pension system and so forth. Obviously, we have a triple lock until 2020, which is three different ways in which people's pensions go up. A new way of thinking about that would be a triple guarantee for old people in this country that would be a guarantee of income, housing and care. I do not think you can think about any one of those in isolation from the other two.

Bishop of Carlisle: That is very helpful, thank you. Who do you think should be acting on this? Is it a political thing or is it something that NHS England should do?

Simon Stevens: No. It is clearly a matter for government and for Parliament.

Bishop of Carlisle: Thank you very much.

The Chairman: What about funding models for social care? That was one of the questions that the Lord Bishop asked. Do you have any comments on a possible funding model?

Simon Stevens: As we said briefly earlier on, we have a mixed funding model as between support from public sources, support from individuals and support from the NHS. I am hesitant at this point, surrounded by Lord Lipsey, whose explosive intervention blew up the Sutherland royal commission, and Lord Warner of Dilnot fame. Obviously the expertise is represented on your side of the table rather than on mine. When you look at the experience of other countries, you can see that if we are looking for some form of insurance model it needs to be some form of social insurance model or mandatory long-term care coverage, because I think you get market failure in private insurance markets for long-term care. The experience of the Germans, the Dutch and the Japanese all points in that direction.

Lord Warner: Can I ask about this business of bringing money to the party from the social care side, so that I understand where you are coming from? I do not disagree with any of your analysis. The trouble is that, at the moment, the policy for integration of health and social care seems to work on an assumption that a certain amount of money can be put into the pot by the local authorities, so they have to come to the party with a couple of bottles themselves, while the approaches you are suggesting to the triple lock leaves them out of the party because it is asking the users to come to the party with a couple of bottles, is it not? They are going to buy more of this care themselves. Does it cause you problems in running an integrated health and care system if the money is

shifted more to direct provision by the users of the service than by the local authority?

Simon Stevens: I am not arguing that there should be any diminution in the public contribution in aggregate to social care; I am simply saying that you cannot, over the medium term, answer the social care financing question separately from the pensions question, the benefits question, the equity release from housing question, given intergenerational fairness issues and the fungibility of funding streams between different elements of the public purse. I think everybody should be contributing to the fruit punch.

Lord Mawhinney: I hope you will forgive me if I say that I am still a little confused. We turn on the media and hear that social care is in big trouble, it is at a tipping point, the numbers of beds is down, it cannot afford to pay their staff, companies are going out of business, and the rest of it. You told us a little while ago about three big steps, which I think you mentioned three years ago, that needed to be addressed. We had five funding streams for social care in total, manifestly not addressing the issues either from the NHS point of view or, more importantly, from the elderly care point of view. Then you helped us to understand that we have to do this; we have to get into triple locks and we have to get political agreement to change the concept of triple locks. How much time do you think there is before even you and your colleagues will say, "My goodness, there is a real crisis"?

Simon Stevens: Thank you for giving me the opportunity to clarify. I believe that action is needed now, which is what I meant when I said that we could put support into social care that does not require all the complicated stuff involved in redesigning Beveridge. Secondly, there are things that the NHS, with its partners in local government, should be doing over the next several years. Thirdly, post-2020, there is a debate to be had by the parties, by government, about this broader redesign of the financial support for people in old age. I think they are complementary, but there is an immediacy, as you say.

Lord Mawhinney: Will we still be able to sustain a viable, social care model when some of the big issues will not even start to be addressed until some time in the 2020s?

Simon Stevens: As I say, I think there is a very strong case for some immediate support now.

Lord Lipsey: I will try not to explode again, but we are in danger of getting into the same thing that caused the explosion in the royal commission. There are important issues about how you help people to pay for their social care. There are insurance models. There is my favourite, which is the adapted Dilnot model, and some people still want free care, but that has gone. Surely the most immediate, and now crisis-level, problem is that there is not enough social care. You have 26% fewer people living at home supported by local authority carers, you have 5,000 care home beds already lost in the last year and many more under threat, so you have to put people up in your hospitals more and more because there is nowhere else to go. Is that not the priority crisis that faces us over the next few years?

Simon Stevens: Yes, it is.

Lord Willis of Knaresborough: One area that we have not mentioned but which is very pertinent to the issue that you have just been discussing is this whole issue of the digital revolution and how that will assist in maintaining quality of care without always having to have physical interventions; in other words, encouraging more people to do that but with the security of being remotely accessed by secure databases. Where is that on your agenda for action? I would have thought that is something central that we need to develop. I was in St Mary's last week looking at its patient records system, which totally wipes out the need for paper within the system but more importantly can give patients there, and indeed when they go home through their GPs, the same sort of care that they would get in the most sophisticated facility. Where are we with all that?

Simon Stevens: I agree with you. We have a number of care homes across the country, as part of our Vanguard programme, doing exactly as you describe. Probably the most famous is the work being done with care homes in Airedale, but if you go to Gateshead you can see that the extra support that has been put into care homes there has reduced emergency admissions to hospital by around 14%. Sutton in south London is the same. We think there is a big opportunity not just to improve the support that people in care homes are getting from the NHS but to link that up to telemonitoring, which we want to try to layer into large parts of the care home sector over the next several years.

Q282 **Lord McColl of Dulwich:** My question is about preventive medicine and public health. We are in the middle of the worst epidemic for 97 years, the obesity epidemic, which as you know is causing huge increases in diabetes, dementia, heart disease, joint disease, cirrhosis of the liver, and so on. The Department of Health's contribution to this was to persistently maintain that all the calories we eat be expended on exercise, which is totally untrue. How can we get meaningful change in public health and prevention that will have a long-term effect? What is preventing progress in shifting the system towards a more preventive model?

Simon Stevens: I agree with your analysis about the importance of obesity. Perhaps before getting into that we can take a brief victory lap on improvements that we have seen on cardiovascular disease over the course of the last 20 or 30 years. I think people in this country would find it remarkable to hear that we have had a 44% reduction in premature deaths from cardiovascular disease over the course of the last decade, some of which of course is the result of reduced smoking rates. One of the unnoticed but most significant data points that has been published in the last few weeks is the fact that adult smoking in this country has fallen by 1 million in five years; it is down from 8 million to 7 million. That, combined with improved secondary prevention in general practice across the developed world, has meant that we have seen these massive reductions in heart attacks and strokes. That is the good news.

Set against that is the fact, as you rightly say, that we have this significant new health threat in the form of obesity, starting with childhood obesity. The well-known figure now is that when one in 10

children start primary school they are obese, and one in five children when they leave primary school are obese. Something is not working properly for our children during those early years. Obviously there is a whole set of things that we need to get right to tackle that. Some of them are things that require a regulatory response, and the Government's affirmation that they are intending to move forward with a sugar levy to drive reformulation in the soft drinks sector is welcome, together with the fact that they have set a 20% target reduction for childhood obesity, and if it becomes apparent that we are not on track for that it will be unarguable that a wider range of actions are needed.

Lord McColl of Dulwich: Children who are fed on whole milk for the first six years of their lives do not get obese. I do not know what all this skimming is about, but certainly they have not yet tried to skim human breast milk because it has the same quantity of fat as cow's milk. We have a big, big problem with diet. The trouble is that the advice of the Department of Health and NICE is still persisting in the press and the media; they are still talking about diet and exercise, and exercise has very little to do with it. It is good for other things, for the heart and liver, and so on, but not for reducing obesity.

Simon Stevens: My reading of the evidence is the same as yours, which is that it needs to be both. We are certainly not going to deal with the pressures of obesity simply by arguing for greater exercise; we have to change dietary intake. Of course, we have had some success in reformulation with salt over the last decade or so. We have taken 15% of added salt out of our food since 2000. That has contributed to the improved hypertension and cardiovascular risk profile of the population, and on one estimate has saved the NHS £1.5 billion. Dealing with some of these broader population health risks is a key part of the medium to long-term sustainability of the NHS.

Q283 **Lord Bradley:** Can I use the issue of prevention to raise further the issue of mental health? In your five-year forward view you recognised that the cost of not dealing with mental health was around £100 billion, if I remember rightly, which is the total budget of the NHS. You have mentioned some investment in therapists in primary care and the integration of physical and mental health. What progress do you hope to make in the current five-year view to rebalance the spend between physical and mental health? In your next projection, how do you see the move towards parity of esteem between mental and physical health? What levers do you think you can apply to ensure proper integration of physical and mental health for the long-term sustainability of healthcare around the individual?

Simon Stevens: We will not have sorted everything out in mental health services by 2020—we have to be completely frank about that—but we do want to have made some very tangible steps in dealing with some of the obvious service gaps that exist. We have, for the first time, introduced two waiting time standards into mental health services, 25 years after we first layered them in on physical health services. We have set out a very clear implementation plan for the next four years for key services that we want to see improvement on. To take three or four examples, on perinatal mental health services, we know that about 42,000 women a year, as a

result of having a baby, have a severe mental health episode, or psychotic episode. Of those 42,000 women about 12,000 are getting specialist perinatal mental health support on the NHS at the moment. We have set a highly tangible and measurable improvement goal that over the next four years all 42,000 women will be getting that support.

If you think about the fact that a number of patients in A&E departments have mental health-related problems, we know that we need to ensure community crisis response services in every part of the country, and in A&E departments to ensure that there are full liaison psychiatry services. At the moment, 8% of our A&E departments have core 24 liaison psychiatry, the full team, seven days a week. Given the workforce and the funding, we can get that to about 50% by 2020. I could go on with a whole range of very specific things. Rather than having a philosophical debate about this, which has helped to animate the argument—I am not objecting to the philosophical debate—we now have to turn that into some very practical stuff and measure ourselves against it. We are publishing a dashboard for every part of the country to show whether we are or are not making that progress.

The Chairman: A quick question from Lord Scriven and Lord Kakkar, and then Lord Turnberg.

Lord Scriven: I have heard these words about moving from dealing with poor health to wellness and prevention for so long; I was a manager a few years after you on the same scheme. You said in July 2016 in the *Telegraph* that to move from poor health to wellness will require bold and broad reforms. What are those bold and broad reforms, particularly in the NHS when at the moment all management action is about plugging the deficit in the acute sector, and that is where the focus is? How are we going to raise the bar so that it stops being words and we achieve it for the long-term sustainability of the NHS? What are the three key planks that you are going to put in place to make sure this happens?

Simon Stevens: One of our first responsibilities is to our own staff. The NHS has not traditionally been a terribly good employer when it comes to looking after the health of our front-line nurses, GPs and others. NHS England is now, for the first time, funding a GP occupational and mental health service across the country that will go live everywhere from January. We have introduced quite substantial funding incentives for every hospital and employer around workplace support for MSK-related injuries, stress and other conditions that individual members of staff are experiencing, and we are trying to change hospitals and move away from a situation where they are marketing outlets for junk food into places where we have a better array of healthier and affordable food options for visitors and patients as well as for our own staff. So the first of three key planks would be doing something about being a better employer when it comes to the health of our own workforce.

The second would be that in every part of the country, through the local development proposals, the STPs—the sustainability and transformation plans that have been developed—we are looking to drive a set of actions that go beyond what the NHS by itself does and in particular engage, with variable degrees of success, with a wider array of partners, including local government, about some of the other determinants of health in a

community, be it housing, schools or jobs. If you go, say, to the Manchester Health Academy in Wythenshawe you will find an academy school that is supported by Manchester City Council, with support for training for kids into disciplines that will get them into the NHS and the Manchester United Foundation, it is a health-promoting school. Those are the kinds of actions that are beginning to break out around the country on those broader, place-based determinants of health.

Thirdly, the key improvement has been the big improvement in life expectancy for people aged 65-plus since the mid-20th century, the 1950s, which has come about through improvements in secondary prevention managed through GPs from primary care services. All the action we take to strengthen the primary care services will also have this benefit.

Lord Scriven: That is all very well and good. I do not feel there is any strategic leadership in moving from what is predominantly an acute care system to a preventive system. What role are you, in NHS England, going to take that is different from the last 40 years to change how funds move within the system? That is not happening. Strategically, for the long-term sustainability of the NHS, it has to happen. It is one of the blockages. What planning is needed, and what needs to change?

Simon Stevens: I do not know whether you have had evidence from Duncan Selbie from Public Health England, but obviously PHE is the national agency driving exactly what you describe. The NHS contribution often, in a sense, goes beyond our narrow remit. I often make the point that the "H" in NHS is health, not healthcare. For example, we are going to be funding work with the local authorities across the West Midlands to improve mental health support into small and medium-sized businesses to prove the proposition that when you do that you get some savings on the £100 billion you were talking about as the cost of mental health. Those are the kinds of practical actions that are taking place.

Lord Kakkar: Do you believe that the mechanisms exist, potentially through the STPs, to incorporate the kinds of interventions that Public Health England and others might identify on a population basis to drive forward that health agenda?

Simon Stevens: I do not want to be Panglossian about it. Clearly, this is at the early stages of trying to bring more coherence and system leadership rather than that of individual institutions in different parts of the country. We are taking some action nationally. Again, to give you a concrete example, NHS England has chosen to fund a diabetes prevention programme for the country as a whole based on the fact that back in 2002 a well-validated RCT in the *New England Journal of Medicine* showed that lifestyle and behavioural interventions could reduce your risk of getting type 2 diabetes by up to 58%. If that was a new medicine, the pharma industry would be making sure that doctors in every industrialised country were prescribing that left, right and centre, but it was a behavioural intervention and, as a result, it went nowhere. We have taken the decision that we will fund that, run a procurement on that and 100,000 people a year are going to be getting that support. Where we see these kinds of well-validated examples that we can drive nationally, we do

that. Where it requires the kinds of local partnerships that you are describing at STP level or local authorities, we will attempt that as well.

Q284 Lord Turnberg: We were chatting about this question a little before, but every witness we have seen, and you too, has spoken about the need for devolution and the need for integration of NHS and social care. Greater Manchester is the example everyone cites. How generalisable is that? We have heard witnesses say that it is not. What are the problems that we have to overcome if we are going to spread that sort of thing, presuming it becomes successful?

Simon Stevens: I think it will be only partly generalisable, so I do not believe that it represents the new model for England. This goes back, in a sense, to our horses for courses conversation. I think there are some specific circumstances about Greater Manchester itself, about the relationships that have been able to develop and about the changes that are required. Who knows in a decade's time? Over the next three or four years I see only a minority of the country that have the prior conditions that were in place for Greater Manchester, but recognising that they were there I therefore enthusiastically backed what they are trying to do. Howard Bernstein, the outgoing chief executive of Manchester City Council, and I co-chaired the Greater Manchester Partnership Board to get this up and running over the last 18 months.

Q285 Baroness Blackstone: As a preamble to my question, some of the witnesses we have seen have said that the centre is too big and too top-down. You sit at the centre. People talk about 4,000 staff in NHS England and, "What the hell are they all doing?" What is your response to that?

Simon Stevens: It is severalfold. We have taken about 50% out of the costs of running the administrative part of the National Health Service over the last five years. By the standards of any other country, our administrative costs are very modest. However, I do not think that in itself invalidates your point. Our approach will be to lay out for each of the 44 geographies the people who are potentially available to work in their area on this other stuff, and then give them the opportunity to redeploy them on to the things that we know we need to sort out. We want to sort out early diagnosis in cancer services; we know that we want to implement the new ways of providing mental health services, as we discussed. Some of those folks need to be redeployed on to that task. Rather than a new, big bang, top-down reorganisation, which I think would have most people in the health service jumping off a cliff, we are trying to do this organically.

Baroness Blackstone: You are saying that you should focus more on the things that can be done only at the centre and do fewer things that can be done elsewhere. Is that how I should interpret what you have said?

Simon Stevens: Obviously we have been bequeathed a set of elaborate superstructure arrangements by Parliament, for which we are grateful. My basic approach here has been that collectively we should act as if the system makes sense, and then it is more likely to.

Baroness Blackstone: Applying that, what single plea should this Committee make in its report that would support you in your role as chief

executive of NHS England on health and social care?

Simon Stevens: I very much appreciate the offer. I am going to decline to answer that if I may, because I know that has been a favourite question for all your witnesses. You have had such an array of evidence, including the fantastic discussion that we have had this morning, that to single out one thing would be not to do justice to the breadth of the conversation.

Baroness Blackstone: Very well.

The Chairman: I think we have given you a run for your money, so to speak.

Simon Stevens: Might I make one, final, historical observation, which I think is interesting, given all the debate about the fact that the NHS is said to be under huge pressure, and all the rest of it? I would like to read you a statement, if I could, from Rudolf Klein, who I think is one of the finest commenters on the National Health Service. He said: "Since its creation, the National Health Service has been in a permanent state of crisis. In the 1950s there was the drama of overspending, culminating in Bevan's resignation. In the 1960s, there was the drama of confrontation with the general practitioners. In the 1970s, the drama of confrontation with just about everybody: nurses, ward orderlies and consultants. In the 1980s, the drama of impending collapse, with large numbers of the healthcare professions abandoning the wards and operating rooms to take to the television studios to prophesy that the day of reckoning is fast approaching. The longest deathbed scene in British institutional history appears to be nearing its climax. The next instalment of the series may, who knows, even be the last?"

That was written 33 years ago. I think it is important to put one's deliberations in the historical context here. I believe that the health service has been serving the people of this country well for 70 years. I think it is getting increasingly good, it is entirely affordable and it is a net asset for the country as a whole. Thank you very much.

The Chairman: Left with the current funding model and the current way of developing it, it will be sustainable? Or if that changes?

Simon Stevens: Parliament had its first debate about the sustainability of the National Health Service in 1951 when we were spending 3% of our GDP on it.

The Chairman: Thank you for that. Thank you, Simon.

Simon Stevens: Thank you.

House of Commons Health Select Committee – Oral evidence (QQ 286-291)

Evidence Session No. 31 Heard in Public Questions 286 - 291

Tuesday 13 December 2016

Watch [the](#) meeting

Members present: Lord Patel (Chairman); Bishop of Carlisle; Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witness

Dr Sarah Wollaston MP, Chair, House of Commons Health Select Committee

Q286 The Chairman: Good morning, Sarah. Having watched last Thursday's "Question Time", which you were subjected to, I am hoping that this is a better experience. On the other hand, we do not have a couple of the characters who were on that panel, although I will not name them. Thank you, Sarah, for coming. Your evidence is important to us because you have been involved on a weekly or daily basis sometimes in looking at the health service and, as we want to hear about, the current issues and how they can be made to make the NHS sustainable looking at 2025 to 2030 and beyond. It is that aspect that we want to hear from you. We know who you are, but this is a new experience for you sitting that side of the table.

Dr Sarah Wollaston: Indeed, it is very strange being on this side of the table.

The Chairman: If you do not mind, say who you are and, if you want to make an opening statement, please feel free to do so.

Dr Sarah Wollaston: I am Sarah Wollaston and I am currently Chair of the Health Select Committee. I have been the Member of Parliament for Totnes, which is in south Devon, since 2010. Prior to changing my initials from "GP" to "MP", I was a clinician in the NHS for 24 years and was also involved in education in that I was teaching and training junior doctors and medical students and was an examiner for the Royal College of GPs as well part time in primary care in Dartmoor.

The Chairman: Do you have an opening statement?

Dr Sarah Wollaston: No.

The Chairman: I will kick off then. I saw you were sitting there in the session with Simon Stevens and it is the same question: looking at 2030,

what does sustainable healthcare of 2030 look like and what do we have to do to get there? What do you think are the greatest threats to the long-term sustainability of the NHS and how will you overcome them?

Dr Sarah Wollaston: First, I think we need a more integrated health and social care system, but we should not look at this as an academic sort of exercise in administration. It matters that we integrate care around individuals, that we can better meet their needs and that we try to go further on reducing health inequality. That is the inequality not just in life expectancy but in disease-free life expectancy and, to do that, we have to go far further on prevention, which I know has also been a focus for this Committee. Underlying this, we need to resource it properly, and that represents, in my view, very good value for money and that the public really value our NHS, and rightly so. What we need to do is make sure that we think about it being both health and social care together. It is something we have been trying to do throughout the history of the NHS, but I think there is more we can do to make it a better system for people.

The Chairman: I see that you wrote a letter on 26 October to the Chancellor about your current concern. Is the concern that you highlight of the current status likely to continue?

Dr Sarah Wollaston: The issue that we wrote about was that we felt that perhaps the Government think they have given more to the health system than is really the case. What we have traditionally looked at is total health spending, so when the Government talk about spending an extra £10 billion on the NHS, what they are referring to is NHS England, not the totality of health spend, which also includes things such as prevention and Health Education England. Therefore, if you shift money from budgets, such as prevention and health education, into NHS England, you can artificially appear to be giving more.

Equally, if you change the baseline so that you include a six-year period rather than a five-year period and you adjust the data on which you calculate real-terms increases, then you can move from £4.5 billion to £10 billion, which is an altogether different figure. If you are thinking that you have invested £10 billion in the NHS, why would you feel that you should invest more? Therefore, I think it is very important that the Government are very clear in their use of data and understand that the scale of the increase of demand is quite extraordinary. If we have seen a 31% increase in the number of people living to 85 and beyond in the decade to 2015, that does not increase the costs of defence and not so much of the Home Office, but it leads to an extraordinary increase in demand for the health and care system. Of course, it is a fantastic thing and is a great success that we are living longer, but it requires much more planning and an understanding of the true costs of that if people are going to be able to live with dignity and as independently as possible.

Q287 **Lord Warner:** The Committee has had a lot of evidence to show, and the previous witness referred to this, that over the last 20 to 25 years there has been a huge lumpiness in the way money has been given to the NHS and, indeed, to social care, with very little synchronisation year on year between the money given to the NHS and the money given to social care. It has not been a happy history for the longer-term planning of using

whatever money is available in a sensible way. Has that been a feature in the work done by your Committee? What work has been undertaken on the way NHS finances have been handled? How confident are you that those systems and processes will produce a sustainable NHS in, say, 2030?

Dr Sarah Wollaston: Both this Committee and the last Committee have had a focus on social care and the balance between health and social care. I think you, Lord Warner, stated that we would not start from here if we are spending less than 1% of our GDP on social care. If you look now at where our population sits and the change in our demographic, that clearly is not meeting people's needs, and that is the point here. We now have more than a million people who have unmet care needs and we have many informal carers providing more than 50 hours a week of care with no support at all. The problem is that these people are now ending up in more expensive settings, where they do not want to be, receiving worse care, because if you do not need to be in secondary care in a hospital it is not the safest place for you to be.

This is creating huge costs, which is something the Committee has looked at and many others, of course. For example, I know that the National Audit Office has estimated a huge cost of, I think from memory, £820 million in delayed discharge costs. We are seeing all the other markers of stress in the system, be that increased waiting times in A&E, increased waits to move from A&E after a decision to admit into secondary care or delayed discharges through the system. Overarching that, if you step aside from the figures, there is the amount of personal distress it causes to individuals and their families when their care needs are not met, so it is of great concern. I think we have the balance wrong, which needs to be addressed, and there is an issue with underfunding now of the whole system.

Yes, there is much that the NHS could do to improve its efficiency. We have heard evidence that efficiencies in social care have reached the limit, the system is now cut to the bone, and there is very little room for further efficiencies in social care. Overall, this is a system in distress, so it is very welcome that this Committee is looking not just at what needs to be done immediately but the horizon-scanning up to 2030.

Lord Warner: What help can you give us on the views of your Committee on where additional sources of funding could come from for health and care?

Dr Sarah Wollaston: We took evidence from Kate Barker of the Barker commission, and of course there are a number of options on the table here about how this could be funded. My personal view, because I cannot speak for my Committee on this, is that our current system serves us very well and we have a very efficient system, which is publicly funded. The evidence that we heard in the last Committee from Kate Barker was that, if you move to having a system of private insurance, it ends up being topped up by the state for those who cannot afford to pay in any case, so how does that look different from a system where the insurance model is state-based? Personally, that is the system I think we should stick with, whether we go down a route which is more taxation or a route that more looks at how you build intergenerational fairness into the way

we fund it around national insurance, with which you will all be very familiar, and we have heard from other witnesses what those options are.

I also think that we need to look further at the opportunities we have to nudge behaviour change at the same time as raising money. The sugary drinks levy, I think, is a very good example of that where you can help to nudge behaviour change and a reformulation by manufacturers at the same time as raising money. As you heard from your previous witness, what needs to be there is transparency for the public so that, if this money is not being directly hypothecated, they can see that the intention is to spend it on health gains, because that commands public support. We know from polling that the public support increased funding and increased taxation if it is going to health and social care.

Lord Warner: So, as an elected politician, you would favour a move towards some form of hypothecation?

Dr Sarah Wollaston: The trouble with direct hypothecation is that as your economy moves up and down you can end up having these fluctuations, which you have already spoken of, Lord Warner. I think a very clear statement that this is the intent for it and that there will be a commitment to give this funding, in principle, to healthcare gives it greater public support, and they can see transparently where it is going.

Baroness Blackstone: Would you use national insurance payments for this purpose?

Dr Sarah Wollaston: Yes. Well, that was one of the suggestions, which has been that those over 40, who can afford to do so, should be paying more through their national insurance. Of course, the other suggestion was that those who are over pensionable age should continue to pay national insurance contributions. As I say, it would not be for me to say which model this Committee should adopt, but I certainly think that is a very interesting proposal and, as I say, some intergenerational fairness, I think, is important in this.

Lord Kakkar: To pursue this point of the lumpiness and the need to get a more consistent, long-term, five or 10-year settlement in terms of funding for the NHS and social care, do you think, sitting in the House of Commons, that it would be possible to achieve that kind of political consensus? Is there a will for that in such a way that this could be deliverable?

Dr Sarah Wollaston: I cannot tell you how depressing I find it sitting in the Commons Chamber and hearing the kind of yah-boo politics over this issue. I personally think that we need to do the same with health and social care as was eventually done over pensions: an acceptance that the scale of this is so great and it will be a challenge for whoever is in power, so it is in the interests of all political parties to get together and have a mature discussion about how we fund this so that it does not become such a political football. I personally feel that this is the right time in the electoral cycle for that to happen because the closer you get to an election the more difficult that becomes.

Bishop of Carlisle: Can I clarify what you were saying earlier? A number of our witnesses have said that the integration of health and social care

would greatly improve the quality of care for individuals, but would not save much money in the long term, just redistribute it. I got the impression from what you were saying before that you think it could save quite a lot of money as well.

Dr Sarah Wollaston: I think it is a good thing. Of course integration can identify unmet need, so it does not necessarily save you money, but it can help to identify individuals whose needs you are not currently meeting. Also, I think you need to give it time because some of these measures will take time to deliver their results.

I would say that it is not just about pooling the budget; it is about people working together and remembering the purpose. Sometimes, you can have a joined-up system, but unless it feels joined-up to the person receiving it, it is pretty pointless. What matters to individuals, for example, is that they have a single point of contact, that they do not have to keep telling their story over and over again and that they have more control over their records and who shares those records. There are lots of different ways to talk about integration, but as long as you remember that it is about the individual rather than the system I think you get a more effective response. It is about relationships and allowing people across health and social care to develop those joint relationships. Sometimes, putting people physically in the same building can make a difference, but if you think that joining up the budgets on its own is going to do the trick, I do not think so; it is about a change of culture and practice as well.

Lord Willis of Knaresborough: Most witnesses have described local government as being very close to the social care issue because that is one of their prime jobs, looking after the vulnerable within their community. What we are seeing is that the 2% has not been applied by all authorities and, despite all the *cris de coeur* that we see in the media, local authority balances have started to increase in many cases. The question I would like to ask you is: should we not put a greater level of responsibility on local government to increase their ability to raise a precept up to, say, 5% to achieve a significant amount of new income into the system directly responsible to the people who are going to gain from it? Surely that is the way rather than looking to central government all the time to provide funding. If you agree with that premise, what are the pitfalls?

Dr Sarah Wollaston: One of the pitfalls immediately is the wealth of your local area. If you are in a relatively wealthy area, then it is easier for you to raise money from the precept, but, within that area, you will have a higher proportion of people who are self-funders in any case. If you are a local authority in a very deprived area, a much higher proportion of your population will have care needs that they are not funding themselves, yet your ability to raise funding will be less through that system. Yes, I would support, as a short-term measure, more flexibility to increase the precept, but I do not think that we should think of that as being the solution here, particularly for the most challenged local authorities, because it simply will not work for them and we will need something that will support the system through another mechanism, in my view.

Lord Willis of Knaresborough: We had the same argument over business rates, which are collected and rebalanced. Surely we have to look imaginatively at how we involve local politicians and local communities in raising the revenue to support their people rather than saying, "This will not work"?

Dr Sarah Wollaston: Yes, I absolutely support the principle that some of this is raised locally, but, as I say, unless you have a redistribution mechanism of some sort, you will find that the people with the most severe needs will be left behind. That is my concern.

Q288 **Baroness Blackstone:** We have heard a lot of evidence of the pressures on the workforce in health and social care, whether it be too much bureaucracy and regulation, skill shortages that are not met or a failure to change the nature of the skills mix. Could you say something about where you think the main pressures are coming from?

Dr Sarah Wollaston: Certainly, having workforce shortfalls increases pressure, and not just shortfalls in the NHS but in social care as well, and that is very serious. I think you are absolutely right about the skills mix. When I look back to when I started as a doctor in 1986, at that time there was very little, relative to today, that nursing staff were doing. They were not putting in intravenous lines, very few of them were taking blood or administering intravenous drugs or changing ventilator settings. All of that is now part of the skillset of nursing staff, and that is absolutely the direction that we will need to continue to travel in. If we are going to meet workforce needs in primary care, for example, we will not do it all through general practitioners; we will need to bring in many more specialist nursing skills, community pharmacist skills, physician associates, physiotherapists and mental healthcare workers. I think the primary care of tomorrow will look very different from the primary care of today, just as practice now is very different from how it was 20 years ago. What we need to do, however, is train that workforce. It is not only about recruiting them but about the ongoing, continuing professional development that you give people that allows them to feel valued and retained within the service.

I think there is a huge amount that we should be doing, and regulation, of course, is part of it. It is of great regret that the draft Law Commission Bill on the regulation of healthcare professionals was not taken forward; it would have been an ideal opportunity to have done that at the end of the last Parliament. We have a very inflexible system. We are training up, for example, a number of physician assistants to work in primary care, and this is an unregistered, unregulated workforce. That makes it more difficult for them to be employed because of the issue of insurance, so we may be letting these people down; there may be a lot of people being trained for roles in which it is very complex to be able to employ them. The Government absolutely need to get on and sort out the regulation rather than doing this in a piecemeal fashion. They need to allow more flexibility for the system to adapt and respond to the new workforce.

Baroness Blackstone: Do we also need better workforce planning?

Dr Sarah Wollaston: Yes.

Baroness Blackstone: How will we get that?

Dr Sarah Wollaston: Obviously, the system we have now looks as if it may be more promising, having a sort of overarching body in Health Education England, though it is very unfortunate that it has had its budget cut in real terms. Also, there are a lot of things on the horizon which will be difficult to plan for in the sense that we do not know what the effect of Brexit will be. I think it should be an early and first priority of the negotiations to sort out the status of EU nationals in the UK, as well as UK nationals in the wider EU, because of the impact on our workforce, so that is an unknown.

There is also the change away from the bursary system. I can see the principle of that in allowing more places for people to train, but we do not yet know how many people who currently choose to train not just in nursing, but as radiographers, speech therapists and so forth—the wider workforce—would choose a different degree as a result of the loss of bursaries. There are a lot of uncertainties ahead and it is very difficult to have a system that plans accurately for that, but it does need to have the flexibility to adapt rapidly if it can be seen that recruitment is suffering as a result of those changes.

The Chairman: From the inquiries of your Committee, does it give you confidence that there is some forward thinking done by anybody of this nature?

Dr Sarah Wollaston: There is some forward advice and thinking, but, as I say, there are a lot of unknowns and uncertainties in our future workforce. We need to be as flexible as possible to respond where there are problems. The system that we currently have with regulation is an example of something that is totally, woefully inflexible to deal with having a future workforce. However, there are some things I feel very hopeful about—for example, as we heard earlier, allowing people who are currently working as healthcare assistants to progress through into nursing. If you look at the Cavendish review, for example, looking at the problem in the healthcare assistant workforce, both within hospitals and social care, there is a very high turnover in social care which is not just about low pay but about the lack of opportunities. In some areas, there is around a 40% or 50% turnover in the care sector. Allowing people to have opportunities to see that as a career and move all the way through into being assistant practitioners and nursing associates and on into degree nursing through the apprenticeship route, I think, is absolutely fantastic. That is an example of the system being responsive to needs, so I do not think this is altogether a story of failure, but there needs to be much more flexibility.

Lord Warner: You mentioned Brexit, but we have been lacking in self-sufficiency in health and care staff for a very long period, and we still have a position where 40% of the care staff in London come from overseas and 40% of the surgical specialists are trained overseas. Is it a delusion that we can become self-sufficient, or will we always, not just with Brexit, have to have an immigration system that allows us to recruit people from abroad, certainly in the period up to 2030?

Dr Sarah Wollaston: Personally, I think we benefit from having a mixed workforce, we benefit from understanding about other people's systems and our health professionals benefit from being able to work abroad as well. I ought to declare a slight personal conflict in that my daughter is currently working in Australia for a year, so I ought to make that clear. When she returns next year, she will not only be good at dealing with snake bites but there are all sorts of things that you bring from that experience of working abroad, so I think we should welcome all of those staff. When we think about the care system in particular, 80,000 of the 1.3 million social care workers are born in other countries in the EU. Our system would absolutely collapse if we did not allow and encourage people to move flexibly, so I think, as I say, it should be a very early priority of negotiations to protect and value this workforce.

Lord Warner: But it is not just Brexit?

Dr Sarah Wollaston: No.

Lord Warner: This is a wider issue than just the EU, is it not?

Dr Sarah Wollaston: A wider issue, yes, I think so, but I personally think that it is a benefit. If we have an attitude that says that only home-grown doctors are good enough, I think the NHS will be missing out on understanding about a wider global perspective of health and care.

Lord Ribeiro: From a large section of doctors at the Southend Medical and Dental Society on Thursday, I got a real sense of disempowerment. They feel, as a workforce, that they do not have control of their lives and that maybe that is because of the structure of management. One of the things that has happened is that if you go around Europe or the United States you will find medically qualified chief executives. I think probably the last medically qualified chief executive we had was Jonathan Michael at Oxford. Is there something about the career structure that needs to change? Do we need to encourage more doctors to think about management as opposed to just clinical practice?

Dr Sarah Wollaston: Yes, that is absolutely true; we should give people experience of management within their training. Keogh's clinical fellow scheme is an example of a good scheme that allows people in their training to have time out to do that. Also, as people get towards the end of their careers, rather than retiring, encouraging people to be retaining their skills within the system, within management and training is a very positive thing. There is much more we could learn from other systems about morale more generally and how other systems maintain that. We are not very good, for example, at allowing clinicians across clinical boundaries to work in the same hospital as their partners, which has a huge impact on morale. I think there is much more we could do to support health professionals to feel valued and want to continue in the NHS.

Lord Ribeiro: Do you see this getting worse as the gender mix of the health service changes?

Dr Sarah Wollaston: I heard earlier about the criticism that a lot of female GPs work part time, but, in essence, many of them work part time while their families are very young, but then, as I did, come back in and

do other roles. If you are teaching and training part time and working part time as a clinician, it does not necessarily mean that the system loses you altogether, but you may be coming in in a mixed role and spending five or 10 years when you are not working so many hours. As I say, that also adds something when you come back perhaps with a more mixed skillset.

Lord Scriven: Sarah, you started by giving a very nice description of integration around the individual and, clearly, there is a lot of talk within both health and social care about that. I am getting the feeling from workforce planning that the NHS is doing its thing and local government in social care is doing its own thing. Has your Committee come across any place-based approach to workforce planning and integration of staff? If not, do you think that this is something that will need to be seriously thought about and implemented to bring about a more seamless system of both planning and implementation of service to individuals?

Dr Sarah Wollaston: I think it is patchy, so some areas are doing better than others, but there needs to be a complete refocus on this. If, for example, you put an advert out for somebody to be a healthcare assistant within a hospital, you will be flooded with applicants; if you do that within a social care setting in the community, you will not, so is there a way that we can make it so that people can rotate through? How can we make sure that, during people's training, they get more exposure within community settings? That is not just for nursing staff but also for medical practitioners and pharmacists. The trouble is that people do not think "community" when they are going through their training—the status seems to be all about being in a hospital—but, in fact, what we need is a rebalance. Because of our changing demographic, we need to rebalance and think about what people's needs are for the community. In order to get people thinking about community settings when they are qualified, they need to have sufficient exposure to that during their training, and that is not happening across the board, I am afraid.

Lord Scriven: Obviously, some of that will be local, but do you think there has to be any systematic change, either in training bodies or funding, to make this happen? A lot of people talk about things locally, but I am not clear as to who at the central level is driving that.

Dr Sarah Wollaston: To give you an example, through SIFT, the service increment for teaching, what percentage of that is paid to primary care for training as opposed to hospitals for training? We know that from the Health Education England budget of £5 billion, £3.5 billion goes directly to funding the salaries of staff and training. How can we change the way that resource is distributed so that more of it allows for training periods in primary care? How can we get bodies, such as the GMC, for example, to look at the curriculum so that there is more emphasis on primary care? This is where the need is, and 70% of everything we spend, we were told as a Committee, in the NHS is on long-term conditions and that will get greater as our demographic continues to change. We have the resourcing in the wrong place to cope with that demand. We are facing ever-more demand on primary care and the ability to cope is really stretched to the limit.

Q289 **Baroness Redfern:** How can we reduce the impact that pressures in the

social care system are having on the NHS? You have alluded to joined-up budgets not being an answer and you have mentioned the short-term increase in precepts for local authorities or looking at other mechanisms or the redistribution of mechanisms, as such. I wondered what your thoughts were on the reforms you would like to see to the funding for social care.

Dr Sarah Wollaston: I am not saying that we should not join up budgets, but we should not just think of it as being the solution in itself. I think it would help because, unfortunately, sometimes you can spend money in one part of the system and it creates savings for the other part, which is not much of an incentive. I am not saying that they are not part of it, but I think people think that just by joining them together you automatically get improvements, so I do not think that is the case. We need to do all of the above, in other words. We need to look at how we integrate around individuals, how we get individuals within the systems working together and how we integrate around individuals so that they have a single point of contact. There is a whole series of things that we need to do to get to where we want to be, even things, for example, such as the way we look at records. We still have a very paternalistic attitude to medical records, that they are all the property of the Secretary of State. I think we have to radically rethink that so that individuals have their own records or have full access to their own records and can decide who to share them with in every part of the system and how much of them they wish to share. They might wish to share, for example, just their drug history with their local community pharmacist, or they might wish all of it to be available to the out-of-hours care provider or to those who are looking after them in social care, so let us look at the way records can empower proper integration and self-care.

Baroness Redfern: So it is about confidence in that data sharing, as such.

Dr Sarah Wollaston: Of course, absolutely, and it needs to be within the power of individuals to say that they do not want certain people to be able to access their full records and how much of them they would like to share. To have a properly integrated system, record sharing is very much a part of that, if you are going to be able to have a system that works better to meet your needs and where you are not going to be constantly having to repeat your story at every turn and have the wrong records in your notes, for example, because, if you own and see your records, you will pretty soon spot if somebody has made an error.

Baroness Redfern: How do you think progress is being made on the integration of social and health care?

Dr Sarah Wollaston: I think the big challenge at the moment is funding. For example, the system in Torbay does very well in integrating health and social care, but the real limiting factor now that it is up against is funding. Because of that, we have seen that the Care Quality Commission has recently rated the prime provider of care within Torbay, which is Mears, as inadequate. That is due to a combination of things, such as understaffing, a very high turnover of staff, inadequate staff training—all these things. If you do not have sufficient funding within the systems, you have many staff vacancies, you have providers withdrawing from the

market and it makes it much more difficult for you to move towards a fully integrated health and care system. I think funding is essential, training the workforce is essential, as are joint working, shared records and an absolute focus on it being about individuals and how you wrap a system around them rather than just thinking of it as a sort of academic system issue.

Baroness Redfern: On the issue of funding, and I do not want to put you on the spot, do you think there should be a shift with more money coming to social care and less to the acute sector?

Dr Sarah Wollaston: I would not say less to the acute sector right now because they are already in a very significant deficit. Just saying, "We will move it from here" and giving them an even greater deficit would not be the answer. I think that the system, as a whole, is short of funding and that needs to be addressed. If there were extra money available right now, I think it should be prioritised for social care, which would benefit health as well because we are seeing so many people ending up in acute settings because of the problems in social care.

Baroness Redfern: There should probably be another step, intermediate care, in the middle of that so that we can get people out of the expensive acute beds and not necessarily going into care homes.

Dr Sarah Wollaston: Yes.

Baroness Redfern: As Simon Stevens said, to remove the lumps probably there should be a middle way.

Dr Sarah Wollaston: Absolutely, and the best bed is your own bed, if that is the right place to be. If there is the intermediate, yes, it is not just about those intermediate beds in the sense of being a step up so that you go there as an alternative to hospital; it is also about the step down as you come out when you might not be quite ready for home, but you have rehabilitation beds within the community that can get you ready for independent living again.

Lord Warner: I find it a bit curious, and I wonder if you do, that, under successive Governments, we have managed to run a system where we say that we are in favour of integrating health and social care, but we leave one Cabinet Minister responsible for health and the care policy, but we give another Cabinet Minister the responsibility for the money for social care. That is an interesting way of running things, but it sounds not likely to produce the results that you want in terms of integration over time, and all Governments have done that. Do you think that it is time to revisit that particular issue?

Dr Sarah Wollaston: Absolutely, I do, and it is at other levels of the system as well, so a single commissioner locally for healthcare and even, preferably, for housing as well because they are all part of the same, at Cabinet level, yes, to have health and social care within a single departmental responsibility and, if we look at prevention, because we need a radical upgrade on prevention, a Cabinet Minister responsible for looking at that. There is a Marmot agenda about it being the wider determinants of health, which is looking across government and joining up how we can improve prevention.

Lord Willis of Knaresborough: I would like to take you back to this issue of funding because simply putting a lump of money in at this moment in time to support social care, which I am not saying is not the right thing to do, by the way, does not resolve the problem. We are talking about sustainability and I want you to give a personal view on creating a sustainable funding stream for social care. Where does it come from?

Dr Sarah Wollaston: There is an issue about right now.

Lord Willis of Knaresborough: I accept that.

Dr Sarah Wollaston: We have so many markers of distress in the system, but I absolutely agree that you need to take the views of how we do this and not to have the sort of bumpy ride, feast and famine, that we have heard about. If you link it directly to being a percentage of GDP, that would not be the right way forward; we need the health and care system to know exactly what is coming down the line so that it is phased and not a very sudden increase.

Lord Willis of Knaresborough: Is it coming from direct tax? Are you going to put up taxes then?

Dr Sarah Wollaston: I personally think that we should use a public mechanism.

Lord Willis of Knaresborough: So we raise income tax.

Dr Sarah Wollaston: Either that or through national insurance, but I think you need a mechanism to bring more money into the system as a whole. It is not for me to tell you which would be the right mechanism, but I think that needs to be something with cross-party consensus about how we achieve that in the long term.

Q290 **Lord McColl of Dulwich:** Are we doing enough on prevention to ensure that the healthcare system will be sustainable over the long term? What do you think are the greatest barriers to progress on prevention?

Dr Sarah Wollaston: The answer is we are not doing enough. I think there are very good reasons for doing this. First, we save the system more down the line if we do it, but also it is about reducing inequalities. The Prime Minister, in the first paragraph of her first speech, talked about the burning injustice of the life expectancy inequality, but we also need to look at disease-free life expectancy. You are not only likely to die sooner if you are disadvantaged, but you are also likely to live more of your life with the burden of disease, and much of that is preventable, so we should be doing everything we can to look at that and to see it as a social justice issue as well.

I think the key barrier to this is political will, frankly, because sometimes it means making politically difficult choices. If you explain to people why you are making those choices and present it as a form of nudge, you are not telling people that they cannot do things, you are not banning things, but you are making it, at the point people are making decisions, easier to make a better choice. I think that the sugary drinks levy, for example, is an opportunity for that to happen, and it is of great regret that there is not a direction that it has to be passed on at the point of sale. Although it

will have an effect in helping to drive reformulation because of the different bands of the levy, there is no requirement to pass it on as a price differential. At the point that you choose a carbonated drink, if there is no difference in the price it is less likely to be effective, and we know that even small price differentials can make a huge difference. If you look at the plastic bag levy, for example, you can spend £100 on your shopping, but you will not spend 5p on that plastic bag. I think it is an example of how it does nudge people, because there is nothing to prevent you from buying the plastic bag, but there was an extraordinary change in behaviour and there was an over 80% drop in the sales of plastic bags. I think small price differentials can make a big difference, but they take political will. I think it is the political will to do it that is lacking and the Government need to get on and do it.

Particularly if you are taking money out of the public health system—and there have been real cuts, including in-year cuts, to public health—there is an even greater responsibility on the Government to give councils the levers to do things themselves. For example, you could choose to give local councils the ability to have health as a material consideration in the planning system or you could choose to make health a consideration in the licensing system, and I do not know why they do not just get on and do that, so there are lots of things the Government could do to make a difference and they should get on and do it, in my view.

Lord McColl of Dulwich: If you had a Minister for preventive medicine, would you see his role as trying to stop the vast amount of conflicting advice that has been given from the Government and from authorities, such as you must not have more than two eggs a week, which is quite wrong, or that doctors must not call patients “obese” because it is judgmental, although it is an accurate diagnosis? With this Minister you envisage, would he have some sort of control or direction?

Dr Sarah Wollaston: I would not necessarily think that it should be the Minister that should be telling people what to do because there is not a great deal of evidence-based thinking that goes on in the Government, as far as I can see, but I think certainly they should take advice. Of course, thinking does sometimes change over the years and we should update that advice when the evidence is there to update it.

Lord Warner: Would it surprise you, Sarah, to know that the officials in the Department of Health said that there has been no in-year cut to public health, so it is very interesting to have your testimony on that particular issue?

Dr Sarah Wollaston: It was an in-year cut when I looked at it.

Lord Warner: On the issue of funding for public health—and you mentioned the ability to slightly sneakily put money across to NHS England—is there a case for creating a more independent focus for public health and prevention? Who is really in charge of the nation’s health, and can truth be spoken to power in this particular area, which in many ways is a Cinderella service? Do we need something more robust that advises the Government about some of these issues and cannot just be shut up?

Dr Sarah Wollaston: One of the things that was welcome from the Health and Social Care Act was the shift of public health and to have the

responsibility primarily sitting within local authorities, because that is primarily where public health happens. Yes, there have been some caveats with that, but I think that that was the right thing to do to make that happen. Of course, local authorities have, in many cases, been imaginative about how they commission those services, thinking about what users want, so there are examples of services that look more user-friendly in the way they are delivered since they have been commissioned by local authorities. However, a lot of what they do is also what we would traditionally think of as front-line health services, such as sexual health and various other prevention services—for example, smoking cessation services. All these kinds of things and health visiting are now sitting within local authorities. If their budgets are being restricted and squeezed, the things that they have to provide as statutory services can continue, but it is the rest of it that is being very severely cut back in prevention services, such as weight management services and stop-smoking services. This, I think, is a real threat to making the changes we want to see going forward of having people leading healthier lives, and it is things around physical activity which, we know and I agree, independently of diet, are very important. All those kinds of services are being cut back, which is a great shame; it is very short-sighted.

Lord Warner: So we have a protection problem locally and nationally.

Dr Sarah Wollaston: I think it should be protected. The public health budget should be ring-fenced because, otherwise, as local authority budgets are squeezed, it is the things that are non-statutory that get cut, and we have heard in our Committee evidence that that is taking place.

Q291 **The Chairman:** Your Committee has taken lots of evidence over the years, and you have been Chair of the Committee for the last parliamentary Session and this one, so you have huge experience and knowledge about what is going right and what is going wrong. Let me ask you this question: what are the three or four likely scenarios that, if not addressed, will make healthcare unsustainable looking forward to 2025 to 2030?

Dr Sarah Wollaston: I think we need absolutely to focus on prevention and self-care. That is very clearly the case. I think that if we continue to have a very fragmented model we will be missing many opportunities to commission much more logically for health and social care. We are wasting huge amounts of energy in endless contracting rounds, for example, rather than having it integrated, where genuine integration can trump competition and the wasteful contracting. By having separated, fragmented systems for health and social care, we are wasting energy and money and are not meeting people's needs, so I think that should be a clear priority for the future.

The Chairman: I stole Lady Blackstone's question.

Baroness Blackstone: I think you have covered it really, unless you want to identify a single key suggestion.

Dr Sarah Wollaston: The other area is the effect of variation: there is leadership, there is what is happening with the workforce and there is safety. There are so many issues—I think yours will be a very long

report—that there is not time to touch on today. The role of leadership is extraordinary. We have heard time and again that that is what is driving culture change, making things happen and dealing with variation and morale within the workforce. You can make differences and make efficiencies in the way health and care operate, but, without good leadership, that is much more challenging.

The Chairman: Your Committee has covered a lot on the issues of funding and financing, but, going back to Lord Warner’s question, I do not think your inquiry has covered the issue about the cyclical nature of funding.

Dr Sarah Wollaston: We have certainly heard people comment on it. Having a huge glut of funding arriving at one time is not a challenge that we have faced in this last Parliament, I have to say. That, in itself, can be a challenge as well. We are half-way through the most austere decade in the NHS’s history. We spent in the last Parliament, an average, we heard as a Committee, of a 1.1% increase, and that is well below the background rate of increase in demand, so that is the key challenge we face here and now and we must address that; the system is short of funding.

Lord Warner: Can I ask you the question I asked Simon Stevens? We traditionally get into a mess on the NHS from time to time and we ask for a commission to be set up to sort it out, and the commission comes along and we may or may not take any notice of what it says. Is there a case for moving along what I call the Office for Budget Responsibility path and saying, “Well, it is very difficult for elected politicians to make big changes in this system, and there should be a kind of guardian keeping an eye on the longer-term funding systems, the workforce issues and investment decisions”, not to interfere in the work of Simon Stevens or NHS Improvement or whoever, but to keep the Government focused on what the five or 10-year needs are of this national icon? Do we need to start thinking about that?

Dr Sarah Wollaston: I absolutely agree with that so that you have somebody taking the long view and saying, “What do we need to make this sustainable in the long term?” and to be responsive to changes. Yes, I agree with that.

Lord Lipsey: To follow that up, is there a greater role for an assertive Parliament? The fact that we passed the Health and Social Care Act 2012, despite, I think, a near universal view, except by the Secretary of State, that it was not really fit for purpose is a criticism of all of us in both Houses, I think.

Dr Sarah Wollaston: That is right. I think certainly Parliament should insist that there is a political will for parties to work together in the national interest to come up with a sustainable, long-term funding settlement, because the public really value the NHS and social care and there is so clearly a problem.

Lord Willis of Knaresborough: When answering my questions about the funding of social care, the one area you did not mention was Dilnot.

Dr Sarah Wollaston: Yes.

Lord Willis of Knaresborough: On 15 November, Lord Prior made the point that it would be implemented by the end of this Parliament. Is it your Committee's view that that is still live and that, if it is live, it will be a significant part of the solution to sustainable funding of social care?

Dr Sarah Wollaston: Part 2 of the Health and Social Care Act was rather dumped in, I thought, a disgraceful fashion. Being snuck out as a Written Statement just before Parliament rose, I thought, was the wrong way to do this. Even though there had been a clear call for it in response to the introduction of the living wage, it was clearly not going to be possible for them to do both. They have kicked it down the road a bit, but it is still there because we legislated for that, and I was on the Care Bill with Lord Warner. They cannot keep ducking it. Apart from anything else, councils will have to start again putting a lot of energy into how they are going to put the machinery in place for the metering of that because, otherwise, they will be facing appeal after appeal with people arguing about whether something was included or not included towards the cap in their care costs. They need to get to grips with this. Either they need to say, "It's not affordable" and be honest with the electorate, or they need to be setting out how they are going to fund it, in my view.

Lord Willis of Knaresborough: Could your Committee give them a nudge on this?

Dr Sarah Wollaston: I will put it on the list, yes, thank you very much.

The Chairman: I assume that you are a member of the Liaison Committee.

Dr Sarah Wollaston: Yes.

The Chairman: The Liaison Committee on 20 December, which is next week, is taking evidence from the Prime Minister, and one of the questions you are expected to cover is the funding of the National Health Service and social care.

Dr Sarah Wollaston: Yes.

The Chairman: What are you expecting the Prime Minister to say to that?

Dr Sarah Wollaston: I cannot speak for what she will say in advance, but I shall certainly be asking a lot of questions about the future sustainability of health and social care; it is of critical interest to all of our constituents.

The Chairman: We will watch with interest.

Dr Sarah Wollaston: I shall also be asking her about it at PMQs tomorrow.

The Chairman: Sarah, thank you very much. You have been absolutely candid and very helpful. Thank you for coming.

Opposition parties – Oral evidence (QQ 292-300)

Opposition parties – Oral evidence (QQ 292-300)

Evidence Session No. 32

Heard in Public

Questions 292 - 300

Tuesday 13 December 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witnesses

Jon Ashworth MP, Shadow Secretary of State for Health, Labour; Rt Hon Norman Lamb MP, Spokesperson for Health, Liberal Democrats; Dr Philippa Whitford MP, Shadow Westminster Group Leader (Health), SNP.

Q292 **The Chairman:** Good afternoon, lady and gentlemen. Thank you very much indeed for coming this afternoon to help us with this inquiry. This House of Lords Select Committee has been set up to look at the long-term sustainability of the NHS, looking at 2025, 2030 and beyond, and what will be required to make both healthcare and social care sustainable. We are pleased to have you representing the three opposition political parties and to hear your views. We will be hearing from the current Secretary of State once you have finished. We are being broadcast. We will send you a transcript in a couple of days; feel free to correct but not change the transcript. You know the rules. For the record could you say who you are and your party? If you want to make a very short statement please do so, otherwise we will progress with our questions.

Dr Philippa Whitford: Dr Philippa Whitford, I am the SNP health spokesperson and a surgeon. I think most MPs across the House want the NHS to have a strong future but there is often disagreement about the best way to do that. It would be beneficial if this Committee could try to find some common threads that would allow a baseline going forward around which people could have a more open discussion.

The Chairman: You are the fourth surgeon in the room.

Dr Philippa Whitford: So do not get ill.

The Chairman: We have some physicians, do not worry.

Norman Lamb: I am Norman Lamb. I am the Liberal Democrat health spokesman and was Minister for care and support between 2012 and 2015. I said something about this subject yesterday in the media. It is critical that we look at the health and care system together. My fundamental point is that the NHS faces an existential challenge. Partisan politics has ultimately failed to come up with solutions, therefore you need to find a process by which you can come up with a long-term sustainable solution. That is why I have argued for a cross-party process. It has to be initiated by the Government; it will not work unless the Government buy into it. A once-in-a-lifetime process to engage with the public so that you take them on a journey with you about how much we are prepared to pay for a modern, efficient and effective health and care system is critically important is the only way in which you can break this logjam.

Jon Ashworth: I am Jonathan Ashworth; I am Labour's shadow Health Secretary, a post I have had for about two months now. I am delighted to be here. I am very much looking forward to the conclusions and deliberations of this Committee, not least because you have considerable expertise. Like Norman and Philippa, I hope that this Committee will consider not only the long-term sustainability of the National Health Service but social care. It is increasingly obvious now, not least from the media coverage of the last 24-hours, that the two cannot be separated out. The Labour Party is very much looking forward to engaging in the debate about these matters as we form our policy platform for the next election.

Q293 **The Chairman:** Thank you very much. I will start with the funding issue that you mentioned. We have heard consistently throughout the inquiry that the current funding system or settlement is insufficient for the funding of both healthcare and social care, particularly so for social care, and will need to increase if the system is to remain sustainable in the long-term. Do you all agree with that statement or do you have another opinion? How do we facilitate a better dialogue with the public on the options for health and social care funding?

Dr Philippa Whitford: Politics is about priorities. When you have whatever money you are going to spend you work out what you are going to give priority to. In the media and in most discussions with the public it is clear that they rank the NHS and social care incredibly high up that list, often in a way that is not taken account of in this place. I do not think we always have it as high up the list as the public would put it.

There are three major sustainability challenges. There is the increase in demand, with an ageing population but a population that is not always ageing well and is starting to collect illnesses, which is increasing demand and pressure. We are short of workforce, with the lack of doctors, nurses and specialists. Then there is money. We spend a lot of time talking about the money but the money is the easier of the three to deal with because you make a decision.

We have to look at changing the shape of the NHS, looking at sustainability. One thing that is putting a lot of pressure on it and squandering money is the marketisation in the NHS, which is incredibly

wasteful. It is quite clear that the Department of Health does not actually know how money is spent on the whole convoluted process of bidding and tendering. PFIs are bleeding a lot of health areas and health economies dry. With as low an interest rate as any of us are likely to see in our lifetimes, is this not a time when some of the more expensive ones could be bought out? That is not my area of expertise, but there are these things digging away under the NHS that should be looked at.

The key way to release money is integration. I agree with Norman that social care and health need to go together. Part of that integration is not bidding and tendering and competing with each other; rather, it is working together.

The Chairman: Do you think the funding is adequate?

Dr Philippa Whitford: No, I do not think it is. Per head of population, we are still the cheapest health service where you get a comprehensive service and do not have to pay. We spend just over £2,000 per head in comparison to America, which spends twice that but 40% of the population are not covered at all and those who are have to find 20% of the cost. We get a good deal for what we pay but the question, as Norman was saying, is: what do we want and how much are we willing to pay for it? We then need to try to make sure that we are not undermining it with in-built inefficiencies of structure which mean that health economies are doomed because they are competing with each other instead of working together.

Norman Lamb: I agree that the funding settlement is wholly inadequate. Wherever you are on the political spectrum, it makes no sense to be projecting over a sustained period of time to spend a reducing percentage of our national income on health and care, which is what is happening. If we look at any of the analyses of the gap in funding by 2020, it gets worse from there on. There is not a moment in time when it is bad and it then gets better; it gets progressively more difficult.

Anita's organisation predicted a £6 billion gap in social care funding, some of which is made up by the council tax precept in a very unfair way, in my view, and some of it by the better care fund, but it comes late in this Parliament. However, it still leaves a very substantial gap in social care, quite apart from the substantial gap in the NHS.

I am a believer in the tax-funded system but there is a difficult reality that we all have to confront and think about and that is that our tax-funded system does not appear to have kept pace with demand as well as other systems around Europe. I have not done a full analysis but it seems to me that where there is a premium paid in a social insurance system they appear to have kept pace with demand better than we have. That is an uncomfortable position for those of us who support a tax-funded system and we need to think about how we confront it.

I do not think there is any case for fundamentally moving away from a tax-funded system. As Philippa says, it appears to be quite an efficient way of spending money and delivering results. However, we have to confront this problem that Governments progressively have not been willing to increase tax to fund growing demand in health and care. That is why I think there needs to be some consideration given to the idea of

hypothecation in some shape or form. To coin a phrase, I think there could be hard or soft hypothecation. That might be getting into dangerous territory, but psychologically it is quite important to have some independent assessment on a periodic basis of how much the health and care system needs in order to fund a proper, effective system. On top of that, if people could see on their pay packet that this is the amount they are paying for their health and care system, psychologically it becomes much easier to make the case to people to pay a little more, if necessary, to maintain funding for the system.

Jon Ashworth: There is not a huge amount of disagreement between me and my colleagues here. For me, the NHS is the fairest way of providing healthcare. It is arguably the most efficient. It certainly still has popular support and I believe there is no reason why it cannot be sustainable in the long term. Throughout its history it has had to deal with increasing demand and increasingly complex needs. The key thing we have to consider, which is why this Committee's work is so important, is where the NHS will be in the next 20 to 30 years.

Everyone in the NHS world at the moment is obsessed with the five-year forward view, quite understandably so. However, there are something like 200 weeks left of the five-year forward view. When you look at the demographics of society, with the ageing population, the number of over-75s by about 2040 will be approaching 10 million. As people become older and have increasingly complex needs, we need to have an understanding of how we fund the NHS to meet those demographic changes.

I see no reason why an NHS funded from general taxation cannot be continued and maintained in the country. The Labour Party would never countenance a system where we were asking people to be charged for seeing their GP or anything like that. We still believe that an NHS free at the point of use and funded from general taxation is an efficient way of providing healthcare.

Q294 **Lord Warner:** I am not going to make the obvious remark that we all want a red, white and blue hypothecated tax, but I will ask if each of you would separate out new funding streams for social care compared with health. They are already different as one is means-tested and one is not. Is there a political advantage in having a longer and stronger public debate and discussion about whether in the longer term we should take social care down a social insurance route? Would that make it politically easier, as has happened in Japan and as has happened in Germany, to maintain its buying power?

Norman Lamb: I think all these things should be up for discussion. That is why I called for this national debate—a public discussion that a cross-party commission could generate. I struggle to justify to myself the fact that a very wealthy person who has cancer has all their medical needs paid for but a person on very modest means in a semi in Salford suffering from dementia ends up losing everything. This is the basis of our 1948 settlement, yet it does not seem very fair. All of these things need to be up for discussion, including the proposition that you put forward.

The Chairman: Lord Lipsey wants to explore these issues in more detail.

Q295 **Lord Lipsey:** In the crisis we are in with social care at this moment, which has been very well highlighted by the *Times* series over the last couple of days, would you not all agree that what we need now is an injection of cash into social care?

Norman Lamb: I would totally agree.

Lord Lipsey: I have one supplementary question on this, particularly for you, Norman. I see the case for having a multi-party approach to this, but when we tried it in the last Parliament unfortunately it broke down because the Tories could not resist accusing Labour of imposing a death tax. How do you think it might be different next time around?

Norman Lamb: I went to see Peter Riddell when he was at the Institute for Government to talk about this because there are moments when you have to recognise that partisan politics is not coming up with solutions. The brutal truth is that none of the political parties at the last election had a solution for the long-term funding challenge of the health and care system. No party proposed any mechanism to increase funding for social care. I had taken the Dilnot proposals through into legislation which would have brought more money into the system. As far as I am concerned, it is tragic that it was abandoned, and rather cynically so, straight after the general election.

I do not begin to claim that it is easy but it is undeniable that partisan politics has failed. When you look at processes such as Adair Turner with the pension issue, it did break through. He managed to get all-party buy-in and came up with proposals that were then implemented. There are some historical precedents. I cannot sit here and name them all for you, but there are moments when you have to recognise that a different approach is needed to break the logjam. It is a long time since 1948 and the original Beveridge settlement; it is time we revisited it.

Lord Lipsey: More money now?

Norman Lamb: Yes, I totally agree with you. It is undeniable.

Dr Philippa Whitford: In Scotland we are working on 2030 at the moment. Vision 2020 was done in 2011 because it is like the Titanic, it takes an awful long time to introduce any change in structure or direction. Even working in five years with the five-year forward view, although it is an improvement on year by year, it is far too short. We have things around national insurance which start at an incredibly low threshold and hit people who do not pay tax, but once you retire, no matter how well off you are, you are not paying national insurance at a time when you are using services more. There may be something to be looked at in that: raise the threshold at the bottom but simply continue it. If you are doing very well in retirement, you would continue to pay national insurance. Some people will not pay any NI for 30 years, during which time they might be using an awful lot of services.

The Chairman: Before you come in, Norman, that is what Lord Warner was beginning to refer to about alternative models, on which Lord Lipsey asked his questions, about people who are retired but still earning quite a bit, à la Japanese- or German-style taxation system.

Norman Lamb: In the *Five Year Forward View* Simon Stevens raised the role of employers and how we engage them more in the well-being of their workforce to stop the flow of people into ill-health. I am chairing a commission on mental health in the West Midlands and we are hoping that we might be able to trial what we are calling a well-being premium, which would be a discount on your business rates in return for evidence-based interventions which we know work to reduce sickness absence, to reduce the flow of people out of work.

There is an interesting further question: is there a case for employers to make some sort of contribution towards the NHS and perhaps—an innovative idea—avoid having to make the contribution if they can demonstrate the interventions they are taking to improve the well-being of their workforce? Somehow we have to find mechanisms to get employers engaged. Some are very good but the majority do not fully engage in this. We could be achieving much more in terms of good, preventive care in that way.

Baroness Redfern: Jon mentioned looking at general taxation. Would that be a flat rate taxation and therefore are you giving up the idea of a mansion tax, which at one time was thought could support the NHS?

Jon Ashworth: I think the mansion tax is something that the Labour Party should continue.

Baroness Redfern: Would you continue with it?

Jon Ashworth: We would continue to explore that. Being honest with you, we are at the stage in the parliamentary cycle where we are looking at all these matters anew. If you were to invite the shadow Chancellor to a future hearing, he could perhaps tell you what our taxation policy will be at the next election.

Baroness Redfern: That would be very interesting.

Jon Ashworth: It is an awkward moment in the cycle for the opposition spokesperson because if there is a general election in 2020, we are not going to outline our tax and spending plans in 2016. I appreciate that that may well be frustrating for the Committee but that is the position we are in. I strongly believe that the future of the NHS can and should be funded by general taxation.

On Lord Lipsey's point, I agree that social care needs an urgent cash injection. We were all surprised and astonished that there was nothing in the Autumn Statement. From my reading of the comments from Simon Stevens and others, I was expecting there to be an injection. Again, we are led to believe that there may well be something in this week's local government finance settlement, but I fear that just raising the council tax precept does not go anywhere near the requirement.

I am very happy to engage in a broader cross-party debate about the future funding of social care. You are absolutely right, the Labour Party has had its fingers burnt on this. We entered a set of discussions in good faith, we thought we were having very good discussions, but we walked out of the room and saw a big poster of a gravestone with "Labour's death tax" plastered all over it. We are very happy to engage in discussions but we are wary, given what has happened in the past.

Norman is right, of course, that Adair Turner's commission did arrive at a consensus on the future of pension provision. However, I think a broader consensus had developed beforehand on earnings being linked to the basic state pension. By that point we had cross-party support for that, the TUC had come out about it, various business organisations were calling for it, and influential voices in the media were calling for the earnings linking of the state pension. It is not clear to me, other than that we need to deal with social care, if there is a broader coalescence around one policy solution on social care yet.

Norman Lamb: I would agree with that, there is not a consensus here. We have not even started to have the discussion, but I do not think that is a reason not to have it.

The Chairman: Is there likely to be a political consensus?

Norman Lamb: I do not know whether it is achievable. I realise that there is a view in this Government about the need to reduce the percentage of GDP going in taxation, which creates a tension, but we need to have the discussion and we need to reach a national view about this. Unless we try, we will never know whether we can achieve agreement.

Q296 **Lord Warner:** Listening to this discussion between the three of you, it seems almost impossible to think that this Committee could say anything very useful that would get you all around the table, particularly because of what Jon is saying about being at this point in the electoral cycle. What is starting to emerge for us as a Committee is that if the elected politicians and the NHS cannot solve the longer-term planning, why do we not have a kind of OBR-type independent body? That may stop the warring factions or at least it would try to develop some common ground on funding workforce investment strategies. If it was genuinely independent, it might actually get the warring factions into the room. I do not think that anything we say as a Joint Committee would get you all into the room for a discussion. What do you think about the alternatives?

Jon Ashworth: You are far too modest, Lord Warner. Given your background and influence as a former Health Minister and so on, we are all very much looking forward to what the Committee comes out with. I am very much attracted to the idea of an OBR-type body which gives periodic reports on the financial pressures on the NHS, what is needed and what are the workforce pressures, and offers a degree of objectivity in the planning which is slightly separate from the political knockabout that inevitably happens in the House of Commons. It is a very sensible idea and is something I would support. I would also encourage the OBR to be allowed to cost the policies on the manifestos of political parties ahead of a general election. One of the biggest controversies in the debate about the NHS finances at the moment is whether Labour was going to spend as much as the Tories and whether the Tories are spending £10 million. That is all very interesting but if we had had the OBR cost the political parties' manifestos we might have had more clarity on those figures at this stage of the Parliament.

Norman Lamb: I was trying to hint at support for an OBR process when I was talking about a hypothecated tax and an independent periodic

assessment of how much you need to raise to spend on achieving an effective and efficient health and care system. In an age when trust in politics and politicians is at an all-time low, creating an independent process that gives people some sense of reassurance about the amount that we need to spend makes it much easier to make the case for increasing the amount people have to pay, if necessary, to fund the system.

The Chairman: Philippa, would you support an OBR?

Dr Philippa Whitford: I totally support the idea of an arm's-length body but you have to remember that the OBR only reports in, it just says, "This is what it will cost, you are on track, et cetera". We get reports on performance from the National Audit Office whereas really what you require is an arm's-length body that is part of the decision-making so that it does not become nailed down into the five-year cycles. You can never let go of it completely politically, but you can look at setting down what are the aims of an NHS, as Norman says, on an occasional cycle. The problem is that it comes right in here to the Floor of the Chamber and what we have is something that looks like Punch and Judy.

After my maiden speech, I thought of leaving the first debate I took part in because, having come a few weeks earlier from a hospital, I thought that if I were watching this on the television I would be totally depressed. They were not arguing about the NHS at all; it was Punch and Judy. It would need to be more than an OBR; it would need to be a decision-making body that is a bit more arm's-length.

Q297 **Lord Willis of Knaresborough:** I am incredibly frustrated, particularly so today, because I am looking at timetables. There are three years until the end of this Parliament and you are obviously not going to make any decisions at all on what your policy is even by then. There will be another five years before you can implement something else. By that time the whole system, given what we have heard in evidence, will be in utter and total chaos. Without political leadership there is no way forward. You promote the idea of having an arm's-length body that somehow will come up with solutions to solve political problems and, Philippa, you started by saying that at the end of the day these are political decisions. We heard from Mr Chote at the OBR last week in that these are political decisions. I put it to all three of you: where is the political leadership going to be within political parties to say that this has to be a new settlement? I do not see that.

Dr Philippa Whitford: I do not mean that there are no politics in it at all. What you are aiming to achieve, you have to decide politically. What is it we provide? It comes out of taxation. Of course that is a political decision. What is its priority in comparison to cutting inheritance tax or invading somebody or buying some new aircraft carriers? That is political.

Lord Willis of Knaresborough: Everyone who has come before this Committee from all sorts of organisations has been able to answer the question as to how they see the funding settlement as we move forward. We have three political leaders here and none of you has an idea.

Dr Philippa Whitford: I would disagree. Obviously, the health service that my party runs is not this one and looks utterly different from NHS England. We have had political leadership. In Scotland we abolished trusts in 2004; we no longer have primary care trusts. We now have integration—joint boards between local authority and health boards. We have place-based planning. We do not have tariffs; we do not have marketisation. That is for political leadership to decide.

Lord Willis of Knaresborough: So this is an England problem?

Dr Philippa Whitford: No. The demand and the lack of workforce is everywhere. The additional problem that has been created here of tying one arm behind your back concerns the money, effort and time that are wasted in bidding and tendering and tariffs and all sorts of perverse incentives within NHS England that are squandering it. When I became a doctor in 1982 we spent 5% of GDP on health. We had long waiting lists and we had old hospitals. If we had invested at that time to where we are going to end up, it would have been transformational. What did we do? We have gone round and round reinventions of how we run the NHS—the different structures from health authorities to PCTs.

Lord Willis of Knaresborough: So you would have a total reorganisation, is that what you are talking about? We should go back to a single body that runs everything?

Dr Philippa Whitford: I would work back to a public NHS, yes. There is so much money being squandered in marketisation in the NHS.

Lord Willis of Knaresborough: We have an answer there. That is one way, a single organisation which is run from the top, telling everybody what to do.

Dr Philippa Whitford: I did not say run from the top. We set out our aims and it is helpful

Lord Willis of Knaresborough: If it is a single organisation it is run from the top.

Dr Philippa Whitford: It is still helpful.

The Chairman: I am going to try and control this a bit more. Norman and Jon, do you want to come into this conversation?

Norman Lamb: We put forward a submission in the run-up to the Autumn Statement. We made the case for a £4 billion injection into the NHS and the care system. We set out where that money should go and the fact that a significant element of it should be investing in the transformation.

The Chairman: The main question from Lord Willis, who will tell me if I am wrong, is to know whether before 2020 there is likely to be any statement from the political parties—Philippa said what the SNP did—as to their plans on funding healthcare.

Norman Lamb: Absolutely. Along with that I have set up an expert panel to advise my party, which will report within six months. It includes the former head of NHS England, the former head of the RCN and many other eminent people, together with two health economists, looking specifically

at the case for a hypothecated health and care tax and the level of that tax that is needed to properly fund the system. We will come out with a policy next year, as soon as the panel has reported, to contribute to this debate. We are moving forward with it and are going to come up with a clear position on that.

Jon Ashworth: You speak of your frustration, but imagine my frustration as Labour shadow Health Secretary. Obviously, the Labour Party is going for a debate, a discussion and a policy-making process. I want us to be in a position where we go into the next general election with a clear policy on NHS funding.

Speaking in a personal sense, NHS spending rising by around 4% seems a reasonable yardstick to aim for. I am very proud that the previous Labour Government increased NHS spending to the European average and, although I appreciate that the calculation has slightly changed, that seems a reasonable long-term ambition for the next Labour Government to aim for. What I cannot do is guarantee to you here today that a Labour Party is going to spend x billion on the NHS and we are going to raise that money from this particular level of taxation or from this particular funding mechanism.

On social care, the academic evidence out there seems to suggest that there is a shortfall of about £2 billion at the moment. I would hope that the Government could find that £2 billion from somewhere. The Government are making a series of decisions about whether it is inheritance tax cuts or corporation tax cuts or capital gains tax cuts. The Government have found hundreds of millions in capital investment for new grammar schools, so I believe the Government can make a different set of choices at the moment to fund the shortfall in social care.

On the NHS more generally, given that it is going through this huge financial squeeze and that by 2018 head-for-head expenditure is going to be falling, I think that is a wrong set of choices for the Government to be making. I believe through general taxation we could fund the NHS properly. However, you will have to be a little more patient with regard to the specific figures.

Lord Kakkar: I would like to confirm that there is a consensus view that a lack of political consensus is doing real harm in terms of delivery of the NHS and being able to plan for the longer term. Would it be correct for this Committee to conclude that from what you have said and therefore try to establish a means by which that political consensus may be achieved?

Norman Lamb: I totally agree. There is a sense of complete inertia. We are sleepwalking towards the edge of the precipice. There is an urgency, therefore, about this and I think your suggested conclusion is the correct one.

Lord Kakkar: To build from that, would you agree that one of the real implications of a failure to achieve political consensus at this vital stage is the inability for us to empower and develop systems leaders to take any meaningful action? Even as we start to localise delivery, have STPs and so on, there is no certainty in anybody's minds that they can take a decision and do anything even in the medium term that can make an important

contribution to more sustained delivery either now or in the longer term.

Dr Philippa Whitford: We are hearing back from leaders that the way the STPs are being done is backside forwards. I think they are the way we should be going—going back to place-based planning for a population. However, instead of it being quality, outcome and finance, finance is being put at the top, so they are being told, “Do not come here until you can meet this number”. That is not going to achieve the correct answer. The problem we have is that politicians are able to pull something out of the air, such as the seven-day NHS. What does the seven-day NHS mean? You will be able to see your GP from eight in the morning until eight at night, any day you want to turn up. Was that discussed with anybody in the real NHS world?

When we move towards an election time, people are doing soundbites around the NHS because it is so important to the public and we are not moving forward, looking at the reality. I think STPs could make a huge difference, but tariffs, where the hospital earns money only if it keeps people in and we want it to send people out, means that you are actually asking the chief executive of that hospital to cut the throat of his own business to make the STP work. We need to get rid of these structural perverse incentives to allow these local health economies to work together around the patient.

Lord Kakkar: Listening to that, it strikes me that there are two levels at which one needs to try and pursue the question of political consensus. There is the national debate and consensus in this Parliament and the other place with regard to debating these issues of funding and also more important structural questions. Then at the local level there is the need to have political consensus in taking the difficult local decisions that will allow for greater place-based care, transformation of care and the adopting of new practices. In the heat of local politics and the need for individuals to seek re-election, how can that level of local political consensus be achieved?

Dr Philippa Whitford: Obviously, we seeing the impact on public health. One of the greatest things we can try to achieve is health in all policies. We will debate different policies on different days; we will take votes that completely counteract what we said the day before because we are not thinking about the greater impact of housing, work, active transport, et cetera. Moving public health more into local government is good, but then you suddenly have evidence versus a council election in x months’ time and you therefore have exactly the same issue that occurs here.

Norman Lamb: It is important to say that there will be some STPs around the country which deliver quite dynamic, interesting and worthwhile results. We must not dismiss the whole process but it is a flawed process. When you talk about how you achieve political consensus locally, the answer is not to have a process involving just leaders, excluding in many cases even non-executive directors of the trusts involved, and present to the local community what looks too much like a fait accompli. In my view, to take people with you, you have to involve them from the start.

There was an interesting process in Canada back in the 1990s when they faced a really tough budgetary position. They established a process which really engaged the public on the difficult choices that have to be made, the money that was available and how best to spend that money. Unless you do that from the start, people will not buy into it. Local people faced with a proposal either to close or slim down their local hospital do not begin to understand, and neither should they, the complex judgments that have to be made about the best allocation of resources. They will simply resist. You will never achieve that consensus and politicians will then row behind that local community.

Baroness Redfern: Would you have prevention as your number one focus?

Dr Philippa Whitford: Where the NHS and social care are at the moment, I think social care probably has an immediacy about it that is more crisis-lined, but we have to be serious about public health going forward.

Lord Warner: So I am clear where you are on STPs, let us assume there is a wonderful world in which everybody is consulted about everything on STPs, where do you three stand on the whole issue of a Health Secretary having the final say on whether a major department or whatever should be taken out of an acute hospital? Are you advocating that if there is a good process then the local people decide and the elected politicians will not interfere? I say that having sat in rooms with large numbers of MPs coming to lobby me about their acute hospitals. Are you offering an end to that process, provided there is a decent STP process?

Norman Lamb: I am minded to agree with that proposition. In the Department of Health I saw the most ridiculous level of micromanagement; for example, every Monday morning in the Secretary of State's room, looking at every hospital in the country and its performance against access standards, and reports back on why a particular hospital is not performing up to the required standard. Ultimately, that approach is unsustainable. People at the local level are disempowered and it drives everyone crazy. As is implied by the Manchester approach, you need to give more power to localities to determine how best to spend the money that is available.

Jon Ashworth: That is a very good question. My instinct is that politicians and the Executive are responsible for allocating money and ultimately, therefore, have to be held to account. You are quite right, unless you have built around that some very clear guidance and infrastructure, you could have politicians making the most politically expedient decisions to help such-and-such an MP defend their marginal seat, with the opponent saying, "Close the hospital".

On the STP issue, the Labour Party is not opposed to the principle of STPs—the idea of trying to work around what is now a fragmented system to build more collaboration into the process; indeed, to plan in a local area. We think it is significant that the STP has the word "plan" in its title. That is something that the Labour Party has been very much in favour of for many years. A more strategic hand in the design of local healthcare is something we would support but we would want to test all these STPs by

a number of yardsticks: are they genuinely jointly owned with local authorities? Have local people really been consulted and are part of the decisions? Do they solve social care issues in the locality? Do they provide decent mental health services? Do they deal with the ageing population in the locality? These are the tests that we would be applying to individual STPs.

More broadly, my worry is that what started as an important approach to work round the Health and Social Care Act is increasingly about filling the financial gaps in the system. That is something we are deeply concerned about.

Lord Kakkar: Do you think that the devolution approach in Manchester is going to change the way that general elections will be fought there with regard to health?

The Chairman: Yes or no?

Norman Lamb: Maybe. It is hard to judge but it may do that.

Jon Ashworth: I am not sure, really. Without wishing to get too party-political, there is somebody in the Committee who perhaps lost their seat in the Commons because of the campaign about the local hospital from their political opponents. I suspect political parties, whether we like it or not, will still run those types of campaigns and I suspect, sadly, that they will still influence voters.

Dr Philippa Whitford: I do not think we have ever had the conversation with the public about how health has changed. The big boxy ambulance has everything in it that was in a casualty department when I graduated and therefore they still think it is all about buildings, but you cannot shut hospitals or bits of hospitals until you have built up the community service that you think is where people should be. The problem with the STPs at the moment is that they are going to slash things in hospital to then provide the budget. That means you are going to have a gap of a couple of years of wondering what is going to happen to people. You still need to bring back transformation money to develop your community service first.

Q298 **Bishop of Carlisle:** Philippa, you were getting into your stride earlier on about public health and prevention. I would like to come back to that, if I may. The three of you have made comments in the past about how important it is and all the witnesses we have seen have said it is vital to the long-term sustainability of the NHS. I am not asking you whether you think it is important, as I know you do, but how are we going to give it that priority in the future? Do you think the kind of body Lord Warner was referring to might have some part to play in doing so? If not, how can we reorganise things in such a way that it is taken seriously? Governments do not seem to have done enough on this in the past.

Dr Philippa Whitford: Again, I would take a punt for health in all policies. In my line of work as a breast cancer surgeon looking after people at end of life, it is remarkable how little is important at the end of life. Your health, your well-being and the people you love are all there is, yet they always get parked in exchange for something else when we are debating here. If we have the health and well-being— meaning physical and mental well-being—of our citizens as something we measure every

policy against, whether it is here or whether it is local government, you can imagine the direction it would send you to: what would your town centre look like? Would it be for car parking or would it be for active transport, walking and meeting people and cycling? Exactly what would we be focusing on? As I say, in the Chamber we will have a debate about needing to protect women from violence and support them and the next day we will vote on housing benefit that is going to be cut and is not going to support the long-term sustainability of women's aid and shelters and so on. We talk about it but we are not serious about it.

In handing over public health to local government, which I think had a lot of advantages, although there were a few odd things about losing access to NHS data, it was cut at the same time. You cannot enact a big change and cut at the same time. Change itself always takes time and money. We need to have that public health voice at the table saying, "This is not how we should design our roads. That is not what our schools should look like. We need to get serious now for the coming generation".

Norman Lamb: I think you have to have a pooled budget. We have to move away from this awful silo mentality. Within that pooled budget you have to have incentives that are aligned to achieve prevention, as Baroness Redfern was mentioning. At the moment the incentives are all over the place. We incentivise activity in acute hospitals, as Philippa was saying, but not in other parts of the system. However much we talk about prevention, too often preventive services are cut in order to prop up acute hospitals. If you have a pooled budget in a locality it is much easier to ensure that within that locality the focus is on prevention. I heard a fantastic talk by Dr Arthur Evans, who heads up mental health in Philadelphia. There they have mapped the whole city, identifying those parts of the city where children suffer multiple traumatic events in childhood. We know that that leads to awful consequences for their life chances, health, employability and all the rest. They are intervening right at the start to ensure that those children are given support to prevent the problems ever becoming entrenched. That sort of inspired thinking has to start to work in this country.

Finally, we need to do much more to build up the economic case for prevention. The LSE has done some very interesting work. To take the example of early intervention in psychosis, we know that if you invest £1 in early intervention services you get a return of £15 over a 10-year period, so why are the Government not doing it for goodness' sake? If we can build an economic case to seek to convince the Treasury of the value of investing in prevention, we may start to get somewhere.

The Chairman: You referred to mental health quite a bit. Lord Bradley, do you want to ask your question?

Q299 **Lord Bradley:** Pursuing mental health a little further, each of your parties has made very strong pledges around mental health. The *Five Year Forward View* identified the economic costs of not tackling mental health as being over £100 billion—the full cost of the NHS. What are the issues that are affecting the delivery of mental health services in the long-term sustainability of health and social care? What is your assessment of the progress that has been made so far on the delivery of mental health

services, moving towards parity of esteem, where still about 80% goes to physical health but merely 15% to mental health? Can you comment on the integration of physical and mental health as part of that long-term sustainability?

Norman Lamb: I very much agree with that last point that we manage spectacularly to neglect the physical health needs of people with mental ill-health so that they end up dying as many as 15 years earlier than other people. However, we also neglect the psychological needs of people with chronic physical health problems. Somehow we have to bring this together so we treat people holistically. There is an issue about the under-resourcing of mental health services; there is a basic injustice, in my view, that people with mental ill-health do not have the same access to evidence-based treatment as others do. How can you possibly justify having maximum waiting time standards across all of physical health and not in mental health? It is a discrimination that has to be ended. There is a massive economic cost to that as well as the moral imperative for ensuring that people get treated equally. Along with the need for more investment in improving access and improving prevention of mental ill-health in the ways I have talked about, we need to spend the money more effectively.

We spend far too much money on containing people, sometimes in institutions, without any real ambition for their improvement. We allow people to drift into the criminal justice system. It was an enormous pleasure to work with you in your work on liaison and diversion; this country is leading the way on such programmes. However, we have to shift resources from containment to prevention and recovery. In Sheffield, where Tim Kendall (who is now National Clinical Director for Mental health) was Medical Director, they managed to repatriate everybody who had been in out-of-area placements and managed to reduce the long length of stay, which is generally not therapeutic for people. They managed, therefore, to close beds and invest the money they had saved in supporting people at home and stopping crises occurring in the first place. I think that is inspired and is the sort of approach we need to apply across the system—more money but spend it better.

Jon Ashworth: I entirely agree with Norman, who has done much work on this both in government and out of government. Mental health has not had the resource priority it deserved for many, many years under successive Governments. It has not had the political priority either. If you think back to general election campaigns, whether at a local level or a national level, there are plenty of campaigns about saving hospitals, saving A&E, saving the walk-in centre or, at a national level, politicians squabbling in the national media about the NHS. Whether that is “Jennifer’s Ear” in 1992 or “24 Hours to Save the NHS”, or whatever slogans the political parties come up with, hardly ever has mental health featured in that electioneering. That tells you something about the political priority that politicians of different parties in successive Governments have given mental health. Finally, there is a broader acceptance now in society that we have not given mental health the priority it deserves and I think attitudes are changing.

May I say something quickly on public health and prevention more broadly as I did not have the opportunity a few moments ago?

The Chairman: Yes, please.

Jon Ashworth: When we are talking about the sustainability of the NHS, it is correct that we focus on the finances, it is correct that we focus on workforce issues, but we have to think about how we put rocket boosters, if you like, under the prevention agenda. We are still smoking too much, drinking too much and eating the wrong foods too often. The understanding of diabetes in my own Leicester constituency is very widespread because of the demographics of Leicester, which I am sure you will all appreciate. However, I do not think that society more generally has woken up to how devastating diabetes has been, in the same way in which over 20 or 30 years we have come to understand the implications of smoking too much and drinking too much. That is why the obesity strategy from a few weeks ago was disappointing; I think it was watered down and we could be doing a lot more on the advertising of sugary foods. It is right that we have restrictions on the foods which appear on children's television and so on. I have young children. On a Saturday night I let them watch "The X Factor". As we are running up to Christmas I will let them stay up until about 8 pm and watch other shows on ITV. Literally tens of thousands of calories, probably hundreds of thousands of calories, will be advertised between now and Christmas on ITV at 8 pm which children will be watching. When they are watching it they say, "Dad, can I go to McDonald's? Can we get this? Can we get that?". Unless we are bold and more radical on advertising, I do not think we are going to solve the obesity crisis which is costing the economy tens of billions at the moment.

Baroness Redfern: When we are talking about obesity it is all about working with families. We can have any number of promotions, but it is about working with those families because it is a generational issue. Some focus should be put on that. People say that you cannot measure prevention, but I think you can because the stats will eventually come round. If the focus is on prevention, it is worth doing.

Dr Philippa Whitford: There is a very simple thing that has caught on in Scotland, called the Daily Mile, started by a primary school in Sterling where a teacher just took the pupils out and ran them around a field, and they behaved better. We talk about prevention for physical health; we talk almost not at all about prevention for mental health. We see the Change4Life adverts on the television, whether we follow them or not, but how do you look after your mental health? Do we know? Has someone told us? We need to get the preventative agenda into mental health for children and adults. We also come back to integration, we need to be holistic.

The Chairman: I am going to ask Lady Blackstone to move to the last question.

Q300 **Baroness Blackstone:** What is your single key suggestion for change that the Committee ought to recommend to support the sustainability of the NHS?

The Chairman: Very briefly. The Secretary of State behind you is listening.

Dr Philippa Whitford: I have tried to ask what the cost of the mechanisms of marketisation are but it is not collected centrally and it is not known. There is no evidence of any benefit, which means we have no cost-benefit analysis. There are estimates which reckon that it is somewhere between £5 billion and £10 billion. That would be a good head start to transformation.

Norman Lamb: A fundamental shift towards prevention and ensuring that the incentives drive behaviour in that direction.

Jon Ashworth: I totally agree about prevention, but when push comes to shove it needs money and you have to put the money into it. I appreciate that is the whole point of this Committee, but it needs more money. It is as simple as that. I am sure Jeremy will get it from the Chancellor.

The Chairman: Thank you all very much. I know how busy you are and it is very kind of you to find the time.

Secretary of State for Health – Oral evidence (QQ301-313)

Evidence Session No. 33 Heard in Public Questions 301 – 313

Tuesday 13 December 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Examination of witness

Rt Hon Jeremy Hunt MP, Secretary of State for Health.

Q301 **The Chairman:** Secretary of State, thank you very much indeed for finding time to come and address us. I know it is an enormous amount of time out of your busy life and we are extremely grateful to you.

As you gather, this inquiry is looking at the long-term sustainability of the NHS and social care, so looking beyond 2025, 2030. We do not want to focus on current or immediate issues, although we inevitably get into them; it is the future that we are more interested in.

We all know you, but please introduce yourself so we get it on the record. If you wish to make a brief opening statement, that is fine. Otherwise, I will go to the questioning.

Jeremy Hunt: Thank you very much for inviting me. I welcome the discussion. I will not make an opening statement because I am sure there are lots of questions but I think it is absolutely the right discussion to have.

The Chairman: Thank you very much. If I might kick off, as you might expect, it is about funding. We have heard considerable evidence that funding pressures are the most significant threat to the sustainability of the health and social care system, and that spending on health will need to grow considerably over the longer term if the health and social care

systems are to remain sustainable. I do not know if you would agree with that. My supplementary to that is that there seem to be conflicting views on whether the funding requested by the NHS is forthcoming, and you might confirm whether that is correct or not. Also, looking beyond 2020, which is this Committee's main concern, we will inevitably have to look at different funding models. Do you think we should be doing so, or would you agree that healthcare should always be free at the point of need, and that you and future governments should not deviate from that?

Jeremy Hunt: Those are obviously three critical questions. Let me deal first with the very short-term one, and I am very happy to come back to it if you want. There is a slightly fake debate going on about whether or not the Government have honoured what they said in the spending review this time last year. We had a request from the NHS for what it thought it needed to kick-start its own plan, the *Five Year Forward View*, and we negotiated a spending settlement. It was a very long and difficult battle, in which I was negotiating on behalf of the NHS, for what it said it needed, and we received a settlement that the NHS said was sufficient.

It is a £10 billion increase for the NHS but some of that £10 billion, as you will know, is funded by cuts in central budgets held by the Department of Health. Under the new legislation NHS England is separate and independent from the Department of Health, but we have always been very open, as we were this time last year. When we negotiated the spending round NHS England was fully aware of where the extra £10 billion was coming from. The crucial discussion then was that they were very clear that they wanted the settlement to be front-loaded; they wanted the majority of the settlement to come early in the Parliament, and that was a very difficult negotiation, because the natural thing for the Treasury to do would be to increase the extra £10 billion in a straight line, £2.5 billion a year for four years, but the NHS wanted the money to come early, so that was in the end what we did.

I do not want to pretend that means it is easy on the NHS front line. I think it is incredibly tough, for all sorts of reasons which we can go on to discuss. It certainly does not feel as though there has been a bonanza. Things are tougher than they have ever been and NHS staff are working harder than they have ever been.

On the question about sustainability, I think there is a rabbit hole that you can wrongly go down. Often the question is posed on whether the NHS is sustainable, and I think that is the wrong question to ask, because what the NHS stands for is a set of values that we will never abandon as a country—certainly I, as Health Secretary, and this Government will never abandon, which are very important principles, of which one—

The Chairman: Does that mean you will maintain free at the point of need in perpetuity?

Jeremy Hunt: Yes. Sadly, I am not going to be Health Secretary in perpetuity but as far as I and this Government are concerned, we are absolutely committed to that principle.

The Chairman: You might be in a higher office.

Jeremy Hunt: That is not said about me very often but I will take the compliments where I can.

The Chairman: The issue is whether in future any government should maintain that principle, which the public is clearly keen on maintaining.

Jeremy Hunt: I think the core principle of the NHS is that it should not matter what the size of your bank balance is; you should always be able to access high-quality care. That was the promise made in 1948 by a Labour Government that set up the NHS based on a Conservative Health Minister's White Paper in 1944. It unites both sides of the House of Commons and the House of Lords. I think it is very misleading and unnecessarily worrying to the public to talk about whether the NHS is sustainable, because they worry about those core principles.

The bigger question is how all health systems across the world will be sustainable in the face of the huge pressures of an ageing population, with advances in medicine and technology that are making us all live longer and are fantastic for all of us. There is a bigger question, which is not really about the NHS because I do not think we will ever change those principles, but is about how we will get more resources into healthcare systems, not just in this country but even in America, where they spend twice the proportion of GDP that we do. There you have to have a strategic, long-term view, which is what I think this Committee is trying to do.

Q302 **Bishop of Carlisle:** You mentioned the growing demand on the NHS with the ageing population, multiple morbidities and so on. The Office for Budget Responsibility has suggested that after 2020 the proportion of GDP that will need to be spent on the NHS will need to increase, whatever happens. First, do you agree with that and, if you do, how do you think that could be funded?

Jeremy Hunt: Broadly, I agree that as we get older—I want the NHS to be the safest, highest-quality healthcare system in the world. I think that is what the British people want, and we are going to have to find a way of getting more resources into the NHS and the social care system as we deal with the extraordinary demographic pressures of 1 million more over-75s by 2020, and that will continue. I was quite relieved to read that some American researchers have said that our life expectancy will never increase beyond 115, which they have somehow identified as the highest it can go. I thought, "Phew!" Yes, we will have to find a way of devoting a greater share of our national resources into health and social care, without doubt. The point I would make is that this was a call that Tony Blair made in 2002, and it was also a call that George Osborne made when he decided to protect the NHS budget in 2010, and indeed increase it in 2015.

If I go back to the Blair analogy, where he very explicitly said that he wanted to increase the proportion of GDP to the European average, he was able to do that on the back of a strong economy. The biggest risk to the principles behind the NHS that we all hold dear is if the economy went pear-shaped. That is the thing we have to worry most about. I do not think it will; happily, we are doing better than many feared post-Brexit, but that is the biggest single risk. If the economy continues to grow, it is

a choice for governments to continue with the current funding model. I personally think it is a sensible choice. It is probably the choice that is closest to what most British people want.

Bishop of Carlisle: Would you see that funding continuing to come primarily from taxation?

Jeremy Hunt: Yes, I would.

Bishop of Carlisle: Thank you. Can I ask one other thing: the *Five Year Forward View* talks about the importance of funding social care and public health. At the moment that does not seem to be happening, and obviously there are long-term implications of that. Do you think a forward-looking thing, which I know is difficult politically, say a five- to ten-year plan for public health and social care, might go some way towards resolving that problem?

Jeremy Hunt: We have a long-term plan for both social care and public health. I think they are both different. The long-term plan for social care is complete integration with the NHS. That is what is now starting to happen in parts of the country. Frankly, it is crazy that people have to navigate the complexity of two different systems. It is not fair and it is expensive, so we need to bring those two systems together.

On public health, the first observation I would make is that we have one of the best public health records in the world in this country, and we are still going strong. We are one of the first, probably the second or third country in the world to have standardised packaging for cigarettes; we have teenage smoking rates down to below 5%, which is a lot lower than it was when I was a teenager, watching my friends go behind the bike sheds. The world has changed a lot. I think the UN did a report a couple of months ago that said we are the fifth healthiest country in the world. I memorised the countries: Iceland, Andorra, Sweden and Singapore were the only ones that are ahead of us, so we have a very strong record.

In public health I do not think it is primarily about money; it is about taking big decisions, such as we were hearing from Philippa Whitford, on obesity, standardised packaging, stopping smoking in public places, but that absolutely has to be an important part of the picture.

Q303 **Lord Warner:** Can I pursue this issue which has come out in the evidence of the longer-term smoothness of the funding for the NHS and social care? The evidence being presented to us—and this is not a party political point because it goes back over 20 to 25 years—is that you have these huge spikes in the way money is given out to the NHS, and there is no synchronisation between what is given to the NHS and what is given to social care. This makes the planning of these services very difficult for those trying to manage them, and probably fairly difficult for Ministers as well. What we are grappling with is how you start to smooth some of this out. We all accept that you cannot ignore the state of the economy in the allocations but we ought to be able to do a better job. One of the issues preoccupying us is whether you, as the Government, need more help to get that planning over the longer term right. The department's evidence to us was that you are stuck in a five-year groove; that is what the officials were saying. Do we need something like the OBR? Medicare has a

set of trustees which are looking to the future. Do we need something which would help governments try to focus on a longer-term view around funding, workforce, and investment issues?

Jeremy Hunt: It is a very interesting point. I think I know you well enough to know that you are not party political anyway but perhaps I could say—

Lord Warner: I gave that up some time ago as a bad job.

Jeremy Hunt: I think it has been particularly lumpy in the last six years because of the economic context we have been in, which has made it particularly challenging. It was incredibly disappointing that we were not able to protect the social care budget in 2010 as we were able to protect the NHS budget, but the reality was that the economic crisis we faced in 2010 meant that it was an absolutely huge effort to protect the NHS budget, which is the second biggest budget in government, and meant that other government departments had to have correspondingly bigger cuts, and it was not possible to give that same level of protection to the social care budget. Because of the 2008 financial crisis, we have been through a lumpy period.

I do not want to pre-empt your later questions but, broadly speaking, I think there is merit in the direction of travel of what you have said, for this reason. If you look at the positive lumps, if I can put it that way, if you look at the spike in funding in 2002, that was based on the Wanless report, and five years later Wanless concluded that 43% of the extra funding had gone into higher pay and prices and not into better services for patients. There was a lot of talk about that at the time but, if you went to the root of it, one of the reasons was workforce planning. You can put extra money in but, if you do not have the doctors and nurses there to deliver the extra care, what you end up doing is inflating the prices you pay to the current workforce, which is very nice for them but is not necessarily what the taxpayer intended.

We need to be better at taking a strategic view because if, as I suggest to you, over the coming decades we will need to spend a greater proportion of our GDP on health and social care, we will need more doctors and nurses. Doctors take six years to train and nurses take three years to train, and we need to start thinking about that now, because the truth is, even while we are in the EU and we can import as many doctors and nurses as we wish from EU countries without restrictions, we still have rota gaps; we still cannot find enough of them, because every country is facing the same problem. One of the most important reasons for taking a longer-term view is to be able to be more strategic about our workforce planning.

The Chairman: That is a very helpful comment.

Lord Warner: Can I move us on to social care, where the one thing which has been absolutely consistent in the evidence to us is that, putting it very crudely, the NHS is shooting itself in the foot by neglecting social care because of the effect it has had on discharges, sizes of A&Es, bed occupancy and so forth. What is the Government's longer-term plan for social care? We do not have a view, other than that it is very clear from the evidence that there has to be a plan. Do you have any views about

whether there should be more discussion with the public about whether the family should do more, or whether we need a social insurance system of the kind in Japan or Germany? How would you see us approaching this? I am not talking about sticking plaster at the moment; I am talking about the longer-term game plan for social care.

Jeremy Hunt: First, we completely recognise that there is a serious issue when it comes to social care. I have always seen my job as being as responsible for the social care system as for the health system, even though it falls under local government and under CLG as a government department. For someone with dementia, it does not matter where the care and support they get comes from, but we need it to be good and we need them to be treated with dignity and respect. We are constrained by our economic context but if you wanted some evidence that we recognise the pressures, as is well known, funding on social care fell in the last Parliament but in the first year of this Parliament has gone up by £600 million in cash terms. There can be a debate about whether that is enough but there is a definite change of direction in funding.

You are right to say there is a longer-term issue, and it is a complex one. In a nutshell, we need, as a country, to start saving for our social care costs in the same way as we save for our pension. It needs to be a normal, automatic thing for everyone to do, and we need to make sure there is a proper safety net there for those who have not been able to do that. It is a difficult issue because, on the one hand, you want to encourage saving, but we also want to live in a civilised country where there is a safety net below which no one falls. I think we need to do some radical thinking about how we tackle that problem, because at the moment we are not in that place.

Lord Warner: Do you think that your position as the Health Secretary for the NHS and the policy on social care but not, so to speak, the handler of the budget for social care, is an impediment to integration?

Jeremy Hunt: I do not particularly, because it is not as if there are big disagreements inside government. The issue is that we are constrained by our economic context, but we are very aware of the pressures. One of the things it is worth pointing out is that the pressures on the NHS which you have talked about vary a lot. You have places like Torbay, Peterborough, Rutland and Newcastle, where there are virtually no delayed transfers of care in hospital. The latest figure I saw was that half of all delayed transfers of care are in 20 local authority areas, so there is quite a lot of variation. As a short-term measure, we need to focus hard on the areas where there are problems and see what we can do to sort them out. I still think there is a longer-term problem. We need to get into the habit of saving more when we are younger in the way we do for pensions.

Lord Warner: Is Dilnot critical? Is implementing Part 2 of the Care Act a critical part of your longer-term agenda, capping those catastrophic costs?

Jeremy Hunt: I think Dilnot is one part of it. I am not sure it is the whole solution. We have found it difficult to persuade insurance companies to come out with insurance products, as we had hoped would happen, to cover the £72,000 that people might be liable for. One of the complexities

in this area, as you will be very familiar with, is the fact that it is a sort of Russian roulette as to who has to pay care costs. One in four of us will pay more than £100,000 but a lot of us will pay absolutely nothing. In that context, it is quite hard to persuade people that they need to put aside money when they are younger.

Lord Warner: I should have declared my interest as a member of the Dilnot commission. I apologise, Chairman.

The Chairman: If I pursue the question that I think Lord Warner asked, and that you have partly answered, do you think we need a greater public debate about individuals' responsibility for planning for their social care? If we are going to do that, what funding model do we present to them? Lord Warner referred to other models, such as Japan and Germany, where people who are richer but do not pay any taxes such as insurance tax, national insurance, could begin to pay for their social care.

Jeremy Hunt: We need to have that debate but this is about long-term incentives in the system, which was the debate that we had in the 1940s and 1950s around pension savings, which in the end gave us a pretty robust pension system, but we also need to recognise that there are short-term pressures in the social care system that will need to be addressed before those longer-term changes kick in.

The Chairman: If the Government were to come out tomorrow or the day after and announce some short-term fix for the current problems for social care, would that not be an opportunity to say, "But at the same time we now need to have a dialogue about the longer term" and engage the public?

Jeremy Hunt: Yes, I think we need to have that debate. It is always easier to address short-term problems if you are also thinking about the long-term issues as well. The name of the game is to find a way of getting people in their 20s and 30s to think it is part of being a citizen to think about what will happen when you are much older in a more realistic way than is currently happening.

The Chairman: The Japanese system is that you do not start paying towards a social care tax till you are 45, and you pay for the rest of your life, if you are earning money, so it is not the younger but the older people.

Q304 **Lord Lipsey:** The reason you have given, as I understand it, is you had to put healthcare up because you had given a commitment and therefore social care was left behind, but is it really true that there was not money available that could have been put in the direction of social care? To give two examples, you have adopted the extremely expensive triple lock on pensions; some of that money could have gone into social care. To give another example, in the summer you put up the nursing care allowance, which is paid only to better off people in nursing care, by £190 million, and that would have come in very handy for better social care at the moment. Is it really a shortage of money or is it that you are not giving priority to social care?

Jeremy Hunt: I do not want to pretend that there are not pressures in the social care system. I am alive to those every day. The triple lock was

a manifesto commitment made by David Cameron in 2010 because he felt very strongly that, when we were going into a recession, we had a big financial crisis, he did not want people who were not able to boost their earnings through work to suffer, so he thought it was right to protect pensioners as we went through that very difficult period. That is why he made that commitment for two elections in a row, and we believe it is important to honour those promises, otherwise you destroy trust in the political system.

The broader point is that a promise you make on the triple lock and on the NHS has implications for the departments that are not protected. That does not only include the social care system; it also includes the police, the education department, the armed forces, and they have to bear a bigger share. My hope is that if the economy continues to grow, we can move away from this business of having certain departments that are ring-fenced and certain departments that are not, because we can be confident that we will be able to increase the budgets of all government departments. That has not been the case for the last two elections.

Lord Ribeiro: You slightly hesitated when you talked about the funding of the health service through taxation. Part of the evidence we have heard today was discussion around the use of national insurance. One of the problems about social care is how you encourage, as you have said, people over the age of 40 to invest in their future. Frank Field has come up with this proposal of looking at national insurance as a vehicle for doing this. Do you want to comment on that?

Jeremy Hunt: Frank always has interesting ideas but essentially, as I understand it, he is not talking about a new funding model; he is talking about ring-fencing an existing tax, which I do not think addresses the longer-term issue. I am a supporter of our current system. Lots of people say, "What about an insurance-based system?" The interesting thing is, if you look at the insurance-based systems that exist, they tend to be much worse at cost control. The NHS is very widely admired for its ability to control costs. An MRI scan costs three times more in America than it does in England, despite having the same machine and the same operators, because when insurance companies are paying the costs, no one has a motive to keep costs down, but with a single payer system you can. That is one advantage.

Another advantage, which might sound a bit surprising given the conversation we have had about lumpiness in settlements, is that taxpayer-funded systems tend to have more stable income. If you have a system funded through insurance, it tends to fluctuate a lot more when countries go into recession, but governments tend not to change health budgets too much through recessions. I am a supporter of the single payer system broadly. I think in the end the question is whether we are able to keep growing the economy as strongly as we need to be able to continue to put the extra resources in.

Q305 **Lord Bradley:** This is a very short question, for clarification on the timeframes that you are talking about. You have identified a short-term problem with social care funding and said that we need to move perhaps in the long term to people saving for their own care. Where do you fit the

short term and the longer term together? How quickly do you think you can get to a funding position where people have saved against the short-term problems we have now? How long are you going to have to fund the short-term problem?

Jeremy Hunt: I think there is a real commitment in the Government to address the longer-term funding issues in the social care system during this Parliament. I do not think we are saying that we want to wait until post-Brexit or until another Parliament. We recognise that this is a really serious issue that needs to be looked at sooner rather than later.

Lord Bradley: How long would that have to flow through for before you get an alternative in place?

Jeremy Hunt: The reality is that putting in place longer-term incentives so that people save more for their social care costs will not make a material difference for decades, but it is still the right thing to do, and that is why we still have the short-term pressures that we have to manage because we want to make sure people are treated with dignity and respect.

The Chairman: Am I hearing correctly that you are suggesting that in the short term the Government would have to deal with the short-term crisis in social care, but at the same time the Government intend in this Parliament to bring forward a proposal for a long-term solution for social care?

Jeremy Hunt: I would use the word “pressures” rather than “crisis” but, broadly speaking, I think that is correct. We need to find a way, through evening out the variations between different areas, pressing ahead faster with health and social care integration, doing what we can to relieve the pressure being felt everywhere, but I also think this is a time when we need to put in place a long-term settlement for the social care system, absolutely.

Q306 **Lord Turnberg:** I wonder if could pursue Lord Ribeiro’s question a little further. Your suggestion is that people should begin to pay for an insurance system themselves, put away something for their likely care needs in the future, but what about a hypothecated tax, using the national insurance model, which incorporates the idea that as people age, they put in as much as they can according to their earnings? We know that people earn more in the last 20 or 30 years of employment, and we also know that people in retirement often have quite an income, which could be incorporated into that. Instead of making it more a voluntary thing for them to put away money, this is in the system and could be used for health, and particularly for social care. Do you not think this is a reasonable way forward?

Jeremy Hunt: I suppose the difficulty I have is that we are collecting and spending the money that is used for national insurance at the moment.

Lord Turnberg: But not necessarily for the NHS.

Jeremy Hunt: No. If you were to give all that money to the NHS and social care system, you would have to take the money away from somewhere else or you would have to put up taxes overall.

Lord Turnberg: The putting up of taxes to groups that no longer pay national insurance is what is being suggested by this method.

Jeremy Hunt: I think the judgment, which is obviously not my responsibility, about tax rises—I say this in a completely non-party political way—is what is consistent with a strong and growing economy. All tax rises take spending power out of the economy. One of the reasons why you have the challenge about the need, which was shared across all parties, to make spending cuts in both 2010 and 2015 was the recognition that we needed to allow consumption to take off and allow the economy to grow. That is the difficult territory you get into. If you are effectively arguing for a tax rise so that more money goes into the health and social care system, I think the Chancellor would say that his judgment is that, for the economy to be strong, the current fiscal envelope is the right one.

Q307 **Baroness Blackstone:** I do not think that is economically terribly literate, in the sense that older people spend much less of their income than younger people, because they have bought their house, their furniture, they have their small car that they keep for a long time, et cetera. Asking them to make a larger contribution to something that is hypothecated, where they can see the link between the extra amount of money they are paying and improved healthcare when they get dementia, or improved social care when they become very frail, they would find easier to understand than making an overall tax rise which would also affect many younger people, who have greater spending needs than those in the category that Lord Turnberg is talking about. I know this is not entirely your responsibility but I feel your response did not make much sense on what we know about people's spending behaviour.

Jeremy Hunt: With respect, I think you would find a lot of older people who would disagree with that, and who would say they spend a very high proportion of their income. A lot of older people are extremely poor.

Baroness Blackstone: Of course, but there are a lot of younger people who are even poorer and they have children.

Jeremy Hunt: We have to be careful here, because family budgets are very tight for people at all ages, and particularly now. I am not sure that well-heeled retired people in the Home Counties are particularly representative of older people across the country.

My broader point is a very straightforward one, which is that the level of tax an economy takes is directly related to economic growth and to consumption more broadly. The old people I know are great spenders of money. They do not secrete it away. I do not think there is a cost-free tax rise, if that is what your argument is. I think the judgment made in 2010 about the level of tax and spending to allow the economy to grow was the right judgment, and I think it is very important that we continue to set the levels of tax and spending at a rate that will allow the economy to go from strength to strength.

The proof of this argument is that by the end of the last Parliament we were able to make a big commitment of extra resource to the NHS on the back of a growing economy. In the end, the win-win here is to make the

judgment that is right for the optimal level of economic growth. In the end, once you get that right, you can have all sorts of discussions about getting extra funding into the NHS and social care system.

Lord Warner: Can I go back and challenge you a little bit on this? There was a proposition that if we allowed people to pay more for their social care after they have died, you take no spending money out of the economy at that point. You milk an asset. Your party—I am not being party political but it is an unavoidable fact—

Jeremy Hunt: None of us is today.

Lord Warner: It is a historical fact that your party ran against that, and a deferred payment scheme was an integral part of the Dilnot commission. That has disappeared. That does not take spending power out of the economy at all. Is this pure politics, that we did not like to appeal to the *Daily Mail* or the *Daily Telegraph*, or is that still an option, that you could pump money into social care? There is a lag, it is not immediate, but you start to get more money coming into the social care system post-death.

Jeremy Hunt: I think that is a slightly unfair description of history, if I may say.

Lord Warner: I did live through it.

Jeremy Hunt: There was indeed a lot of politics around the 2010 election on that issue but, if you look at what happened in the last Parliament, the Government accepted Dilnot, introduced Dilnot, we are going ahead with Dilnot, but we have also legislated now for the deferred payment scheme, so that no one has to sell their house if they need to pay for residential care costs, and it is exactly the model that you are talking about; it becomes a charge on their assets after they have died. I think there is indeed merit in that approach and that is why we are doing it.

Q308 **Lord Willis of Knaresborough:** I was struck by your difference between long term and short term. Your short term for social care has now been described in decades, so I think you will need a long-term plan for the short term before it comes to pass.

I wonder if I could move on to the issue of workforce, which you were discussing with Lord Warner earlier. Nobody on this Committee, and I am sure you, would disagree that there has been a real failure in long-term workforce planning. All political parties are culpable in that sense. I want to ask you, looking ahead to 2025, 2030, are you confident that you will have the right policies in place to have the right capacity, but principally to also have the right capabilities? I declare an interest as the author of *Shape of Caring* but it seems to me that it is not just a shortage of personnel at the moment; it is the fact that many of them do not have the right skills to perform what is required in both health and social care. On capacity and skill mix, assure the Committee you have got it right.

Jeremy Hunt: Thank you. You are absolutely right; this is not an area where any government have covered themselves in glory. We cannot wait until 2025, 2030 to get these policies and frameworks in place because of the time it takes to train people, so I completely agree with your point

that we have to be strategic, and that means understanding what the skill mix will be for a very different population. I think that is absolutely right.

The interesting thing that has changed in this is Brexit—which I did not support; I was a “remainer”. Brexit is happening, and I think that is prompting a very welcome and overdue strategic look at workforce requirements. It was Brexit that prompted me to look at the number of doctors that we were training, and we are currently training in England about 6,500 doctors a year. We need 8,000 doctors a year, but we have for many years been counting on being able to import doctors from other countries to fill the gap. Those international, overseas-trained doctors make a wonderful contribution to the NHS but I question whether that is sustainable given that the WHO say there is a shortage of, I think, 2 million doctors now across the world. We need to train as many doctors as we need; that is the truth of it.

That is one area, at the high end, the most well paid end, but Brexit also makes you ask about unskilled labour, particularly people in the social care workforce. We have 67,000 EU workers in the social care workforce, with no clinical qualifications, performing an absolutely essential job. If you go into a care home in London and the south-east they do a brilliant job and we would fall over without them, but you have to ask yourself why it is that so many British people do not want to do those jobs. My own view is that we need to create a career structure, so that if you are working in direct care in a care home, that can be a stepping stone to the next stage. That is why I announced last month that we are creating a pathway for people to move from direct care to nursing without going to university, so that people can work in a care home, perhaps do some rotations and evening study, get a degree, but they would not have to take time off for full-time study in a university.

What we need to do is make sure that in every part of the NHS there is real career progression as an absolutely vital priority.

Lord Willis of Knaresborough: If you take nursing, which I am obviously more familiar with, we have by legislation to train people in four particular brands, so that unless you do mental health nursing, the rest of the workforce are trained with scant evidence in mental health, yet it is now all-party policy to have integrated mental and physical health. We have to radically change the way we train people, what we offer them as a curriculum. Are you confident that you will be able to help drive those reforms through and take people with you? If you do not take the current workforce with you, we will be no better off, because half of them will be here in 2025, 2030.

Jeremy Hunt: We have commissioned the Centre for Workforce Intelligence to do some work on the shape of the workforce in 2035 and what we would need to do to make sure we can access those skills. I basically agree with you; it is something we have to do, and we have to do it a lot better. There are a number of roles such as physician associates and nursing associates which in other countries work extremely well. Physician associates leverage the time of doctors very effectively. They also create a way into medicine for people who do not have a degree or a medical degree. There is a lot we can do, and people want to work in health and social care.

Lord Ribeiro: We have heard evidence that there are quite severe staff shortages in the health and social care area, and your announcement of 1,500 new medical students is very welcome, although we know it takes 10 years before any of them will hit the ground running and we know that there will be a shortage of about 10,000 GPs by 2020. The Francis report highlighted issues around nursing numbers, and we have problems and issues over agency nurses as a consequence of that—very good-quality care but it comes at a cost. There is also the issue around GPs aged over 55 and retention, keeping the workforce.

While we do not enjoy a Soviet-style system where we can direct our labour, the problem we have is that doctors have a choice; they can choose what field to train in and where to go, and they may not necessarily follow a pathway that the public needs. How will we deal with all this? How can we unscramble this and get a flexible workforce that is able to deliver in 2030 or whenever?

Jeremy Hunt: I have discovered over four years of doing this job that, despite the appearance of Stalinist command and control in the NHS, in practice the Health Secretary has very little command and control at all. I think you are absolutely right, particularly with respect to doctors. It is very clear that we will need to train a lot more generalists. We are very lucky to have our traditional general practitioners in this country. They are perfectly positioned to look after growing numbers of older people who we want to keep healthy and happy at home. In fact, internationally people look at the NHS and say we have a huge strategic advantage because of our tradition of general practice. That is why, as part of our funding commitment to the NHS, we have said that we will increase the funding going to general practice by 14% in real terms, which is £2.4 billion a year by the end of the Parliament, which is a very significant increase, and we are aiming for around 5,000 more doctors working in general practice, which will be the biggest net increase in GPs in the NHS's history.

But you are right; it is not what we plan for. Part of this will also be talking to medical colleges and schools. To deliver that, we need around half of doctors to want to go into general practice when they graduate. We are not doing too badly. There is a lot of interest in that but that is something we have to bang the drum for. I think it will be the most exciting area of change. If we are talking about an integrated health and social care system, a GP will be an absolutely critical player in that. I agree with you. A very big thing that we have to do is persuade people that that is the most exciting area of the NHS to go into.

Lord Ribeiro: Is it important too to have in that mix the primary and acute care service that the *Five Year Forward View* suggested? Where you have an urban situation, for example, where general practices are not up to scratch, you provide the opportunity for a hospital that can deliver that care with general practice. In other words, we do not want one system, one size fits all. Is that part of your thinking?

Jeremy Hunt: Very much so. It is partly an urban/rural thing but it is also sometimes, frankly, where you have the best leaders. In Salford Royal you have an inspiring leader, Sir David Dalton, who has not only created one of the safest hospitals in the NHS but he has taken over all

but one of the GP practices in Salford and is setting up a fully integrated health and social care system, with shared electronic health records. What he has done there is extraordinary. If you were going to transform the NHS in Salford, you would not want to back anyone other than Sir David; he is the right person to do that, but there are other parts of the country where you have brilliant local authority leaders. In Birmingham they have very enterprising GP groups. The NHS England plan is to essentially back the people showing the strongest leadership skills, and to recognise that there are parts of the country where that will be acute-led, and others where it will be primary care-led.

Q309 The Chairman: In one of the evidence sessions with the professionals and the regulators, particularly for doctors, we tried to pressurise them into agreeing about the need for more generalists and to have a generalist trained much faster. So far they have not been tempted to go down that path; it is always 10 years or 12 years, where other countries train them in three years. How are we going to make them reverse this issue?

Jeremy Hunt: I am afraid I need to plead clinical ignorance on that, because it is quite difficult for me, as a non-doctor, to make a judgment. I would want to talk to people like Bruce Keogh to ask whether that is possible.

The Chairman: Quite a few doctors around this table would be signed up to that proposal.

Jeremy Hunt: My experience of the doctors and the Royal Colleges I work with is that there is a lot more flexibility on those issues than there was even five years ago. If you had tried to introduce physician associates five or 10 years ago, you would have had headlines about doctors on the cheap. The same thing with nursing associates. Now they are widely welcomed, and what is changing is that people on the front line realise there is so much pressure that none of these schemes is about replacing them but about supporting them to do their work better. These are the kinds of discussions we definitely should be having.

Baroness Blackstone: Picking up the point you made about supporting them to do their job better, coming back to GPs, we are told a lot of GPs are very demoralised. I wonder whether it is because they do not get enough professional support, and they are asked to do too wide a range of things, some of which are below their pay level, where their extensive training is not needed to do what they do, and other things are rather difficult for them, including some of the decisions they have to make on commissioning and so on, for which they have not had any training. I wonder whether we should not look at a primary care workforce which is more thought through, so that each general practitioner would be working with a mental health counsellor, a community pharmacist, nurses who do inoculations, so that some of this work—they have been trained to do more than these sort of things—is done by people with the right training. I do not think we have thought enough about how that skills mix should work.

The other small point is on training, and I agree with the doctors around the table: for somebody who has been in higher education, the length of

training seems exceedingly long. The small point I have a chip on my shoulder about is that, if you are a graduate and you decide to do medicine, most of them are forced to start all over again and do a five-year, first-stage training—it is utterly absurd—including graduates with degrees in biochemistry, masters degrees, and sometimes even PhDs. Something is wrong and needs to be looked at, and it can only be dealt with by somebody in your position, who can try to shake it up and get people to think about this.

Jeremy Hunt: I think that is a very fair point. There is a lot of inflexibility. I think it is beginning to change. There is also a lot of inflexibility if a junior doctor wants to change specialty. We make it very difficult for them to do that. We shoot ourselves in the foot, because then they decide they want to become a locum.

With respect to GPs, what you are talking about is exactly what the strategy is. That is what the GP Forward View talks about. It has been widely welcomed by the Royal College of GPs, the BMA, and all the industry leaders. I think it is very striking. If you look at some of the most forward-thinking American healthcare organisations, such as like Kaiser Permanente or Group Health, and how they do primary care, it is a completely different model. We have one size fits all at the moment in general practice in most places, with 10-minute slots for appointments, and GPs absolutely exhausted after seeing 30 to 40 people in one day. What they need with their more complex patients is to spend 30 minutes, 45 minutes, getting to the bottom of all the issues that a patient is grappling with.

What happens in those different models of care is that, when a patient arrives, they will be seen, typically, first by a nurse, who will look at all their long-term conditions, go through their notes, check they are completely up to date, and would only page a doctor when that initial assessment is complete; that nurse can have a fairly brief conversation with a doctor, who can make the critical clinical judgments on the basis of all the evidence that has been gathered by the nurse who does that.

A lot of those organisations have medical assistants who go round with the doctor everywhere. These are often people without degrees, the equivalent of A-level students. They fill in all the medical notes, and take the admin work from the physician, as they call them there. The people who organise that system say the biggest single benefit is the elimination of GP burn-out; people go home happy, feeling they have spent the day using the skills they have. I think we strongly want to encourage this. I went on that trip with the then President of the Royal College of GPs, and since then she has been a very strong supporter of that kind of change in approach.

Lord Warner: We had evidence from the GMC that what is holding a lot of this up is the inability to make the regulatory system adaptable enough to approve, in the interests of public safety, the physician assistant, and the nurses were saying some of the same things. That is totally within the Government's control, to adapt this 1983 regulatory system, which really rather controls the GMC about how they can do their job. What are the Government's plans for accelerating that reform?

Jeremy Hunt: We have committed to introduce legislation for regulatory reform. It is a question of finding a parliamentary slot. I agree with that but I also think there are lots of things you can do without changing the regulations, and we should get on and do those as well.

Q310 **Lord McColl of Dulwich:** Secretary of State, preventive medicine: you mentioned life expectancy improving. In the States it has started to fall, and it will be falling here too, because of the obesity epidemic. Of course, as you know, it is increasing vastly the number of diabetics, people with dementia, people needing joint replacements, and so on. This arose because of false advice by unscrupulous scientists, and NICE, and the Department of Health, who kept saying all the calories we eat go on exercise, which was not true. Mrs Thatcher used to say, "Don't bring me problems, bring me solutions". What do you think about this solution: that this Committee suggest that we have an all-out campaign throughout the country, involving everyone, informing them of the facts about obesity—not telling them what to eat but at least telling them what the scientific facts are? What would you say to that?

Jeremy Hunt: I think it would be an excellent idea. We have looked very hard at the scientific evidence, and there has been research done by people such as McKinsey as to what policy interventions make the biggest difference. I agree with you that obesity is rapidly overtaking smoking as the biggest public health threat. There is a big issue about equity as well, because it affects poorer people much more than it affects wealthier people, I think essentially because a lot of the cheaper food that you can buy in supermarkets is less healthy. It would be an excellent idea to do that.

Lord McColl of Dulwich: Even if we suggested that poor people ate less of the wrong food, it would still be better than what they are doing at the moment.

Jeremy Hunt: I think everyone needs to be equipped with the knowledge as to what it is healthier to eat. I think that is very important.

Lord Bradley: The *Five Year Forward View* makes it clear that a significant investment in mental health is crucial if we are going to have long-term sustainability in the National Health Service, however you define sustainability, particularly own intervention and preventive work. What is your assessment of the progress that has been made to deliver on the commitment to parity of esteem between physical and mental health, and the integration of physical and mental health that you mentioned earlier?

Jeremy Hunt: I think we are making good progress but there is a long way to go. When you have an ambition such as parity of esteem, you are being dishonest if you say this is something you will achieve overnight. At the start of the Parliament we asked Paul Farmer, the chief executive of Mind, to come up independently with a plan that he thought would be good progress towards parity of esteem over this Parliament. He came up with the mental health Forward View, which involves treating 1 million more people every year for mental health conditions than we are currently treating, a transformation of CAMHS, a transformation of our suicide strategy, and a huge number of extra people going through

talking therapies. We have committed to that, and we are going to fund it. I think we are broadly on track with our objectives in meeting the commitments we made to do that.

That is not to say there are not lots of things we should be doing now that we are not. We continue to do our best.

Lord Bradley: What would be your estimate—difficult question—of when we might get to parity of esteem? How are you defining it?

Jeremy Hunt: He says in that report that he thinks it will be a 10-year process to get to parity of esteem. He is more knowledgeable than I am about these matters, but I would hope by the end of the next Parliament we would not be having these discussions. I think there are some early encouraging signs, incidentally. If you look at the proportion of CCG budgets spent on mental health, last year it was 12.5%, now it is 13.1%, and even in the last two years, around £1 billion more is projected to be spent on mental health this year compared to a couple of years ago, so I think people are putting their money where their mouth is.

Lord Bradley: But on that percentage increase, it would take somewhat longer than 10 years to get to parity of esteem.

Jeremy Hunt: I do not think parity of esteem is about 50% of funding going to mental health. Parity of esteem is about people's mental health not being the poor relation, and always getting the priority it deserves alongside all the physical illnesses.

Baroness Blackstone: Because local authorities have been under the cosh and had their budgets cut quite extensively in recent years, I wonder what assessment your department has made about its impact on public health. Public health expenditure has certainly gone down. You were very bullish earlier about our performance in some international league tables as far as public health is concerned, I think. It is news to most of us probably that Andorra, Sweden and Iceland are the only ones who are ahead of us.

Jeremy Hunt: And Singapore.

Baroness Blackstone: That is one part of public health. Obesity is also a public health issue, and I think we are the second worst in the world after the US there, so clearly there is a need to spend money on public health. If you back what Lord McColl was saying about a national campaign for people to understand much better what causes their obesity and what the consequences of their obesity will be, we cannot sit in a situation with public health budgets being cut any longer, can we?

Jeremy Hunt: I am afraid I do not accept that a public health budget being cut automatically means that we are unable to make progress on the big public health issues of the day. There are some efficiencies that can be made, but there are some big things that you do in public health that happened under the last Labour Government, such as banning of smoking in public places, that have a huge impact on public health which are not about expenditure.

In the case of obesity, Duncan Selbie, the head of Public Health England, which every now and then issues reports that are quite critical of the

Government, says he does not know of a country with a more ambitious obesity strategy than we have. If you look at the evidence base on obesity, the single biggest impact that you can have on obesity is getting manufacturers to reformulate their products, so that the amount of sugar in a frozen pizza, for example, comes down. If you can do that in a clever way, people do not notice the change, just as we have done very successfully in reducing salt in the products that we all buy. We have a plan aimed at reducing the amount of sugar in food consumed by children by 20% over the next four years. That is a very significant ambition, and we have said we are taking nothing off the table if we do not make progress towards that goal, and Theresa May has said the obesity strategy is a first step. We will go further. We also have the sugary drinks tax, which again is a pioneering thing, which will see a huge amount of extra resources going into school sport.

I think we are doing a number of things. I recognise the fact that a number of campaigners would have liked us to have gone further, but I think there are a number of things happening which we need to see through.

Baroness Blackstone: Is your assessment of the cuts in public health one where you are quite phlegmatic because all these other things you mention do not cost that much money?

Jeremy Hunt: No. I think it varies from council to council. I am very concerned when I hear stories about sexual health services and addiction services being cut, because local authorities have a statutory responsibility to provide those services and that should not happen. I think sometimes, in fairness, the issue with those addiction services is the same issue we have in other parts of the NHS, that, frankly, services are not joined up. If you talk to nurses in addiction services, they say it is very frustrating because there will be an NHS nurse commissioned by the local authority, but to solve the problem of someone who is a drug addict they need to talk to the housing department to sort out their accommodation, or they might need to talk to the local Jobcentre to sort out getting someone a job. What we need is a much more joined-up approach to some of our most vulnerable people.

Q311 **Lord Kakkar:** Secretary of State, I should at the outset declare my interest as chairman of UCL Partners, which hosts the national Innovation Accelerator. Can I pursue the question of how important you think it is that there is uptake of innovation and technology at scale and pace across the NHS to secure its longer-term sustainability, and how that might be achieved, particularly a fully digitally matured NHS at a time of some financial constraint, and how in that context there will be a strategy to fully optimise the use of patient data to drive an NHS and health informatics strategy?

Jeremy Hunt: It is a really important question, and I think the short answer is this is an area in which we have been behind but we are hoping to leapfrog the rest of the world due to a very remarkable thing that our GPs did about 10 years ago. They decided to ignore the Government's plans for a national IT programme in the NHS and exercise their right to go their own way. The government programme collapsed, but they set up

fantastic electronic health records, some of the best primary health records anywhere in the world, where the software is done by two British suppliers. Amazingly, without anyone murmuring about this, without any request for funding from the government, they have digitised people's lifetime records, going right back to the pre-internet era, and we have complete medical histories we are now able to use. What we do not do at the moment, but it is starting to happen, is allow those records to flow around the NHS, but we have complete histories of people, which is a fantastic asset. If you are trying to set up electronic health records in America, you simply do not have that asset to use, because they have very good electronic hospital records but those are episodic records, not people's lifetime records.

Now we have around two-thirds of A&E departments able to access people's GP medical records, and next year we will go a step further and introduce what we are calling the Blue Button scheme. At the moment you can access your own record if you go to your GP surgery and get a code, so you can go online and access your record, but from next year we will have a system where you can go online and identify yourself online without having to go to your GP surgery. That will be very significant, because people will be able to download their record on their phone. People with long-term conditions will be able to get engaged in their own treatment. What it will mean is, for example, if you call 111, we will have the 111 app and ask you questions electronically. It will be able to quiz your medical records, so if you are a diabetic, it will ask you questions about your diabetes. This means that if you need to talk to a doctor, the doctor will be a lot further down the road in understanding your situation than is currently the case. It will save a lot of time.

In short, I think there are some very exciting things happening.

Lord Kakkar: Do you think that we pay sufficient attention to that area and that we are making sufficient progress, with regard to this Committee's question about long-term sustainability, the consensus view that innovation and technology will play a vital role; that that part, in addition to finance, workforce and so on, is being properly addressed and planned for?

Jeremy Hunt: I am confident that it is being properly addressed and planned for, and I was very careful to secure the funding necessary for that in the spending review a year ago. I have made big, bold statements about it. I perhaps rather bravely said I wanted the NHS to be paperless by 2018 in my first few months as Health Secretary, and I am quite relieved that most people seem to have forgotten that I made that promise.

The Chairman: To remind you, it is now on record.

Jeremy Hunt: I think we are making good progress. There is definitely lots to do. We are weak at the moment on hospital IT systems. Professor Bob Wachter of the University of California, San Francisco, came over and looked at the state of hospital IT systems, and has given us some very good advice. He does not think 2018 will be possible, it will not surprise you to hear, but he has given us some very good advice about

how we can get our hospitals to world-class levels over the course of the next five years.

Lord Kakkar: Going to the conclusions of this Committee, would it be fair to say that you would share a view that, if there were a failure to optimise on these different domains, whether it be health informatics, the adoption of innovation or digitisation of the NHS and the health record, the longer-term sustainability of the NHS may be jeopardised?

Jeremy Hunt: Absolutely. I think this is a completely necessary condition to get this right.

Q312 **Lord Scriven:** I have been listening very carefully and quietly to what you have been saying throughout your presentation to the Committee. On future trends, what is happening, human behaviour and how this is adapted into the NHS, the NHS is being particularly slow at adapting disruptive technology, for example, which will change significantly not just the way in which healthcare is provided but health itself potentially in the future. What is happening regarding a systematic approach to the use, planning and policy changes that will be needed in the uptake of this kind of adaptive and disruptive technology and how it is implemented into the NHS? It is not just about the planning; the NHS falls down quite a lot in the implementation of some of this.

Jeremy Hunt: I think it is a very fair criticism. If you look at innovative new medicines, our uptake is far too slow. That is partly because we have a national system, which is respected across the world, the NICE system, but it is also quite clunky. We do not have the nimbleness that we need and we are looking very closely at what we could do to deal with that.

Lord Scriven: Could I push you there? What are you looking at in making it more nimble?

Jeremy Hunt: The essential problem with the system that we have at the moment is that, when you have a new drug that NICE says is good value and therefore should be adopted by the NHS, that creates a financial problem for NHS England and for me—that is inevitable—but we do not allow a situation where a willing buyer and a willing seller can come to a commercial agreement about the price at which that drug is distributed in the NHS. We make that impossible with the NICE system. Many of these pharmaceutical companies would give us huge discounts, well below the NICE price, to get their drug taken up across the NHS, but our system does not allow that to happen. That is obviously greatly to the disadvantage of NHS patients.

More broadly, we do not have financial structures that incentivise smart decisions. One of the things that the CCGs are in the process of doing, and through them the STPs, is for the first time tracking the total cost of each of their patients. That is really important, because if you have a piece of disruptive technology that can help a diabetic improve adherence to their regime, you would be able to say to a CCG, "If you spend £100 on this little machine, you will reduce the annual cost of your diabetics from £5,400 to £4,200", and it is a no-brainer for them to buy one of these devices for every single diabetic. Because they do not have that data at the moment, which we are in the process of sorting that out, they look at

that device and say, “That is £100. That is going to cost me money. I do not want to spend money on that because I am already overspent.” That is what we need to change.

Lord Scriven: Could I ask one more question? Clearly, the NHS is a very large organisation, and you are talking about devolution and working more locally. Disruptive technology tends to be more—not big bang but small issues, and there is an issue about culture and access into the NHS for disruptive technology. Is any work being done on how you access and use generic disruptive technology and implement it in an NHS-type approach?

Jeremy Hunt: There is a lot of thinking going on about this, but the conclusion we have come to, or at least that I personally have come to, is that, when it comes to disruptive technology, the old model which says you have a single payer, who is the Health Secretary, and he or she decides the best technology for people with dementia living at home, and then we adopt it and roll it out across the whole system, is too slow and clunky. This is a very big system, and we need to free up the CCGs to purchase innovatively and to experiment. I think that would be a quicker way to get new technologies adapted than if we rely on national bodies to do all these processes. National bodies can assess for safety and value for money, but I think we need to free people locally to experiment more.

Lord Willis of Knaresborough: I was struck last week when we had Baroness Cavendish in front of us looking at the speed of roll-out of new technologies. For instance, I was in St Mary’s hospital last week looking at their patient record system. It is totally paperless, automated, and is now in something like 200 hospitals across Britain. Unless you have a system whereby those who are slower to adopt can be encouraged to adopt a proven technology which is working, you will not get the fast roll-out.

The other critical part is it being able to talk to GP systems. One of the problems with GP systems—and you are right that they have moved ahead at pace—is that quite often they are on disparate systems. They have now started to change all that. I wonder if you have that bit in hand as well to drive things, as well as waiting for brilliant ideas to come up from the ground.

Jeremy Hunt: I think the second more than the first. On the second I am very confident; we have been thinking very hard the whole time I have been Health Secretary about how to get GP records to flow freely around the system. That is really happening now. They are certainly flowing as far as the A&E department, but they are not yet flowing inside the rest of the hospital. I think that is well under way, and is pretty impressive by international standards.

The business of getting hospitals with good IT systems to help those with less good IT systems is slower, because we have some reasonable it systems in this country but, according to Professor Wachter, we do not have any that are world-class anywhere. That is his view. He comes from the University of California in San Francisco, where they have 300 robots going around the hospital delivering medicines from one side to the other, so he has high standards. We have found when we have put trusts into special measures the quickest, lowest hassle way to improve an ICT

system is for it to be taken over by a hospital which has a good IT system, and they do not have to do any procurement and just roll out a better system. That has happened very successfully in one or two places.

I think we have a long way to go when it comes to hospital IT systems.

Q313 **Baroness Blackstone:** You were admirably clear at the beginning about the need for much more long-term strategic thinking in the health service, yet all the evidence we have had is that there is not very much of it going on. We were particularly disappointed in what your officials had to say about this, where there seemed to be very little going on in the department post-2020. I wonder what you are going to do to close this gap. It seems to be particularly lacking anywhere in central government.

The other thing you said was that you recognised that economic growth is absolutely central to being able to spend more money on the health service, and nobody would disagree with that. You said that Brexit could be a problem but that so far the economy was doing pretty well post-Brexit. That is very short-term. All the economists are saying that in the long term the economy will be hit very hard by Brexit. That seems to me yet another reason why you might want some modelling to be done on what will happen as far as the pressures on health service expenditure are concerned if we are going to go into a period of very low, or, indeed, no economic growth, or even a recession post-Brexit. Could you tell us a bit about what ought to be done in this area?

Jeremy Hunt: I think the picture you paint of the strategic thinking that has been going on is not entirely fair. I do not think any of us predicted Brexit, which obviously creates all sorts of uncertainty as far as the future is concerned, but the Government are absolutely committed to making a success of it, and I believe we will.

Of the things that you talked about, I would say that workforce planning is an area where we have failed, and successive governments have failed to get this right. Brexit will be a catalyst to get this right, because we are going to be standing on our own two feet and we will have to start thinking much harder without the automatic access to the European labour pool that we have taken for granted for many years. That is an area where we need to be much more strategic than we have been. Being able to announce 1,500 medical places is only a start, but that was four months after the Brexit vote. I think that shows there is a serious effort going into being more strategic in our workforce planning, but there is lots more to do, as Lord Willis correctly says.

When it comes to funding, my own view is that the current model, as I said earlier, is sustainable, providing the economy keeps growing. I think the record of the Government over the last six years is that we have been taking strategic long-term decisions for the growth of the economy. We now have to go back over those decisions in a post-Brexit environment, but I do not believe the fundamental principles of the NHS that we all hold dear should be or ever will be compromised by Brexit or the changing economic situation. I think it should give us even more impetus to make sure we get the economy right, and that we are able to carry on

increasing funding for the NHS, and indeed, in the decades ahead, increasing the proportion of GDP that goes into health and social care.

On strategic change, you have spoken to Simon Stevens today. You have not talked about it much with me, but he has been responsible for a hugely important strategic change in his time as chief executive of NHS England, which is essentially moving the whole NHS to an accountable care organisation model. He could not really start that process until he had his funding settlement, which was last year, and there is a process now of engaging the NHS. You have the 44 STP areas, with some places going better than others, but that is a very big and important strategic change, and I do not believe he could have gone much more quickly than he has in making that happen.

The only other thing, which we have not talked about very much today but I want to mention, is quality and safety. One of the things I have put most effort into is transparency about quality, with the new CQC inspection regime, but also transparency on mental health, diabetes, dementia, cancer and so on. We are by far the most transparent system in the world in quality and safety. Why is that? Because I think our simple objective is that NHS care should be the safest and best in the world, and the starting point for that is to know how good you are. That means being honest about the hospitals in difficulty and the ones doing brilliantly well, and doing something about the ones in difficulty.

This is the last thing I will say on this. I think it is important to say it, because there is not enough credit given to the NHS for how brave it has been. This autumn the CQC finished its round of inspections of major hospitals and has published its State of Care report. It has said that 54% of hospitals are good or outstanding. We had the usual media stories: nearly half our hospitals are not good; another “woe is me” day for the NHS. That was an extraordinary day for the NHS. We are the only healthcare system in the world that can say that 56% of our hospitals are good or outstanding, which ones are not, and what we are doing about the ones that are not. That is a very important journey to go on in becoming the safest and highest quality, which is what we all want.

The Chairman: Secretary of State, despite enthusiasm for more, I am having to call it a day because I promised you we would let you go. Thank you very much for coming today to help us. We appreciate it very much. In return, we will through our report try to help you identify issues that will make the NHS and social care sustainable in the long term, and I hope you will pay it as much cognisance as we have done in listening to you today. Thank you very much for coming.

KPMG – Oral Evidence (QQ 314-318)

Evidence Session No. 34 Heard in Public Questions 314 – 318

Tuesday 20 December 2016

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Warner; Lord Willis of Knaresborough.

Examination of witness

Dr Mark Britnell, Partner and Chairman, Global Health Practice at KPMG

Q314 **The Chairman:** Good morning, Mr Britnell, and thank you for making time to come and see us today. We are most appreciative. Of course, you did a seminar earlier on, before we started our inquiry. This time a formal evidence session is very useful. You will be sent a transcript after our session. Please feel free to correct it but not to change it. We are on live broadcast today. Please introduce yourself for the record and, if you want to make an opening statement, please feel free to do so.

Dr Mark Britnell: Good morning. Thank you very much indeed for inviting me. It is a real honour and privilege. My name is Mark Britnell. I have dedicated my professional life to healthcare; 20 years in the NHS and the last seven as global chairman for health for KPMG. In that time I have had the privilege, if that is the right word, of working in 66 countries on 230 occasions—sadly, I counted it up last night.

If I may, I would like to make some brief opening remarks. I have six points which I hope will shape the agenda. I have read some of the transcripts of your previous meetings. I will be short and to the point.

Point one: the NHS is fantastic value for money. Having worked in 66 countries, I think we get tremendous value for money from the NHS. We all know that OECD spend over the last two or three decades has been two percentage points higher than economic growth, and we also know that our country compared to our European peers lags by some 2% of GDP behind spend, so I think what we pay for and what we get is fantastic.

Point two: obviously, clearly and axiomatically, the NHS can be more productive, more efficient. The work of Lord Carter suggests that running costs per square metre of a hospital range from £100 to nearly £1,000; infection rates post-hip operations have an eightfold variation. I have seen organisations in the States, India, Singapore and elsewhere where that variation would not be tolerated, and it is a shame, after 27 years working in the healthcare profession, that we are still tolerant of that variation.

Point three: as you know—and I think I sent you my book; if I did not, I am very happy to send it to you—I have spent all my professional life trying to reform and improve healthcare. It is my passion and my profession. In my book I conclude that a single or dominant payer is the best form of payment to keep costs down. There are consequences of that, as you are well aware, but after working in these 66 countries, I conclude a single or dominant payer is best to control costs. How that is funded, through general taxation or social insurance, is a second matter and a secondary matter, but we will no doubt come on to that in due course.

Point four, and I think many of the Peers around the table are aware of this pressing concern: if we do not love our workforce more, if we do not try to motivate and manage our workforce in modern ways, we are in the middle of and approaching a larger crisis. As some of you know, I am one of the 12 members of the World Economic Forum Health Council, and recently we have looked at work, along with the World Health Organization, that suggests the number of doctor and nurse vacancies will be 13 million by 2030. I think your time horizon is to about 2025. One thing I know, and many of you know this better than I, is that there is an emerging global market in the movement of skilled labour, especially in the medical and clinical professions. I know because even last week, when I was working in Jamaica and the Bahamas, visiting the University of West Indies, how influential and sapiential our education and medical education system is globally. I think it is time for us to reinvent ourselves, in producing über-modern doctors and a new form of care worker that transcends health and social care, allied with technology. It is a massive global market and we can lead it. If we do not, the Indians will.

Point five: I say this now not because of the fiscal crisis but, after 27 years of consideration, and working with all sorts of Ministers from different political persuasions, it is my view that we need a new debate, as in 1911 and 1948, on the repurposing of national insurance. I say that not because of the financial crisis we are in now—I consider it pressure, by the way, not crisis, not yet. Looking at the demography and the ageing characteristics of our society, where we know that the work/age dependency ratio will decrease by 20% over the next 20 years, we know that by 2020, just three or four years away, we will have 1 million more people aged over 75, and we know that on average now our life expectancy extends by one year ever 4.5 years, you do not need to be a Member of the House of Lords to work out that we have to find a different form of funding.

I have done some work on this. I am not an expert but I think there is £60 billion at play, give or take—and I can talk about that later—for how

we can repurpose national insurance to have a fund which is professionally managed, directed by government, and, dare I say it, much more transparent in the way that funding is supplied to the NHS. I think this new financing and funding model will bring together, quite rightly, and integrate health and social care. In the great reforming traditions of David Lloyd George, Beveridge, the Conservatives with the White Paper in 1942 and the Labour Government that gave us the NHS, it is this sort of cross-party coalescence that we need, which I think you are leading very ably, if I may say so.

Finally, and this is the most important matter, in any great tectonic health change you require three things, and I have seen it happen but not very often. You need tremendous political will and courage, very good managerial skill and time. I believe there are countries that have demonstrated how they can change their health financing, funding and delivery systems by strong political will, great managerial skill and time. I could name a few at random: Japan in 1961; South Korea after their civil war; Mexico; Brazil as it created SUS; Italy even, in the 1970s; and of course, last but not least, the country that people still look to the most, the great United Kingdom, which led the way in 1948.

They are my six opening remarks. I remain, as always, an optimist. These problems are solvable, they are not intractable, but we need to think and act with more speed and, dare I say it, more verve and imagination. Thank you for listening to my opening remarks.

The Chairman: Thank you very much for that, Mark. In fact, you have covered a lot of the things I was going to ask, certainly my first question, and maybe others too.

Dr Mark Britnell: Thank you. Can I go now?

The Chairman: Can I add one question on what you have just said? Yes, we have heard that our model is one of the best, free at the point of need, but it is not delivering in a lot of areas, and you have picked out some of them. What do we need to do to make it sustainable by 2025, 2030, and beyond?

Dr Mark Britnell: I think there are two different phases now. Clearly, we live in strange and interesting times globally, and I get to see quite a lot of that first-hand. The first thing to say is thank goodness we have economic growth, and thank goodness we are leading the G7 in our growth numbers at the moment. Of course, they have been revised a little over the last few months, for obvious reasons, but, as you know, since the Second World War every major country has shared the proceeds of its economic growth in healthcare. If you look at our European counterparts—the Dutch, the French, the Germans—they are now spending 2% or 3% more on healthcare.

I would expect, as people have said, including the Secretary of State for Health, that as our country grows—and it will—some of the proceeds of that growth will be invested and further invested in our National Health Service. I see that as a short-term, tactical play, while giving us the next three to four years to have a much bigger debate about the future repurposing of national insurance, as I indicated in my opening remarks. I believe that between those two issues we can create a much more

sustainable health and social care system, which recognises the will of the British people, which is, as you know, that the NHS is the most cherished institution, more so than our Olympic team, our Armed Forces and our monarchy. I believe both these things need to happen in parallel but I think both things could and should happen.

Q315 Lord Warner: Can I take us back to what you said about a single payer being critical? That fits quite neatly with a tax-funded system. Why are you so enthused about national insurance and what you call repurposing of national insurance, as distinct from continuing with a largely taxation-funded system? What are the arguments? What is the evidence internationally to support that line of argument?

Dr Mark Britnell: First, to make sure I am clear in my argument, and forgive me if I have not been, I am saying that for the next period a gentle increase in taxation or the proceeds of growth is the way to make the NHS and social care more stable, but looking at the demographic pressures over your timescale, I think this debate about national insurance is long overdue.

Let me answer your question specifically. When I say a single payer, I could also mean a dominant payer. Japan, which I know people have mentioned to you, has over 3,000 insurers, so it has many payers, but it only has a single price setter in the Government; the finance ministry sets the prices in consultation with the health ministry, and they do that every two years. That is why I used the word “dominant”. In that case many insurers are a dominant payer in the form of the Japanese ministry of finance.

On national insurance, I will be the first to acknowledge that I am not an expert, and the great work you did with Dilnot I think taught us many things. The reason why I say “social insurance”, or “national insurance”, is that, first of all, it goes with the grain of our British history. It was created by Lloyd George in 1911, with the “nine pence for four pence” quote, where the employee paid four pence, the employer three pence and the Government two pence. I believe that then, obviously, Lloyd George was making sure we were fit, that we had funds when we could not work, that we were fit to fight—he was afraid of the Germans, and I am not saying there is any parallel there of course—and that using something which people understand, which they have paid for, and is called national insurance, helps working people and old people think about national insurance for health and social care, because those two things now, as you know better than I, are a complete nonsense in terms of health or care.

Why do I say national insurance? I am quite open to people cleverer than I having better ideas. It is not quite hypothecated but it is a source of funds which is clearly identifiable. It can be managed more transparently, which I know has been an issue for your Committee. It can also be managed independently by professionals who know how to manage health funds, and there are lots of examples of how you can better manage health funds. Also, I think it allows for us to have a conversation with the country, dare I say it, outwith the political cycle, where of course we lurch from feast to famine, and in my career I have experienced two feasts and

two famines. It allows us to take perhaps a seven-year view, and I say seven years deliberately because it is nearly halfway between five and 10, and we can have a conversation with the British people about what they want to pay for.

I got back from the Bahamas and Jamaica on Friday and I have been swatting up this weekend. Thanks to you for that; the Christmas shopping will have to be done later on this afternoon. I was shocked to read in the IFS report of this year that today's pensioners are better off than today's working people on average. Something has to give at some stage, so when I look at this £60 billion—and I do not want you to shout at me straight away, because these are just sources and applications of funds, and they are all game for a debate as far as I am concerned—we should look at tax relief on pensions; there is £35 billion to £40 billion there. We should look at the triple lock; surely that has had a good run for its money. We should look at who pays and the rate of national insurance contributions. We should perhaps think about national insurance extensions, because the average life expectancy in 1948 was 67 years, and it is now over 80; old people have a direct benefit from what they have paid into, but perhaps we should extend national insurance for people aged over 65. Chris Ham at the King's Fund and Anita and others have talked about prescription charges, and the old chestnut of TV licence and heating.

My argument is that there are funds there that require political choices and managerial decisions, but I think there is enough in there, coupled with the proceeds of growth—thank God our country is growing—that we can have a proper debate over a period about creating something which people see as respecting the will of the people. They love the NHS.

Lord Warner: Can I bring you back to feast or famine? We have had a fair amount of evidence saying that the volatility of the allocation of resources to the NHS has been very poor, up and down, up and down, and no synchronisation with social care. Is there any evidence from overseas that there are countries that take a longer-term view and smooth out what Simon Stevens called lumpiness, so they take five-year, seven-year, 10-year views?

Dr Mark Britnell: They do, and of course, they have a particular form of democracy. There are three countries, two of which you will be very familiar with, and one which you will know about but I think is able to plan over a longer time period for different reasons. Of the three countries I would like to talk about briefly, the most resilient I have seen is Singapore. It scores very high on the World Economic Forum competitiveness rankings and innovation rankings; it is a highly tech-savvy country; it is a small country, with a particular form of democracy. I have worked with their Government and their major clients for years. They are planning out to 2025. After their independence from the British in the late 1950s, like every developing country, they wanted to build great big pyramids of prowess, big teaching hospitals; their ageing problems are significant, and they realise that; they have now shifted gears, moved hospitals into clusters of care homes, GPs, all connected by information technology; 4.9 % of GDP, 83 years of life expectancy. It is a smart and clever system. They plan, because they tend to have one

political party in power for a long period of time—they have elections of course. They are planning up to 2025, and they are planning massive investments in technology, in care homes, but also, as you know, tax incentives for people like me to look after my parents. They are using a combination of law, policy, planning and economic prowess, so that is one example.

The second is China, of course. GDP growth has been constant at 7% for some time now, but in 2009 they realised how disturbing patients were becoming with their doctors—there were fights, arguments—they wanted to share more of the economic proceeds of growth into healthcare. They launched the largest single movement in universal healthcare that the planet has ever seen, with 800 million people covered through universal health insurance—broad but shallow. They are planning out now to 2025, 2030 as well.

Perhaps they are not the same as our country but what underlines both—

Lord Warner: What was the third one?

Dr Mark Britnell: The third one is where I am coming back into territory which we feel more comfortable about, and that is Australia and to a certain extent Switzerland. I say both, because Australia has just celebrated its 26th year of consecutive economic growth, and although its political system, as you know, is very fractious, and it can be very hard politically, they have people planning over a parliamentary cycle, partly because those parliamentary cycles are so volatile, and they are basing that on economic growth. The Swiss, of course, once again, score very high in innovation, education, teaching and flexible labour relations between employers and employees. Their health system, as I say in my book, is the least disturbed I have ever seen. They do that because they simply spend \$9,500 per head, something we cannot do—it is up there with the States—but they do it because their economy is strong.

The answer to your question is yes, I am aware of countries that plan longer. All are predicated on a strong economic base, and all have elections of sorts, some more democratic than others. If you forgive me for saying two more things, and I do not wish to be provocative, but I run a multibillion dollar business, and no one tells me whether I am going to be plus 5, plus 10, minus 5 or minus 20. In one sense we can still plan in the NHS; it is just a lower number than most people want. I do not think it should stop us doing things because we do not know what is coming from year to year, but smoothing out those cycles, as we do in the private sector, is something the Government should encourage in the NHS and for health and social care as well.

That is why I come back to national insurance as being one way in which the Government are still in control but the fund would be managed in a slightly different way, because, as you well know, being a former Minister, and I know, being a former director-general, in that great scummage called the spending review, when all the departments put in their pet projects, most of which of course are good, it goes into that big back box called Her Majesty's Treasury and something comes out saying "Do all of it with less money". That is one way of going about business but it demotivates professionals, it lacks transparency and, worst of all, it

avoids a conversation with the public, who love, as we do, the NHS. We are grown-up politicians, we have led the world in the creation of universal healthcare, and we can lead the world again with a new social fund which looks at health and social care together. Our time is now, and I am glad that you are looking at this matter.

The Chairman: I am going to have to have to manage the time a bit better. I have several hands up. I need quick-fire questions and quick-fire answers, otherwise I will run out of time and we will not get all the questions in.

Baroness Redfern: You mentioned Japan. Roughly half the long-term care financing comes through taxation but extra premiums are paid by people over 40. You mentioned that employers are paying—is it compulsory for employers to pay?

Dr Mark Britnell: Yes. It comes back to my point about political courage. As you know, the Japanese health economy has been flat-lining for 30 years. I do not know whether you know, but it is depopulating at an enormous rate, from 122 million to 90 million, in the next 30 years. I was there two months ago. That political system is fractious, as you well know, and quite fragile. I admire the Japanese. In fact, they are acknowledged in my book because they had the political courage to have an awfully difficult debate—

Baroness Redfern: That is dual funding as such, rather than single funding.

Dr Mark Britnell: Yes, in 2000 they decided to introduce a mandatory social insurance tax of between 1% of income on anybody over 40, while running 3,500 insurance companies across 47 prefectures. They did it. It was not popular. It did not work at first. It has bought them time. It is a good system. It is always under pressure, but they took that difficult political decision.

Baroness Redfern: Is it compulsory for employers to contribute or not?

Dr Mark Britnell: I would have to go back to my book. I cannot remember off the top of my head. Could I get back to you on that?

The Chairman: Would you write to us and clarify the contribution from the employer?

Lord Lipsey: I am struggling with this debate on national insurance. National insurance is essentially an employment-based tax, where you have it. You said something about extending it to older people, but if you extend it to older people's employment, all you get is an extra £100 million a year, which is not material. If what you are saying in the rest of your remarks is correct, that old people are doing rather well compared with employed people, why are we turning to a tax on employment to fund this when we have another thing which affects everybody equally, namely the taxation system in general?

Dr Mark Britnell: First of all, I respect your greater authority on this matter than mine. I am trying to give you an example of a fund that could be managed over a period of time. The money comes from somewhere; whether it is general taxation or national insurance, it is either one pocket

or the other. If there is a way to have a more transparent give and get between taxation and the spend on health and social care, and a conversation with the population, you would know better than I how to do that.

On the issue of a taxation for national insurance on employers, employees and older people, if you push me, I think the NHS is fantastic value for money for this country, but also great for our business. I have worked in many countries that have social insurance. You know that great, apocryphal cliché about \$1 in \$4 from General Motors being spent on healthcare. There are companies around the world that have a double whammy, paying for health insurance for their employees and through taxation. I think having a more discrete fund where employers, employees and, dare I say it, older people pay into a fund because of the benefits they have enjoyed, they will enjoy and they continue to enjoy from extended life expectancy—there may be a better way to do it, because I am not an economist; I am a jobbing health service manager—is a debate through your line of inquiry that should be scrutinised further.

Lord Scriven: A very quick question. You have talked about this discrete fund, wherever it comes from—an integrated health and social care fund. You have talked about a dominant payer. In the British context, who would you see as the dominant payer? At the moment there are a number of dominant payers, and this could be quite tricky. In future, going forward, if we have this fund, who is the dominant payer?

Dr Mark Britnell: In the national insurance scenario that I painted? Many countries have—

Lord Scriven: Just your view of the UK, going forward.

Dr Mark Britnell: Following my scenario, you would have a publicly managed national health and care fund that would be managed by professionals. It would be part of government but not necessarily part of the Department of Health.

Lord Scriven: You would take it away from local authorities as well.

Dr Mark Britnell: I realise the difficulties there about what we do with health and social care but, if you push me, in the final analysis, the dog should wag the tail and not the tail the dog when it comes to expenditure, if that is not being too cryptic.

Lord Willis of Knaresborough: There is a major flaw I can see, and it is probably because I have misunderstood it. Social care is in fact funded through a whole set of different sources. Are you suggesting that all those sources are abandoned for a single source which comes through this system? It means that everything would then be free at the point of delivery, whether it was social care or healthcare. That is a fundamental difference.

Dr Mark Britnell: As you know, there are about five sources of funds that flow into social care at the moment, which gives complexity and problems. Forgive me for a second if I just say that, unfortunately, my mother passed away six weeks ago. She had lived in a care home for three years, with fantastic care by English, Indian and eastern European carers. I have read many of the transcripts over the weekend and lots of

them narrate the problem. All I am trying to do in your last session today is hint at a possible line of inquiry for a solution. I do not think I can defend my argument completely but, yes, these sources of funds should go into a consolidated fund. We should then look at how we can best deploy that fund, and which sources and applications of funds go into it and where it goes. I am calling for that debate to be had and for that line of inquiry to be pursued.

To answer your direct question, yes, I am assuming that all the sources of funds that at the moment go into health and social care may be consolidated into this fund. Whether people would have to pay more into that or not is a matter of the projections which I would expect people to take over a seven to 10-year period. That is the sort of arrangement I am trying to etch out.

Q316 **Lord Kakkar:** I would like to turn to the question of workforce. You mentioned the impending workforce crisis globally, the huge demands that all health economies now have for a trained workforce. Can I ask you whether, first, you have seen other health systems that are able to better demonstrate the value they place upon their workforce, and are also better positioned to deliver planning for the development of a workforce over time, recognising potentially the different requirements for skills mix and the need to provide flexibility for members of the healthcare workforce to develop and change over time in their professional careers? Do you think that, again, there are models elsewhere in the world that have answered that question and, in particular, have been able to address the skills mix in a way that has been acceptable both to professionals and to meeting the needs of the health economy, and whether we, in our own system here, find ourselves with a more demoralised workforce, experiencing more pressure than in other parts of the world?

Dr Mark Britnell: Two opening remarks. First, in my considered opinion from my global travels, the quality of our medical and clinical education and training is second to none. It is something we have given the world that we should be proud of, and that we should exploit and, as I have said, we should export. I will come on to that in a moment. We should be very proud of what we built up in the 19th, 20th and 21st centuries.

The second thing to say is that there is indeed a global crisis now in work. It is not only the 13 million that I referred to for the World Health Organization but something which I do not think is being covered, reading the transcripts. Many of you will be aware of the sustainable development goals that require all countries to achieve universal healthcare by 2030. Think of all the countries we have been taking from and what they will need to stand up their own universal healthcare. Last week I was in Jamaica. They have a doctor and nursing crisis. They have sent many of their best over the years to this country. The point is that we need to wake up, and wake up now, and I am glad this Committee is taking the lead on this.

To answer your question directly, Lord Kakkar, there is no country that I think is the panacea for workforce education and training, but there are plenty of systems and organisations that are working more smartly than we are. They do three things simultaneously, and I am thinking about

India, the States but also the Netherlands—I could go on. First, they are intolerant of clinical variation, and therefore they standardise, consensually through clinicians and international experts, best clinical practice over care pathways, both within organisations and across organisations. Why is this important? The standardisation allows you to self-police, regulate less, and motivate more. It also encourages clinical professionals to hold each other to account, as opposed to a top-down, central diktat.

When those protocols and pathways have been agreed, they become an iron law. It is not cookbook medicine; you can vary and go off the norm, as long as you can explain, but that enables you to put technology in which is completely supportive, which is cognitive, and now increasingly, if you look at the case of Israel, is based on the best algorithms in artificial intelligence for population health. There are clear pathways and strong information technology. What does that enable you to do? Leverage skills to the highest point possible. That means—I do not like the word down-skilling; I think it is incredibly pejorative—that it allows people to work to the limits of their practice. This means, as you know, in India, with cataracts, they are 12 times more productive than we are in the United Kingdom, and I think five or six times more productive in cardiac surgery. They have managed to reskill and remotivate the workforce. They even—and we have not heard a lot about patients today—encourage families to share care. I am not suggesting that today, before anyone jumps down my throat. As you know, Dev Shetty has a great quote from Narayana: “Who knows the patients best? The family”. There is room there for patient activation and support.

Organisations I am thinking of—Geisinger, Virginia Mason, Intermountain you will be familiar with, Apollo, Narayana, Buurtzorg in the Netherlands—all re-profile the skills they need based on the clinical pathways that have been agreed, and they heavily leverage technology to make sure you have support when you need it.

What does this mean in the UK context? I am not an expert in workforce planning and, sadly, I do not know many people who are in our country. There are two things that are clear to me about taking this global export potential to market and winning—and I think we can win because of the strength of our university system. I think we need to train some doctors more quickly, and I think we need to create a new movement of what I call care workers and care givers, and that is nurses and nurse assistants. I do not think we would go wrong if we overtrained, with more doctors and more nurses and care givers; we will need them in our country. As we know, it also stimulates local economies, and it draws people from local economies that look just like me and you when you are being cared for in your moment of need.

Those are two areas I would major on: a massive explosion in care workers, supported by technology, and I would want us to be the first country in the world that has thought about training some doctors more quickly, perhaps using the physician assistant model as a basis on which to build. The reason I say that is, in my experience of 27 years, people are great at getting into little huddles locally and saying, “This pathway here, from this A&E to this old care ward to this community hospital; let’s

have a care pathway”, and they spend two years agreeing that care pathway, only to conclude they need a generic health worker. We have been too specific. Regulation has played its part in slowing down innovation but I think we have to think and act in a different way now. I genuinely believe there is another economic case for demonstrating that we can not only serve our own country but export that prowess to the rest of the world.

Lord Kakkar: May I follow that up? You are saying that in many of the countries where you have worked there is no national planning approach to workforce. You gave examples of health systems that clearly have an approach to developing their workforce. Does that mean that potentially in our own country regulation stifles the ability for an individual health economy to start developing the workforce that it needs?

Dr Mark Britnell: I think it does to a certain extent, although it is easy for healthcare practitioners and educators to always blame regulators, which are not, in my opinion, the root cause of the problem. Yes, it has a role; yes, it would be nice if pharmacists could do more; and, yes, it would be nice if, say, physicians’ assistants could prescribe. All that is helpful, but I do not think it is the root cause of the problem, so I would want to go where the action is, not just try to dump blame on regulators. They are used to it, of course, but I do not think that is the sole source of the problem. It needs to be addressed, but I think there is a much bigger issue about education, training and re-profiling skills dependent on technology.

Also, as you know, in our country, unfortunately, the technologists are a million miles away from the educators. This is not tolerated in any other industry. It is not tolerated in my business, and we are across 157 countries. We need to become a lot smarter at doing that in this country, and I genuinely believe we can rule the world; we can lead the world in a new form of training and education for healthcare givers, carers and workers.

Lord Ribeiro: When the Secretary of State gave evidence the other day he echoed your thought that no Government has done workforce well, and he threw down the challenge that Brexit might well be the catalyst to address this thorny problem. Britain, like America, has for years relied on overseas workers to staff nursing doctors, the lot. What is your vision for what we will see post Brexit?

Dr Mark Britnell: There are many visions, as you know, of post-Brexit scenarios. Before I answer your question directly, I would like to remind you—I do not know whether you are aware of the statistic. Do you know how many more healthcare workers the US employed between 2008, the global financial crisis, and 2013, so when they were going through their tough times? Would anyone like to guess?

The Chairman: Please give us the number.

Dr Mark Britnell: It is 1.4 million people, the size of the NHS. There is a clear and present danger and problem when a country of that magnitude decides to embrace Obamacare, extend coverage, and employ 1.4 million more people. Time is against us, but two things strike me. I genuinely believe, as I just said, that we can train and care for lots more people by

employing and training people in different ways, and we should not be scared of that; we should walk forward with purpose, because I genuinely think we can lead the world in that.

On the Brexit situation, clearly, there are about 140,000 people from outside the UK in health and social care. I am not a politician, but I think these people have to stay in our system. We have to cherish them and thank them for their contribution, while now planning to create new healthcare workers linked to technology. I do not see that as a contradiction in terms. I see it as something we can build on concurrently and also consecutively. That is what I will be trying to do.

Bishop of Carlisle: One of your initial six points was about valuing and caring for the health and social care workforce, and you have talked about cherishing. What do you see as the key to that valuation? Is it training, as you were suggesting; is it thanking; or do we need to pay them more?

Dr Mark Britnell: It is all of those things, as you know, and, depending on where you are and who you are working with, some are more important than others. One of the nice things about a single funded system of course is that pay rates normally rise and fall with the fortunes of our GDP and our economy, and that is quite a sensible regulator. It is Christmas, I am not calling for massive pay rises, but I think there is only so long you can keep your wage restraint. It bounces back eventually, as we have seen over feast and famine. It is a part of it, certainly, but I think the motivation and recognition in training to enable people to give their best in clinical practice is important. I had the privilege of leading University Hospitals Birmingham for six or seven years, and built the largest hospital in the history of the NHS, with staff satisfaction rates of 85%. We did that through professional appraisal, where we listened; we had an honest conversation about what was expected, the give, and the get, and then we mobilised our training and recognition programmes around that appraisal.

Work I have done globally suggests you can get 15% more motivation and productivity out of the workforce by valuing them properly through professional appraisal and development. I would start there. By the way, anywhere I go in the world I play a game at the conferences I speak at. I say, "What percentage of your staff have meaningful appraisal?" I have never been to a country or a conference where more than 30% of hands go up, and in this country it is about that, if not a bit lower. I would start there.

Baroness Redfern: You mentioned the workforce and how regulators can probably get in the way of motivating and collaboration of certain services. What do you think is holding it up? Do you think we have poor management, or are people saying one thing and holding back? Are they nervous, not confident to move and take on new skills and roles? The second part of my question is: can you hold up a country that is an exemplar in health and social care?

Dr Mark Britnell: They are three big questions. The first thing I would want to place on record, having said I am a jobbing manager, is that I think the managers in the NHS and social care do a tremendous and fantastic job. I know they are maligned by some but, with the resources

that we are given, and for what we get, they should be thanked every day, along with our great doctors, nurses, allied health professionals and ancillary staff. They do a great job in difficult circumstances. That is the first point I want to make.

Second, in terms of the regulation, as you have said, and the lack of workforce planning, having worked in the NHS for 20 years at local, regional and national level, I think that what stops better workforce planning is that no one really thinks they are in control of it.

Baroness Redfern: Should we have fewer regulators?

Dr Mark Britnell: It is almost axiomatic that we need fewer regulators, we need fewer providers, and we need fewer payers locally. It is not possible to do what we are trying to do, to transform the NHS, with 200-plus CCGs and so many providers. There is not enough skill on the planet to make that work. It is not just about the English NHS.

Baroness Redfern: A country that could be an exemplar?

Dr Mark Britnell: The ones I cite in my book are the Nordics.

Baroness Redfern: I have read your book.

Dr Mark Britnell: Thank you. If you pushed me today, the Nordics are similar to us, they are north European, higher taxation base, better integration between health and social care—sometimes that is misconstrued by people who do not understand the systems. They have their problems—they tend to plan longer, have less national directives, and have clinically-driven databases which they use for improvement. We have an overactive policy thyroid in our country, as I talk about in my book; every two years we get another national vision for healthcare, but in the Nordics they seem to go about their job much more quietly and thoroughly, and they plan more collaboratively. They are not brilliant; if you look at the last OECD report, it still talks about fragmented care and co-ordinated care, but if you were pushing me today, which you are, I would say the Nordics. Are you pushing me further? Do you want which one of the five countries in the Nordics? It is Norway, but do not tell Iceland because they are doing well as well, and Sweden, and Denmark, and Finland.

Lord Scriven: On this integration of health and social care, a couple of questions: first, do you see in the future it being one body as an integration? If so, how will we get there? Integration has been spoken about for about 30 years. It is a nice word but we do not seem to be able to get there. What will be the key to get us there? The other issue, coming back to what Lord Willis said on your approach to this one fund in an integrated health and social care system going forward, is whether you see, in this new world of integration, a system that is free at the point of need for both health and social care, or would there be co-payments or extra payments for services which were not within an agreed bloc of services that were being paid for under this system?

Dr Mark Britnell: You have asked me three different questions. The global evidence suggests that the best integration is that integration that is wrapped around the patient. All of those pathways need to come together in a care plan between health and social care and different

agencies, including education. I know it is easy to say but all the global evidence suggests that you need a unified care plan. The second thing you need, which we do not have, and we have not talked yet about investment in the NHS—and I will answer the question but you have not asked it yet—is an investment fund. There are billions of yen, dollars, euros, sterling, waiting to come into healthcare. It is a very resilient industry, as you know. The consulting industry globally is growing at 8% per annum, larger than financial services and agriculture. Why is it resilient? There is always more demand than supply, capacity and capability.

I am going to answer your question. The second thing is you have an integrated information system that makes it very easy for self-care, for extended care, and for clinicians, between health and social care, to focus on that care plan.

I would think about a much bolder investment portfolio for information technology, because we cannot train people, and upskill to the very highest level, unless we are leveraging technology, and we are not doing that. That is the second thing I would say. They use information technology very well. Look at Singapore, where they now have these clusters. We helped them create that system: teaching hospitals, care homes, GPs, integrated IT system. It took them about 12 years. It was not one big bang, by the way. They learned from us, as they usually do in Singapore, and did not go the same way we did.

The third thing is this, and I would like to emphasise it. I have tried to come today with a new idea. It may not be the best idea, it may not be the freshest idea, but I am saying we need a debate about this, because demography, not just finance, is forcing us to a different place. I cannot answer your question today. It is the old politician's trick of "Show me the structure and I will reform it". I think form should follow function, and I think what is great about your group, truly, is that I find it surprising that an industry which is £130 billion to £140 billion does not have a capability to forecast over 10, 15, 20 years. It is a dirty word in healthcare. It is probably a dirty word in local government. We are 140 years old, we operate in 157 countries, we live on a quarterly basis, but we are always planning 10, 15 years out. Any good business needs to do that. Frankly, I am glad that you are doing this work. In a sense, I am surprised that you are doing this work and others are not. I am glad you are, and I am sorry to say this, but you are better placed than I am to answer the question you have asked me. I will happily play a part as a member of the public, as somebody who loves the NHS.

Lord Warner: Dementia care and nursing homes by historical accident have ended up on the social care side of the boundary. Is that an exception, or is that usually the position in most other countries?

Dr Mark Britnell: That is a good question. Broadly speaking, from my memory, we are not an exception, unfortunately. The Dutch do it better, as do the Austrians, with their dementia-friendly care homes. They are starting to move into a completely different socialised model of care, which is less medicalised. I know that was not your question but I do not think many other people have embraced it either. All of this is hitting countries at roughly the same time, at the same velocity.

Lord Willis of Knaresborough: One of the common threads throughout your book, and you have mentioned it a few times today, is that you need to have an integrated technology platform to handle data across health and social care. It is interesting that in your book there is no system, including in the United States, that is the size of the UK's NHS; they are all much smaller. The Netherlands is a classic example, as indeed are the Nordic countries. Is it not time that we accepted that the NHS is too big an organisation to develop the sorts of processes you want to see, and that integral to doing so is to break it up into smaller modules?

Dr Mark Britnell: Yes. Singapore, Denmark, and the Nordics, have very good systems, built over time, with a population base of 5 to 10 million. I think there is a different way of going about what we need to procure. Clearly, we have learned a lot of lessons from Connecting for Health. It did some good about the national spine but no, I am not suggesting, for the avoidance of any doubt, that we have another national programme for health. From the GPs—I read the Secretary of State's transcript—you know there is lots of local innovation. It is great, it works for the practice, but it needs to be joined up. There is a wall of investment waiting to come in for education and skills development and the application of IT to leverage skills. Why should we not be the first country in the world to take it?

Lord Willis of Knaresborough: We heard last week from the Secretary of State that all GPs are now fully computerised, whatever that means—I do not know—and that tertiary care is not, yet we spent £2 billion on a centralised system, which absolutely failed. I do not know where we go unless we break the thing up, but you have agreed that it should be broken up into a smaller number of units.

Dr Mark Britnell: Smaller, more manageable, public-private joint venture partnerships.

Lord Bradley: Very quickly, one of the drivers for integration, another idea, has been the devolution model, such as in Greater Manchester, backed up by locality planning and technological development across that footprint. What are your views on that?

Dr Mark Britnell: I think where there is a great history of collaboration, we should proceed. As you know, I spent many years in Birmingham. I always hoped that we might get our act together but sometimes people are not built that way and relationships are not made that way. I think the Greater Manchester model is fantastic. I do not know whether it is for everyone.

I know you want to move on, Chairman, but there are five facets of high-performing, low-cost systems, and your question touches on one. The first is integrated primary community and secondary care, and I cite Israel, with its technology. Why am I saying that? That can work in Manchester. The second is hospitals as health systems, so you unpack health systems and they run clusters. That can happen in Singapore; for that you could read Birmingham. The third is standardise, digitise and leverage skills. I have mentioned that. The fourth is do not forget social care, and the fifth is a dominant single payer.

Why am I saying all of that? Because Manchester and, let us say, Birmingham, if Birmingham goes a different route, are equally valid models; we are a big and a small country simultaneously, paradoxically. Both deserve to be tried out. That is why I think what Simon Stevens is trying to do in NHS England along with his partners is the right way to do it: not a thousand flowers blooming but four or five models that should be tested. I think we need to move the pace on, and the scale, dare I say.

Q317 Lord McColl of Dulwich: My question is on preventive medicine, and the question is: can we reduce demand and need? Half the NHS expenditure, as you know, is involved in treating patients with complications of the obesity epidemic, and some of us, including the Secretary of State for Health and the Minister of Health, are keen for us to focus on a big drive of preventive medicine, an all-out, nationwide campaign, involving every man, woman and child, not telling them what to eat but informing them of the stark facts. Of course, we were very successful in the 1980s in dealing with the AIDS epidemic, and you remember the tombstone. We told them the facts, and it worked. How do you respond to that?

Dr Mark Britnell: When I was a nipper, I was on the management training scheme in the late 1980s at St Mary's Hospital, which, as you know, had a fantastic HIV unit. There has been HIV, seat belts, smoking, obesity. Obesity's time has come. I certainly support what you are implying. It is a silent killer, and it is something the population are not sufficiently aware of, so in the same way we talked about seat belts for trauma and smoking for cancer, I think we need to up our game on obesity.

I sense in our country, as in many others now, a willingness to have that debate. Of course, it has to be more than a campaign but certainly, in the Nordics, for example, they have realised that it is schoolchildren, and roughly 70% to 80% of workers are employed in the private sector, so we need to find a way to get employers also to take this seriously. There are good wellness programmes now, from South Africa to the States to Italy and Germany and so on, where the wellness programmes have given employers incentives to pick up the cudgels. Although it is half-baked at the moment, when we had this debate about national insurance and what you put in and what you get out, I would like to see wellness hardwired into schools, and also the responsibility of employers. We have missed that through our system over the last period.

Lord McColl of Dulwich: There are many parents who do not think their children are fat. In fact, if their ribs are showing, they think they are malnourished. The amount of ignorance is extraordinary.

Lord Scriven: What are the issues for moving from an illness care model to a more wellness care model, which we will need in the future? You mentioned wiring things. Is there anything else you want to add on what we need to do?

Dr Mark Britnell: Not really. I am not an expert but I think hitting it hard at school and working with employers, because that is where a lot of people spend their time, are two areas. I know we do great school work through our school visitors but I think we can do more. They would be the two areas of focus for the campaign.

Lord Scriven: In our care system, social and health, how would you unlock the funds in buildings, in the acute sector? Is there anything you can do over the long term to begin to do that? It has been talked about for a long time but it still reinforces going into the illness rather than wellness.

Dr Mark Britnell: The obvious answer is what I have seen in Israel. They are so tech-savvy. They have four HMOs, combined payer-provider-hospitals-community. Clalit is the largest—I was speaking to them two weeks ago—with 48% market share, so it is a dominant payer. By the way, we can do this because our system is even simpler; we have a purchaser and a provider. They use technology, and they leverage that through motivation, through empowerment, through activation, and we know through work we have done along with others that, as patients get up to level 4 in their patient activation, their consumption of care drops by between 8% and 21%. We are nowhere near that.

Another one of my clients—I hope they forgive me for saying this—is Discovery in South Africa and their product vitality now is all around the world. They use algorithms and artificial intelligence to look at at-risk groups, population health, and they drill in through coaching in navigation with apps and also incentives. In my dream world, with this new fund, whether it is NHS tax-financed or national insurance, the fund would manage benefits: discounted greens, discounted sports goods. It would actively use the weight and the power of our muscle, our purchasing power, to get a better deal for working-class families and others for their basic daily living, which makes it easier for them to live healthy lives.

I think we can be so much more imaginative about what we can do if we start to think about this fund being an active fund, not a passive payer. That is what we have been stuck in for the last 60 years, dare I say it. It has served our country brilliantly, but every 10 years, as you know, give or take—we are overdue a debate at the moment because it is 16 years now since 2000—each developed country spends 1% more of its GDP on healthcare. We have not done that, so the debate is coming and you are leading that debate. I think you should not flinch from drawing some bold conclusions, because the country will thank you for it. Whether other people do or not I do not know. Merry Christmas.

Q318 **Baroness Blackstone:** You spoke passionately about a number of things this morning, but what key suggestion for change should the Committee recommend that would sustain the NHS?

Dr Mark Britnell: There are two: love your workforce and motivate and direct it properly, and think big and long about new sources and applications of funds. If you do those two things, you will have served the country well.

The Chairman: Mark, thank you very much indeed. I know we could have gone on for much longer, because you are full of information. Of course we will read it in the book you talked about. Thank you for coming, and thank you also for coming to do the seminar. If there is any other information you would like us to have based on the questions we asked that would help, please do so. There is one thing you promised to send in reply to the question from Baroness Redfern. Thank you for coming today.

Dr Mark Britnell: Thank you, and merry Christmas to you all.

The Chairman: The same to you.

Dr Mark Britnell: I have the answer to the question of who pays: Japan's 2000 long-term care insurance was split 50-50 between employees and employers. I thank Jonty Roland for that advice.

The Chairman: Thank you very much.

University College London (UCL), Government Office for Science and the Department of Health – Oral evidence (QQ 319-327)

Evidence Session No. 35 Heard in Public Questions 319 - 327

Tuesday 20 December 2016

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Warner; and Lord Willis of Knaresborough.

Examination of witnesses

Professor Sir Michael Marmot, Professor of Epidemiology and Public Health, UCL; Professor Sir Mark Walport, Government Chief Scientific Adviser (GCSA) and Head of the Government Office for Science, HMG; and Professor Dame Sally Davies, Chief Medical Officer, Department of Health.

Q319 **The Chairman:** Good morning. Thank you for coming today to help us with this evidence session; we appreciate it very much. Before we start, I would be grateful if you could start from my left and say who you are so that we get it on the record. If you want to make a brief opening statement, please feel free to do so.

Professor Sir Michael Marmot: I am Michael Marmot. I am director of the UCL Institute of Health Equity.

If I should take my two minutes now, I will. When you think about sustainability of the NHS, one has to put it in context. It all sounds very complicated. I think it is almost Newtonian in its simplicity; it is like billiard balls. You have demand, funding and care, and you have to think of all three. We have increasing demand because of a growing population and an elderly population. In funding, in real terms, NHS inflation has been flat. Then you have to look at quality of care. My approach is to look at demand and the big issue for me in the inequalities is that we show a social gradient in life expectancy but a much steeper social gradient in disability-free life expectancy. People in the most affluent areas live about 12 years of their lives, on average, with disability and then it increases progressively the more deprived the area. In the most deprived areas, people live 20 years of their lives with disability. If we want to make our health system sustainable, we have to address the social gradient in

disability, not just for the poor but right across the gradient because it increases, and I will have a lot to say about how we can do that.

The Chairman: Good.

Professor Sir Mark Walport: Good morning. I am Mark Walport, Chief Scientific Adviser to the Government, and I have a number of interests with respect to your inquiry.

My job, as you know, is to ensure that the Government have access to the very best evidence to help them with long-term decision-making and strategic thinking. I am supported by a network of chief scientific advisers, and you have already had the opportunity to hear from Chris Whitty. I have a broad role in ensuring that the Government make the best use of futures thinking, so the futures work that the Government Office for Science does is part of the Government's horizon-scanning programme and it is a partnership with the Cabinet Office. That was set up in response to the review that John Day undertook and reports to the Cabinet Secretary's advisory group, which comprises Permanent Secretaries from relevant departments.

The future health of the population is of interest to me from three perspectives. First, you cannot meet the challenge of thinking about the future of the NHS without looking at the very best evidence and collecting it. In the context of the Foresight work and the horizon-scanning work, we have completed a piece of work on the ageing population, and I will have an opportunity to say a little more about that, particularly when we talk about some of the demographic challenges that Michael Marmot has been talking about. The third point is that most of the levers that we have to promote the health of the nation, which will, in turn, secure the long-term sustainability of the NHS, sit outside the health sector itself. They are in education, housing and transport, so many different parts of the Government and the wider economy need to play a role. Those are the three reasons that I am interested in providing evidence to you.

Professor Dame Sally Davies: I am the Chief Medical Officer for England. Thank you for the invitation. I shall be brief because I think the conversation will be the most important bit to you, and I am sure some of it will focus on prevention, in which I have a particular interest.

The Chairman: Let me get on to the first question. You have mentioned the change in demography, the impact that it will have looking forward to 2025 and 2030 and the challenge that it will produce for health and social care. Is the health system geared up to meet that challenge, and what do you think the key drivers of that change will be?

Professor Sir Mark Walport: If I start with the demography, it is quite a complicated, multi-faceted picture. Some 75% of the UK population growth between 2012 and 2040 is projected to be in the 60-plus age group, so by 2040 one in seven people will be aged over 75 compared with about one in 12 today. Of course, the challenge is that, while we are all living longer, we are not compressing morbidity, so there are more years of ill health, particularly for women, and years of ill health have not decreased for men.

The next point is that the geography of ageing varies across the UK, so it is not uniform. Coastal and rural areas are ageing much faster than major cities, and people migrate away from cities as they age. We have changing family structures, so it is projected that something like 400,000 more older people will need family care by 2031 and, over the past 10 years, the proportion of over-65s who have divorced has doubled, so these all add to the complexity of the demographic challenge. If you are a working carer you are two to three times more likely to experience poor health than those without caring responsibilities and, to put the old age dependency ratio in context, the ratio of people over the state pension age to 1,000 people of working age will increase from 311 now to about 372 in 2040. Looking at housing, it is not fit for purpose for that change. For example, the number of disabled older people increased from 4.7 million in 2002 to 5.1 million in 2011-12, and all the evidence suggests that that trend is set to increase. It is almost a demographic perfect storm. It is an increase in ageing people, but there are all sorts of other complications that go with it. Those are the demographic facts.

The Chairman: So is the system geared up to meeting this challenge looking ahead to 2030?

Professor Dame Sally Davies: Let me add a couple more facts before I go to that. Of 50 to 64 year-olds, who are employed, as I published a couple of weeks ago in my "baby boomers" report, 42% have one long-term condition and 24% have two or more, and by 2020 a third of workers will be 50 years old or over. You can see the pressure that it is putting on the healthcare system, which was set up as an illness system in the 1950s, not to be a health system doing prevention and aiming to keep people out of hospital. That was not the objective. We have yet to fully adapt to the needs of this changing population and, as the OBR has highlighted for you, as incomes increase, people demand more of healthcare, so we are asking more of our health system than our parents did, and our children will ask more than we did, if that straight line persists.

The Chairman: Sir Michael, a comment?

Professor Sir Michael Marmot: One is looking at the demographics, but I said I wanted to come back to the causes of the inequalities in ageing and healthy ageing, and I think there are challenges. In my 2010 review of health inequalities, I identified six domains of recommendations to reduce health inequalities: early child development; education; employment and working conditions; that everyone should have the minimum income necessary for a healthy life; sustainable places to live and work; and the sixth was taking a social determinants approach to prevention. There are challenges in all six of those that do not look good for the future.

If we look at early child development, the decline in child poverty stopped, became flat and is now increasing, and the projections are that child poverty will increase over the next four years. Another way of looking at good early child development is not just at children in poverty, but at the quality of services for early child development. There is good evidence that good services can reduce the inequalities in early child

development, but we have been closing Sure Start children's centres all around the country— a very bad idea.

In education, the recent PISA scores—Programme of International Student Assessment—show what they had in recent years. If we take Finland at one end and the US at the other among the rich countries, we always do worse than Finland and always better than the US, but our gradient is steeper than in Finland. It is not quite as steep as in the US, which is a very bad place to be. As we know, health has been stagnating in the US and, in fact, life expectancy dropped last year. On education, we are failing our young people because of this steep gradient.

On employment and working conditions, the quality of work matters. There has been a rise in the proportion of work-related illness related to stress, depression and anxiety, which is complicated.

Then, when we look at number four, income, as you know, for people under 60 per capita income has not reached its 2007 level—we are still below it. The projections of what the tax and benefits system will do over the next five years is that, for the bottom decile of income, there will be something like an 8% decline in income, for the next decile about 10%, and, for each decile, the richer you are to begin with, the less deleterious an effect any changes to the tax and benefits system will have. There will be increased poverty and increased inequality over the next five years, which will potentially damage health, particularly for families with children; they will be selectively hurt the worst. If you look at the gap between the minimum income standard for healthy living and the national living wage, projected over the next five years, it will be particularly large for families with children and single parents with children; they will be in real poverty, which will, of course, have an adverse effect on early child development.

Lord Kakkar: To come back to the point made by Sir Mark and Dame Sally, how is this information that you have provided incorporated into long-term sustainability planning for the NHS?

Professor Dame Sally Davies: The way the planning goes— I think it has been explained to you, my Lords is that we get inputs at every comprehensive spending review from all the arm's-length bodies and their analysts on a lot of data, plus we have a team of analysts who work up where we think things are going. That is the basis of the discussion with Her Majesty's Treasury for the financial settlement.

Lord Kakkar: That is for a spending cycle, not for long-term sustainability to 2030 and beyond.

Professor Dame Sally Davies: That has worked very well. I know that you are interested in looking further than a five-year cycle, but, while we can predict some things that are coming, be it artificial intelligence or robotics, I would argue that we probably would not have predicted when I was a houseman that housemen now would not be holding on retractors night after night for gastric surgery because of antibiotics. There are disruptive technologies that come along and totally change it, so we do not want to set it that far out.

On the other hand, to take one of my favourite subjects—antimicrobial resistance—because of the long-term nature that is able to be modelled, we have done some long-term planning, not only for the nation but a big piece of work internationally.

Lord Kakkar: Sir Mark, does the horizon-scanning function feed into a view about longer-term planning for the delivery of healthcare?

Professor Sir Mark Walport: I think that, ultimately, it does. Of course, your Lordships will remember that Lord Filkin produced a report from the House of Lords on ageing and, partly as a result of that, the Government Office for Science undertook the Foresight report on the future of ageing and the Centre for Ageing Better has been set up as a result. That evidence has fed into government.

Let me answer Lord Patel's question directly. Looking at the future, one obviously has to look through the lens of demand and then the lens of supply. Looking at it through the lens of demand, the demography shows that the demand will increase because, as an ageing population increases, if we fail to compress morbidity, which is the big challenge, the demand will go up. A number of things can be done to reduce the demand, including the discussion about housing, transport and all the factors that determine whether people are likely to end up requiring healthcare or not.

On the supply side, which is the NHS itself, one has to look at that through two lenses. One is around efficiency and effectiveness, and a lot of work has been done on that, which we will come to in just a minute on how technology can help. The other challenge is that there is only a certain amount you can do to improve efficiency and effectiveness and, as the volume of demand goes up, inevitably, there will be a need for an increased volume of supply as well. You have to look at it through all those and there is no single dial that you can turn to meet the challenge.

Q320 **Lord Warner:** I have spent a large part of my life engaged in public expenditure reviews, and the thing I have learned from that is that the Treasury is interested in forecasts of money. What I am interested to know from all three of you is that, if you look at Michael Marmot's review, *Fair Society, Healthy Lives*, and what he has just said, there is a whole raft of social policy issues that will impact very seriously on the NHS in the future. Where can the Committee find in the bowels of the Government any piece of analysis setting out the long-term implications of these proposals, not just for social justice but for the expenditure of the NHS? Where can we find this information which will reveal that the Government have costed the implications of failure to change these social policies on the NHS?

Professor Dame Sally Davies: There was a health White Paper quite soon after Sir Michael's report, which addressed some of these issues, as you will remember, and there was analysis behind that. I can tell you that the demographics and these issues are a part of the comprehensive spending review planning and that cycle.

Lord Warner: I am asking for some numbers. Where does it say that if you carry on along this path, the cost to the NHS will go up by X%?

Professor Dame Sally Davies: The numbers have been modelled by the OBR and various people. What we know is that it varies across the OECD,

that we are in the middle of the OECD, and that, because, as incomes go up, demand can rise, it is almost inexhaustible. We will talk in a bit about new technologies, whether they can save money or will cost more money, but there is quite a lot of work if we go looking for it.

Where the problem comes is that housing are doing their work in local government and, more and more, with us giving the public health grant to local government, we are expecting local government to take the right decisions around place and plan for their areas.

Lord Warner: We do not know, as far as I can see. Michael, what is your picture of this?

Professor Sir Michael Marmot: I do not think we generally do the accounting in quite the right way. For example, there are numerous estimates of the cost to the NHS of obesity and there are numerous estimates of the cost to the NHS of alcohol.

If we take alcohol, we know that, in general, the higher people's status, the higher the average consumption of alcohol. It is not the case that the poor drink more than the rich. It goes the other way: the higher you are, the more likely you are to drink and the more you drink, on average. However, when we look at alcohol-associated harm, cirrhosis mortality and alcohol-related hospital admissions, it goes the other way and, the lower you are, the more likely you are to get into harm from drinking. If we really want to address alcohol-associated harm, we have to address not only alcohol but inequalities.

The same goes for obesity: if we want to address obesity, we have to address not just physical activity and diet but inequalities. Now, we do not tend to do the calculations that way, but we tend to calculate the cost to the NHS of obesity-related illness and alcohol-related illness. I would argue that the real cost comes from not tackling inequalities, and we tend not to do the accounting that way.

For what it is worth, in my 2010 review, we put some numbers in. I did not believe them, but we put some pounds in because we thought we had to, though you could come up with any number. I think the real issue is that, whatever number you come up with for the cost to the NHS of obesity and alcohol, you are understating the problem because you are not saying what the cost to the NHS is of not addressing the underlying inequalities.

We know that this has been done many times. I do not usually quote Chicago economists, but James Heckman said that for every dollar you spend on early child development, you save \$7 in less crime, less healthcare use and fewer social problems. Certainly, for early childhood it is a very good investment. At later ages, it is not such a good investment, but most of us of a later age think it is a good investment, despite the fact that there may not be high financial returns.

Q321 **Lord Willis of Knaresborough:** This is a question specifically for Mark Walport, but all the panel may want to respond. It struck me, with my short involvement with science and health, that we spend an enormous amount of time looking for new pharmaceutical modules to improve healthcare, yet all the evidence to this Committee has said that one of the most significant

developments that has to take place is the use of technology and, in particular, the use of digital information to drive a modern healthcare system. What innovations or developments will have the most significant impact, do you think, on the medium and short-term sustainability of the NHS? How good do you think the NHS currently is at taking advantage of these new developments, and who should be driving them? We heard last week from the Secretary of State that, while all GP surgeries are now fully digitised, whatever that means, the tertiary systems are not and there is no real connection between them. Who will drive that because, if we do not get that right, the rest of it, frankly, will just not fall into place?

Professor Sir Mark Walport: Thank you, Lord Willis; there are a lot of questions embedded in that. Taking them in turn, first, of course, it is technology outside the NHS as well as inside the NHS, so there is the whole question of how we can use technology to reduce demand. There is the question of how technology can assist people in ill health in living effectively in the community, whether by better management of their diabetes or better care in the home, so there are very important uses of technology there.

Focusing inside the NHS, first, you are absolutely right that technology to improve the logistics of the NHS will be extremely important. It is about how we connect up data between primary, secondary and tertiary care, and how we use data to link between secondary and tertiary care and social care. The potential here is enormous. This is a worldwide issue. I am probably misquoting Bill Gates, but I think he once said that, basically, technology has transformed almost every service industry that there is, except health, so there is a challenge to get it embedded in health. Part of it is about the natural sensitivities of confidentiality of data, but nevertheless there are very good examples.

You ask how good the NHS is at the uptake of innovation. At its best, it is very good indeed, but the problem is that it tends not to disseminate fully throughout the health service, so you can find islands of very good practice. One example would be the Queen Elizabeth Hospital in Birmingham, where they have had a decision-support tool that they have deployed for over 10 years; they have dashboards on every ward; you can see when every prescription was given and by whom; they have reduced prescription errors; and they have reduced the mortality of patients coming in through accident and emergency.

Lord Willis of Knaresborough: May I just stop you there because we could cite lots of single examples, and that is the problem—there are lots of single examples. If you go to remote parts of North Yorkshire, Cumbria or wherever, you will not find some of those but you will find others. All the evidence is there that you need to do this, so where is the driver to make it happen on a scale? John Bell, for instance, said in the States that digitising the whole system happened within months, or perhaps years. Without that, you cannot depend on all these other systems because they require that digital basis of information. Where are we doing it and who is driving it?

Professor Sir Mark Walport: You are asking a very good question. I am not sure that the Government Chief Scientific Adviser necessarily has the answer to this.

Lord Willis of Knaresborough: But you have all the information.

Professor Sir Mark Walport: Ultimately, this is a leadership and managerial issue, which is how you distribute good practice. As I say, there are many examples of good practice, and this can be done at scale. Scotland, for example, although it has roughly a 10th of the population of England, has reduced amputation rates in diabetics by 40%.

Lord Willis of Knaresborough: Should we split up England, for instance, into smaller NHS units?

Professor Sir Mark Walport: That is effectively what is happening. You can look at what is happening in Manchester, where the budget has been devolved, as an example of where that is happening.

Lord Willis of Knaresborough: But that means nothing to Burnley, which is only a few miles away from it and is not included.

Professor Sir Mark Walport: Again, you are asking a managerial question. You have identified that one solution to divide the country into tractable-size population groups.

Lord Willis of Knaresborough: Would you recommend that?

Professor Sir Mark Walport: I think that is outside my remit, really.

Q322 **Bishop of Carlisle:** This is really a question to Sir Michael. I am going back to your 2010 report, *Fair Society, Healthy Lives*, which you have talked about. You have made it clear that, as you see it, part of the real cost with regard to public health is not tackling inequalities. You have also made it clear that not much progress has been made with regard to your six key objectives over the past six years, and you have painted a fairly gloomy picture of the future. What, as a Committee, do you think we should be recommending in this area? Should it revolve around early childhood, as you were suggesting a moment ago? Is that the key area? Obviously, all these things are interrelated, so it is difficult to single out one, but, if we were to go for something that would make a difference in the future, would that be it?

Professor Sir Michael Marmot: I have always resisted coming down on one. I was asked several times, "What's the one thing that you recommend?" and I said, "Read my report". I think the six are interrelated. For example, I would not say invest in early childhood and tolerate the reduction in spending for public health, because the reduction in spending for public health has been very bad and we should not have done that. Dame Sally talked about the importance of prevention in public health, so reducing the public health spend is bad. Reducing the funding to local government by 23% is also bad, given that public health has now moved into local government, so I would not say only one.

However, if we take early childhood, that relates to a lot of other things; I have already mentioned the income of families with children. If you look at housing benefit, it is absolutely vital for people in work to have housing which then relates to the circumstances in which they raise their children, so by focusing on early childhood, you have to pay attention to the others. You have to look at housing, income, the benefits system and the fiscal system, all with a view to reducing the inequalities in early child

development. It is not a bad place to look because so many other things relate to it and there are, potentially, so many other benefits: a reduction in crime; a better-educated population; a more skilled workforce; more social cohesion; and narrower health inequalities.

Bishop of Carlisle: Has anything positive happened in any of those six areas recently?

Professor Sir Michael Marmot: If we look from 2000 to 2010, we see that life expectancy and disability-free life expectancy improved across the population. That is great; that is terrific. I have always said that we should have two societal goals, one of which is improving health for everybody, which has been happening. The second goal is reducing inequalities, which has not been happening. The gradient of the slope, in both life expectancy and disability-free life expectancy, has not changed in that 10-year period. Some of the reasons it has not changed are some of things I have been talking about and they have not, I regret to say, been very positive.

Q323 **Lord Scriven:** Going back to technology, I am totally perplexed. Medicine is about using data and innovation and modelling, but on the technology side what stops that? In going forward, everything we have heard is that data-driven systems, using technology—disruptive technology—will be vital in helping the NHS be sustainable. What needs to change to have this systematically ingrained in the NHS so it is successfully adapted? I do not mean one-offs, but a systematic approach to dealing with a model of what is happening in the world and making it work for the NHS and patients?

Professor Dame Sally Davies: Clearly, you need a management culture that values that and a workforce that knows how to use it. Although our younger people move past smartphones, many of the workforce do not. You then need enough funding but, as you know, over 70% of the funding in hospitals goes on staff. It is a political fact that you cannot mandate from on high that a hospital does X or Y because most are trusts and they have their own governance. You can do it through commissioning, but this is a very complex area that needs a lot of money. It needs a culture that values the technology and the data that go with it. That is one reason that I welcome Google DeepMind working, as long the privacy issues are right, with the Royal Free, bringing artificial intelligence in there. We are going to need more and more people to show we can do it. It is hard. Cambridge University Hospital, Addenbrooke's, introduced a new system which was very rocky and difficult in the beginning and patients nearly suffered. I am reassured that they did not suffer, but because it was so difficult the chief executive who had had the vision to sign it off was sacked. The culture is not one of grappling with it.

Lord Scriven: If younger people come in and if the management system is right, is there something system-wide that needs to change? Where is the investment model? Sir Mark said that we do not disseminate good practice. That is not just an issue about management of implementation. Systematically, across the piece, what is needed at central level to help and support the inevitable being implemented well?

Professor Sir Mark Walport: There are examples where the NHS disseminates better than almost every other system in the world. NICE is

a very good example where assessments of treatments, be they devices, drugs or other interventions, are assessed and distributed very well.

On data, which is a critical question, part of the challenge is, “I would not start here”, as it were. We start with a system which has separated GP records from hospital records and one hospital’s records from another hospital’s records. The challenge is to take a system where the lines of accountability have historically been different. We need three things. First, we need to achieve integration of health records; that is absolutely critical.

Lord Scriven: How? That is the issue.

Professor Sir Mark Walport: I will come to that in a second. Secondly, it comes to Lord Willis’s point that we need local ownership of this. This has to be done ultimately at a local level. Thirdly, it needs accountability. When you have properly integrated records, you achieve much better accountability for healthcare provision.

At the end of the day, how this is achieved is about management and leadership. That is where science comes to its limits.

Q324 **Lord McColl of Dulwich:** Sir Michael, you mentioned that the demands are due to the old people getting older. The old people have always been getting older, but what is new is that in the last 30 years the young people have been getting fatter and fatter. I look back to the AIDS epidemic when the Department of Health had a very stark, honest approach and said, “If you behave like this, you are going to die”. It was stark—it did not talk about equality, inequality or anything like that. It was just the plain, unvarnished truth and it worked. Some of us, including the Secretary of State, are very keen that we should have a big drive on preventive medicine and point out to the public that half the expenditure of the NHS is on treatment of the complications of obesity. The problem is that the public have been misled by scientists, the food industry, the Department of Health and NICE with all sorts of crazy things such as all the calories we eat go on exercise, which is not true. The emphasis on exercise was a very big mistake. What would you say if our report went for an all-out campaign nationwide, involving every man, woman and child, telling them the stark truth: they are going to die if they go on eating as they are? It is a complicated business but, at the end of the day, you are what you eat. What would you respond to that?

Professor Sir Michael Marmot: When people get concerned about the nanny state I say, “Don’t worry; no one listens”. Simply telling people what is good for them is largely ineffective.

Lord McColl of Dulwich: What about the AIDS epidemic?

Professor Sir Michael Marmot: That was largely ineffective. When we had the no smoking campaign, we had a whole series of efforts other than simply telling people what was good and bad for them. We banned advertising, there was a public places ban, new labelling et cetera. Taking my obsession with inequalities, we know that the ban on smoking in public places is one of the few interventions that actually affected smoking across the gradient. Low-income people reduced smoking as did high-income people did in response to the ban in public places. We know

that simply telling people is largely ineffective. We know that for obesity. We knew it for smoking until we took a “broader social determinants” approach to smoking.

Although obesity is part of the problem, let me go back to the US. I put us somewhere between Finland and the US when I was talking about schooling. We know that the causes of the rise in mortality in non-Hispanic whites aged 45 to 54 are: first, poisonings due to drugs and alcohol; secondly, suicide; thirdly, alcoholic liver disease; fourthly, violent deaths. When you look at the excess mortality in Glasgow compared with Liverpool and Manchester, the causes are: poisonings due to drugs and alcohol; suicide; alcoholic liver disease; violent deaths. These will not be addressed simply by telling people to behave better. We have to deal with the social causes and the same applies to obesity. We have to deal with the social causes of obesity, not simply tell people what is good for them.

Lord McColl of Dulwich: So you do not think there was a mistake in telling people, as was done, that we need a low-fat, high-carbohydrate, high-sugar diet and you must have more exercise. Do you not think that had any effect?

Professor Sir Michael Marmot: I am not against conveying scientific evidence in the clearest way possible. I am for it and we should indeed give people the tools. Simply giving people the knowledge is not enough if you really want to make change.

Lord Warner: Is there not a problem about the protection of resources to carry out these prevention and public health programmes? Looking at the evidence which has been put to us, we are seeing in-year cuts to public health funding locally and, we think, nationally. There is a bit of a smokescreen over it but have we moved to a point where we have to be much more robust about protecting the resources that are allocated to public health and prevention programmes? Talking about the percentage of GDP, should we ring-fence money for a period, such as five to 10 years—something a bit more dramatic than what we have been doing of late?

Professor Dame Sally Davies: Of course I would welcome more money spent on public health field and prevention field, although it need not all be spent by Government at the centre. I could give you examples of our social marketing that have been successful in this arena. At the local government level—the place level—it is important when thinking about health that it is not just about providing sexual health services or stop smoking services; it is about transport policies, green parks policies and all of that. There is no silver bullet for any of these difficult public health issues.

Lord Warner: I have a very straightforward question. Should we protect the money that is allocated and stop in-year cuts? ASH say that cessation programmes for smoking have been cut by about 60%. How do we protect the budget that has been allocated for public health and prevention?

Professor Dame Sally Davies: I thought I gave a straight answer.

Lord Warner: You said you would like a bit more. Are you prepared to go on record and say that there should be some protection for these budgets when they are allocated?

Professor Dame Sally Davies: I am already on record as asking for continued ring-fencing of the public health budget.

Lady Blackstone: Why do you think it does not happen?

Professor Dame Sally Davies: In times of austerity, there are very difficult decisions to be made and central government feel that local government should be able to make its own decisions about it. I have some sympathy with that but I worry about the public health budget.

The Chairman: Michael, earlier you commented on the cuts in the public health budget having an effect. We were told in previous evidence by the Secretary of State, "I am afraid I do not accept that a public health budget being cut automatically means that we are unable to make progress on the big public health issues of the day". We are discussing the big public health issues of alcohol, obesity and others. Does that statement agree with what we just heard about public health cuts?

Professor Sir Michael Marmot: I disagree with that statement. I always saw public health moving into local government as an opportunity. Some people in public health saw it as a threat but I saw it as an opportunity. When I was giving evidence to the Health Select Committee, I told them about Coventry. They then made a trip to Coventry, which declared itself a Marmot city. They said, "We want to take your six recommendations and we want to apply them across the city". That has to happen alongside the kind of things that normally happen within the public health envelope. They have to happen together. Coventry was saying on my six recommendations, "We are going to deal with all of those and we need a public health budget at the same time".

To take Lord McColl's question, I am entirely sympathetic to what you are suggesting about the importance of obesity nationally and the damage it is doing to NHS finances. However, I am saying that alongside the public health budget we have to look at local government activities. Mark Walport was supporting me very much in talking about housing, transport and the like. If you are cutting the public health budget and cutting local government funding that makes the task of dealing with public health extremely difficult.

Professor Sir Mark Walport: We are getting to the nub of the issue, which is that the biggest advances in human health have come from public health measures. Michael Marmot made the point just now that we are talking about a success story. On average, we are living longer and healthier lives than any previous generation of humans. Although there is still a very significant gradient of inequality, everyone is living longer.

The second point, which is starting to come out, is that by focusing solely on the NHS you may miss the big target, which is how you reduce demand and enable people to stay out of the NHS which, as Dame Sally has already said, is configured to deal with disease.

Clearly the best policy requires the best evidence and I would say that public health research is also extremely important. Coming back to Lord

McColl's point about obesity, I agree entirely with the answer that Sir Michael Marmot has given that telling people they must eat less simply does not work. This is a global issue. When populations are allowed access to affordable food with very high calorific intake, they will get fat. It is worth remembering that there is a very strong genetic component to obesity as well. Sometimes the obvious answers turn out not to be correct.

When you come to make your recommendations, it is important that you think about the fact that it concerns the whole of government and that there is a political question about public expenditure at a time of austerity in everything from education to transport to health.

Professor Dame Sally Davies: I would like to add two points. Of course, the Secretary of State had a point when he said that to introduce regulations costs nothing. The latest research, which comes out in the *Lancet* this week, suggests that the sugar levy should reduce obesity in children by 10%. Advances are being made. As we talk about public health, we should not forget the significant expenditure within the NHS on immunisations, vaccinations, screening and the lives that that saves.

Q325 **Lord Ribeiro:** We are getting the message that in terms of effecting change you need to have legislation rather than the need to change people's habits and practices. Thinking back to the ban on smoking in cars with children present, there you are protecting a new generation. That is perhaps where we should be going rather than trying to force through change in established practice with people who may change one way or the other. They have a habit and may not be influenced by advertisements or legislation. However, the next generation will be influenced by it and, therefore, when we talk about the long term, perhaps we should be focusing much more on how we ensure that the young are protected.

Professor Dame Sally Davies: As I have said, there is no silver bullet. We need to approach these big challenges, particularly obesity, in many different ways. I would remind you that, for plain packaging, it took 20 years for politicians to put the law in place because the media and the public did not see it as right until then. The sugar levy is a great start which we will not be able to progress further until the public understand the damage that this is doing to them. I often go out and talk about how now 63% of adults are overweight or obese. That means they are an unhealthy weight and we have normalised unhealthy weight. It is not helped by the media, who show either dreadfully skinny or pathologically fat people and do not inform people who are a bit overweight that it is impacting on their health. There is a long way to go with the public and we need to work, as the obesity plan says, through the reformulation, cutting out 20% of sugar and fats, just as we had a success story with salt. Many things will need to be done. Schools will have a role to play in this, just as educating mothers does.

Q326 **Lord Scriven:** I would like to come back to where we started—long-term planning. At the start it was really interesting that you were giving all these statistics, Sir Mark, about what is happening. Then your answers reinforced what we have found as a Committee, that there does not seem to be any long-term planning about health and social care and what all these issues mean. I am not just talking about advances in one technique or another,

but what it means in moving forward and making the whole system sustainable. I know there are some unknowns in that. Do you generally feel inside the system where you are, and Sir Michael outside, that there is a lack of long-term planning? This is not a criticism, but rather feedback that we have had: to help long-term planning about a sustainable NHS and social care system, we may need independent analysis or an arm's-length body to look at workforce and healthcare systems based on medical advances, demography and productivity in order to help plan and deliver a long-term sustainable health and social care system.

Professor Dame Sally Davies: As I am closest to the system, I imagine it falls to me to start. We have an arm's-length body, Health Education England, which does the long-term planning and has been informed by figures from the Centre for Workforce Intelligence. That is part of it. The question from your perspective is whether it is doing a good enough job. Those of us who are medical know that when Governments have tried to do long-term planning for doctors they have never succeeded. It either overproduces or underproduces. Our experience of long-term planning, at least for doctors, has been a disaster in this country.

There is much more debate around the data, what it means and how to use it than is clearly apparent. I am not convinced that having an outside body commenting over and above the excellent think tanks that we have, which analyse and contribute reports and views which are read very carefully and do help, would be useful.

Lord Scriven: Systematically, where does it feed in to force the system to change and adapt? That is the issue. We do not get a sense of that anywhere. You are dealing with five years or you are dealing with the deficit. Where does all the work that is there feed in and how does it systematically help to adapt so that you make early changes to deliver a more sustainable NHS?

Professor Dame Sally Davies: That is Simon Stevens's job. He receives the data, he debates it with the department and there is a discussion which, as I am more interested in public health, I rarely join. This deals with what it means and how commissioning is being adapted. It was set up by Parliament not to direct services but to commission them.

Lord Scriven: Can you give me an example of any commissioner, again coming back to Sir Mark's point about disseminating information across the NHS, which is a good, long-term commissioner?

Professor Dame Sally Davies: I am not close enough to it. I can find one and send you a note if that would be helpful.

The Chairman: That would be helpful, thank you.

Professor Sir Mark Walport: The question in my mind is: what are the early changes that you are looking for that are not being carried out at the moment? The challenge is to make sure that we take advantage of the informatic capabilities that we undoubtedly have. If you are looking ahead to 2030, what we need to do is what is being done. The question is whether it is scaling up and whether good practice is being disseminated fast enough. Looking to 2030, the things that need to be done are around the NHS having better integration and better informatics, using

technology as it becomes available and adapting homes. We know what to do; the question is how to do it most effectively.

Lord Scriven: Is something systematic needed or is this just ad hoc? That is the question we are trying to address. Everybody outside the service, and even some people inside the service, have said it is more short to medium-term, rather than having some strategic long-term support to deal with the problems and the issues that are coming downstream.

Professor Sir Mark Walport: You have had the opportunity to speak to Simon Stevens, chief executive of NHS England, and you have had the opportunity to speak to Chris Wormald, Permanent Secretary of the Department of Health. Those are questions more for them than for me.

Lord Warner: They gave totally different answers, but we will put that to one side. I want to pursue this a little further. Is it not the case that Governments across the parties—it is not a party-political issue—find it uncomfortable having long-term projections, which suggests they are currently on the wrong trajectory? If you have a long-term view being expressed by an independent body, you start to educate the public. That public debate does not take place under the present sets of arrangements.

Professor Sir Mark Walport: An example of where that has happened is around climate change, where we have legislation going up to 2050 and we have the Paris agreement. Politicians around the world have looked ahead. The devil is in the detail and the implementation, but it shows that it is possible.

Lord Warner: There were courageous people such as Dave King, who was inside saying some of this stuff, but there was an independent body outside stimulating a public debate.

Professor Sir Mark Walport: There was the Intergovernmental Panel on Climate Change, which certainly did the evidence meta-analysis. We know what to do; the question is about implementation.

Professor Dame Sally Davies: Lord Warner, let me reassure you, I know that Ministers and the senior people understand the big issues and that something needs doing. I echo Mark's comment that this is a very difficult, knotty problem and, unless you understand the system well, it is very difficult to get to grips with it, particularly in its present political configuration. We have all been trying for years to get more patient care outside hospitals. There will have to continue to be efforts. It does not need anyone to say that again. Everyone knows that is one of our objectives.

Lord Kakkar: Sir Mark, in terms of the national risk register, how many questions around the sustainability of the NHS would appear in that kind of analysis?

Professor Sir Mark Walport: I do not believe the sustainability of the NHS per se appears but the topmost risk on the national risk assessment is, in fact, pandemic influenza. Health issues come up but not specifically the NHS.

Q327 **Lady Blackstone:** What is your key suggestion for a change that the Committee ought to recommend to sustain the NHS in the longer term? Could you each tell us that?

Professor Sir Michael Marmot: Part of the longer-term planning for sustainability of the NHS has to involve longer-term social and economic policy planning for the key drivers of health outside the NHS. I would argue that there are two reasons the Government should do it. The first is that everybody cares about health. Health wins and loses elections. The second is a rather more intellectual argument, which is that health and health inequalities tell us a great deal about how well we are doing as a society. Given that the key drivers of health and health inequalities are not only what happens within the NHS, but what happens in these wider social sectors, that means we should have cross-government planning for the future so that we do not suddenly say, “Oh my God, we forgot about care”, or, “Oh my goodness, we forgot about early child development”, or, “What a pity that we are not doing so well on education”. We should have cross-government planning for these key domains, which will help the sustainability of the NHS, improve health and reduce health inequalities.

Professor Sir Mark Walport: I would answer in two parts. The first point is whether we really can compress morbidity because that is the critical issue in terms of healthcare need. Going back to Lord McColl’s question, we know in principle that if we manage diabetes better, manage blood pressure better and can keep people’s weight down, that will help to compress morbidity. However, there are still conditions such as Alzheimer’s disease and classical dementia, where we do not know the extent to which we can compress morbidity. We are all to die of something—that is the one thing we know for certain. The question is how long it takes to kill us and how much misery there is on the way. There are some unknowns there.

When it comes to the knowns, it all has to be about the promotion of better public health. Any solution to the NHS challenges involves looking as much outside the NHS as inside it. Inside the NHS it is about efficiency, effectiveness and managing the volume as it comes down the line. We come then to the point Dame Sally has made that we need the right care in the right place. We should not be managing people with minor conditions in accident and emergency departments.

When it comes to public health, it is about empowering individuals to take responsibility for their health, recognising that simply telling them to lose weight does not usually work. Employers are important in promoting the health of their workforce. The environment in which we live, work and play is absolutely critical, so we need to look at travel and housing. Many branches of local and national government have a role to play in this. Unless you look outside the health service, you will not solve the problems inside the health service.

Professor Dame Sally Davies: We need a society that wants to enhance the health of every member in it. That starts with individuals, their families and communities. The NHS has a role to play. Health protection against infectious diseases is very important, but we have to take a very mixed approach to the big challenges such as obesity, continuing concern about smoking and alcohol. We have not talked about

physical activity, about which we have the data and it is shocking how physical activity at all ages is falling, which will have an impact on our health. It is never too late to start.

The Chairman: Thank you all very much. I know you are busy people. Thank you for making time today to come. I know we could have gone on longer but our time is limited. I wish you all a happy Christmas and a happy 2017.

King's Fund, The Guardian, The Lancet, The Economist and the Health Service Journal – Oral evidence (QQ 328-333)

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Evidence Session No. 36 Heard in Public Questions 328 - 333

Tuesday 20 December 2016

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Members present: Lord Patel (The Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Warner; and Lord Willis of Knaresborough.

Examination of witnesses

Nicholas Timmins, Senior Fellow, King's Fund and Institute for Government and former Public Policy Editor, *Financial Times*, Denis Campbell, Health Policy Editor, the *Observer*/the *Guardian*, Professor Richard Horton, Editor-in-Chief, the *Lancet*, John McDermott, Public Policy Editor, the *Economist*, and Alastair McLellan, Editor, *Health Service Journal*.

Q328 **The Chairman:** Gentlemen, thank you for coming to help us in what I think will be the final session of our evidence taking, but I cannot be sure of that. Thank you for coming today. We are very grateful that you have found time from your busy journalistic duties to come and help us today. To start with, it would be helpful if you could introduce yourselves, starting from my left, and if you wish to make a very brief opening statement, please feel free to do so.

Nicholas Timmins: I am Nick Timmins. I was the public policy editor of the *Financial Times* for many years up to 2012 and I am currently a senior fellow at the King's Fund and the Institute for Government.

Denis Campbell: I am Denis Campbell, health policy editor of the *Guardian* and *Observer* newspapers.

Professor Richard Horton: I am Richard Horton, editor of the *Lancet*, and I have a particular interest in international health systems.

John McDermott: I am John McDermott, public policy editor at the *Economist*.

Alastair McLellan: I am Alastair McLellan, editor of the *Health Service Journal*.

Q329 **The Chairman:** I know that you are all used to having quick-fire questions and quick-fire answers. With five of you and 12 of us, we need to manage the time well and get through the questions, because we need a lot of information from you. Let me start off. With your experience and knowledge of the public's views about health and social care, how do you think the public attitudes to health and social care in all its aspects have changed? How engaged do you think is the public's mind about health service and social care issues? How has this trend changed over time?

Professor Richard Horton: Shall I start off? What we know from the British social attitudes survey, which has documented this very well over the years and has been analysed by the Health Foundation and others, is that there is incredibly strong public support. Nine out of 10 people strongly support a tax-funded free at the point of need health system, but that satisfaction with that system is falling. In 2015-16 satisfaction fell by 5% to 60%, and dissatisfaction rose by 8% to 23%. Satisfaction varies across the different parts of the health service. Some 69% are satisfied with general practice services but only 53% with A&E. We are seeing a very dynamic environment for the way the public view health. While they are very supportive of the NHS, they are also very concerned about the direction it is taking.

Denis Campbell: I was going to mention some of the same statistics. This is a slightly less scientific answer than you might want, but my anecdotal, impressionistic response is there is a gap between the emerging realities of the condition in which the NHS finds itself and patients' experience of it—missed waiting times, visible lack of funding, running out of paediatric intensive care beds, having to send young people with life-threatening anorexia to Scotland rather than England and so on—public opinion, because it is clearly rising in the index of public opinion, and government action.

Nicholas Timmins: One of the things about the satisfaction figures, particularly the British Social Attitudes Survey, is that there is always quite a long lag between what is objectively going on in the health service and these numbers. For example, in the 2000s, when money was pouring into the NHS and the service was clearly getting better, it took quite a few years for satisfaction levels to start to rise and they come down quite slowly when the service gets worse, so there is an odd time-lag effect that I think you need to take into account.

As to attitudes to health, health is famously the closest thing that we have to religion. There is still incredibly widespread ignorance about how social care works. It is quite stunning, because there has been plenty of debate about it over the years. Lord Warner will know these figures better than I do, but if you look at the Dilnot research, 60% or 70% still think it is free; they do not quite know what is coming until it hits them.

Alastair McLellan: It is almost as if the public do not read newspapers any more, is it not?

John McDermott: I do not think we really know what drives the satisfaction figures, so we should be cautious in assuming that when they are high everyone is happy with the NHS at that point in time. I suggest they perhaps combine a feeling that people have about their experience

of the performance of the NHS in practice with their views of the NHS in a more abstract way. There is perhaps some evidence from Scotland, where performance is not that good but the perception is that the NHS as an institution is under threat, that happiness and satisfaction with it and belief in it remain high. I do not think we should just start looking at graphs and say, "This is going up, so everything is okay".

The Chairman: Something else brings happiness to the Scots.

Lord Kakkar: Is there any evidence that the satisfaction rating makes it easier for Governments to direct more funding into the provision of health services through increased taxation, or is there no relationship between them; or, as a corollary, that if there is less satisfaction people want to pay more?

Professor Richard Horton: I am not sure there is true cause and effect, but it is interesting to look back to 1997 and see that public dissatisfaction with the NHS was then 50%. Now it is in the lower 20 per cents, so you wonder whether that very high level of public dissatisfaction in 1997 was a cause of greater investment in the NHS by the Government at the time. We have to go back and look at the history of what shaped those decisions. I am sure there is a relationship, but it will be very complex and likely non-linear.

Alastair McLellan: When I talk to policymakers about decisions they make about funding, they do not talk a lot about the social attitudes survey; it is not very prominent on their radar. Perhaps it should be, but in the job I do I tend to judge it as much by what people do not talk to me about as what they do talk to me about. I would not say that in the social attitudes survey public concern about the NHS in general is very influential on policy. There is concern about specific issues—A&E waiting times is a classic example, and GP access is another, although they are very different factors—but I would not say that general attitudes towards the health or otherwise of the NHS prove to be a very big influence on health policy, as far as I have seen.

Lord Willis of Knaresborough: I have two very brief questions. First, is it clear to you who is driving change and improvement in the NHS? Secondly, do you think the NHS is too big to succeed?

Professor Richard Horton: I do not think it is at all clear who is driving it, because we have such a fragmented crazy system. We have what feels like dozens of royal colleges multiplying almost every year. We have outsourced a lot of work from the Department of Health to independent organisations, many of which do a great job, but we have no overall governance. For many of us close to the system we have not seen NHS England become a wild success in being able to co-ordinate those different fragmented elements together into a unified strategy, despite the best efforts of Simon Stevens.

Alastair McLellan: I disagree a little with Richard. There is an awful lot of innovation and endeavour going on, and the fact that it is not as directed by the centre as it was in the noughties is a good thing. I think there is more innovation going on at the present, despite the lack of money—certainly, lack of money is not a good thing—than there was in

the noughties. In the noughties they were back-filling decades of underinvestment, so there are reasons for that.

On the question whether the NHS is too large. There is a criticism that it is too large but also that it is too fragmented and broken up into too small parts. Having heard this debate over and over again in many different forms, it strikes me that it will always be so and it is about getting the balance right and central bodies as well as local ones taking the appropriate actions.

This morning we have been talking about investment in technology. It strikes me that there are two things that drive change in technology. In the private sector it is the profit margin. If Tesco introduces a new form of till technology, Sainsbury has to move very quickly to respond; otherwise, it will lose business instantly. I do not think we want to be introducing the profit margin in the NHS. The other thing is to have some kind of national programme for IT. It did not work so well last time, so there is no simple answer here. As I think a lot of people have said this morning, it is a management problem; it is something you have to manage week in, week out, month in, month out, and make the appropriate decisions. NHS England is still a relatively young body, but it is getting better at that.

John McDermott: I am not a full-time NHS reporter. I cover education as well and in countries outside the UK, but whenever I do report on the NHS I am struck by how the name is such a misnomer. This is an utterly fragmented system. I do not think that is a bad thing per se; it is a bad thing only when people get confused. When there is an assumption on the hospital floor that this is a simple command and control system, or one of markets, in that confusion bad policy is made. Following what Alastair was saying, NHS England is effective when it knows what it is responsible for and what it can achieve and what it does not.

One other thing I am always struck by is the degree to which, even when there is very little relationship between what NHS England can do and the effect on the ground, there is belief in what it can do. Often, you will find hospital officials or doctors and nurses almost waiting for an announcement from on high, even when the means of achieving that are not there. Planning is okay, but you cannot expect them to plan absolutely everything.

Q330 **Bishop of Carlisle:** I would like to return to the question of funding. Almost everybody seems to agree that it would be good if more money went into the NHS, but not everybody wants to find that money themselves; they feel it should be coming from somewhere else. Various witnesses we have seen over the past few weeks have suggested different ways of funding the NHS, including direct taxation, hypothecated taxes, statutory insurance and so on. From your experience and what you have picked up about what the public generally feel, which funding system do you think would be most acceptable?

Alastair McLellan: I imagine it is the one that has the smallest impact on an individual's income.

Bishop of Carlisle: Which would be what?

Alastair McLellan: It is different for different people. The system of funding for the NHS is not broken; it needs good stewardship. The system of funding for social care is broken and needs reforms, and you have heard during the course of your inquiry from many people more knowledgeable than me, and if I may say so my colleagues, on what needs to be done on that front.

Professor Richard Horton: I completely agree with Alastair. It is instructive to look, on the social care side—I know you have heard evidence about this on many occasions and I will not repeat it—at the political challenge Japan faced in the late 1990s. How did it build public consensus for greater investment in social care? They could not do it through a tax-funded system, but they went for the model of long-term care insurance and were able to bring the public with them, solve an acute political challenge, given the demographics, and implement a system—do not get me wrong; they had to modify it along the way—that has been extremely successful in bringing more money into social care and enable planning in the long term. I submitted an article to you which we published in 2011 on an evaluation of the Japanese experience. It might be well worthwhile looking at that experience and thinking about that.

Bishop of Carlisle: That is helpful. One of the other questions I wanted to ask was about how we best engage with the public and have exactly the kind of discussion you are mentioning. You are reckon there are lessons we could learn from the Japanese model.

Professor Richard Horton: Very much so. This is a very carefully planned and implemented model. It was not done quickly; it was done with a great deal of thought and with course corrections along the way, as they understood that it was 20% more expensive when they introduced it than they had originally planned. They had to make adaptations, but they have done it with remarkable public consensus.

Bishop of Carlisle: Was that done primarily through the media? How did they set about it?

Professor Richard Horton: The Government tried to create a national conversation by talking about the challenge: an increasingly aging population and a declining cohort of people coming in to provide the tax base. By that political leadership they were able to build a consensus when they implemented it in 2000.

Nicholas Timmins: Looking at the health side, I would urge the Committee not to go down the road of saying that we should replace it all with social insurance, because frankly, at a very high level there is very little difference between general taxation and social insurance, and it would be a huge distraction. The great advantage of general taxation is that you have the widest possible tax base, whereas with classic social insurance you have employers and employees and you are making it more expensive to create jobs. By and large, in a globalised world you should make it as cheap as possible to create jobs and tax the wealth they produce. Social insurance tends to move against that. That does not mean that there might not be a role for some form of social insurance to

tackle some of the social care stuff, but I would not go down that road for the entire health and social care system.

Baroness Redfern: Going back to Richard, we cannot compare like with like with Japan, because it does not have such an elderly population and it is declining as such. I think 40 year-old people pay an extra amount.

Professor Richard Horton: It is 1% of their earnings.

Baroness Redfern: Yes, and there is a 50:50 split with employers. That is how their system works, but they do not have the growing elderly population that we are going to face.

Professor Richard Horton: They do have an elderly population.

Baroness Redfern: But it is dropping.

Professor Richard Horton: Yes, but they introduced it in 2000. It is seen as a very fair system. You have to fill in a 74-question form. You are then categorised into one of seven levels to see what your eligibility criteria are and the services you get out. All of it goes to an expert committee that makes the final decision. There is a very fair process. The public feel that it is broadly a fair process. It has strengthened social solidarity in Japan, because you become eligible when you are 65 and people start at 40. It has built a sense of community and commitment around the points that are taken into account.

Baroness Redfern: Do you think the general public would welcome that type of funding?

Professor Richard Horton: You have to be careful about cross-cultural comparisons. The Japanese family-based value system is different from the UK's, but they were able to build that political consensus.

Lord Lipsey: When we tried to build a political consensus here there were all-party talks. They were close to agreement, and then the Conservative Party put up a lot of posters referring to a death tax and that was the end of the consensus on social care. I think there was a consensus among politicians that social care is jolly difficult, because only one in three or four people will ever cash in for it, unlike health which we all use, and nobody wants to pay money in now to get something they may not benefit from in 20, 30 or 40 years' time. Therefore, it is not a natural solution to social care, but the consequences are absolutely frightening. We are guaranteeing aid, which is the most unpopular form of public expenditure. We spent £4 million on a girl band, if we believe yesterday's *Daily Mail*, and yet there is a 25% drop in people getting social care at home. How can we crack this completely disastrous failure to provide for the most essential social service you can imagine?

John McDermott: Going back to Nick's point, so long as there is profound ignorance about what you can expect in social care you can start proposing all the different solutions you like, but when nobody knows or believes there is a problem there will not be the political will to do it. One of the benefits that Committees like this can bring is to be a bit more specific about the problem, as opposed to a generic bemoaning of the unsustainability of the NHS. It is not really about the NHS; it is about healthcare more broadly and, in this particular instance, about social care.

Alastair McLellan: Indeed. The report from the OBR, shows that funding for the NHS is entirely sustainable. The NHS does not have a sustainability problem, if I may say so—a dangerous thing to say, given the nature of this inquiry—but the health and social care system in its totality definitely does have one.

Lord Warner: Can I bring you back to the Bishop's question? When I was a jobbing Minister there were two kinds of truths on which you could rely. One was that the public were totally preoccupied with ease of access to the NHS, and the other was that, if you were bold enough to raise extra taxation, it was easier to raise another pound for the NHS than for any other public service. I am not sure whether those truths still hold, which makes it quite difficult for politicians, because certainly the public seem much more critical of the efficiency and effectiveness of the NHS than they were back in my day. Do you pick up any changes around public mood and nervousness among politicians about those sorts of issues?

Alastair McLellan: I think that asking journalists about the public mood is a pretty dangerous thing.

Lord Warner: I have some belief in experts, but carry on.

Nicholas Timmins: I think you are slightly forgetting the past. We tend to wipe out all the horrible bits.

Lord Warner: There were lots of horrible bits.

Nicholas Timmins: If you go back to the late 1990s, there was complete turmoil around the NHS. There were people demanding a rationing unit at the centre, including people from the NHS, so you had to have a rationing body and rationing menus. The whole place was in turmoil. There was huge public dissatisfaction and worry about all of it. Blair had the most expensive breakfast in the world and pledged a lot of money and all that went away. Now we are coming round to another cycle of the same thing.

Professor Richard Horton: The public often have contradictory views about this when you ask. Half the public think that there is an enormous amount of waste in the NHS, but half the public are willing to pay more tax if you ask them to invest in the NHS. I am not sure you get a very clear answer to that question.

Lord Warner: Does that come out in your interviews with politicians? You are the people who are talking to politicians and trying to get their take on the world.

Alastair McLellan: You asked about access. It is interesting that yesterday NHS Improvement effectively downgraded the four-hour waiting time for A&E targets. It is still in there but it is now wrapped in with loads of other indicators. It is a pretty sensible move in my view, but you will know that in your day everybody fixated on the four-hour A&E target. Politicians in general are not quite as focused in a laser-like way on access issues as was certainly the case when you were a Minister. I think they remain fixated on patient experience, not necessarily patient outcome, because patients can measure their experience, but it is a lot harder for them to measure their outcome, because how do they compare it? They can compare their experience; they cannot compare their outcome. They are not as closely fixated on access in that narrow

definition we had in the new Labour years, but it is very much around patient experience. You see a lot of the Hunt approach to safety and quality and his redefining of the Health Secretary's role as being responsible largely for safety and quality, letting somebody else worry about the money.

Professor Richard Horton: I think they are also focused on money. When I speak to health politicians they always blame their Treasury spokesman. They would love to do a million things but they cannot, and they cannot talk about it because they are not allowed to speak about those things. That raises an important point about the role of health in our broader economy. I think we have the argument wrong. I heard Simon Stevens and Jeremy Hunt say in your last evidence session, "Thank goodness we have a growing economy to support the NHS". I think that is entirely the wrong way round. The latest economic evidence shows that investing in health, particularly the health workforce, which is the key here, drives the economy in multiple different ways. It is not just about a healthy and productive workforce; it has an effect beyond that. The caveat to saying that you invest in the health workforce is that it is not more of the same; it is not doctors and nurses but thinking about a completely different skills mix in the health workforce and new cadres of health workers. This evidence has come out since September, which I submitted to you, but a real revolution has taken place in the economic thinking around the role of the health economy.

Nicholas Timmins: We talk a lot about the NHS and whether we can afford it—that it is a burden because it is public expenditure. Let us do this thought exercise. Supposing it was entirely privately provided and financed—it was in the private sector of the economy and it was growing. We would see that as a good thing; it would be a growing industry that was doing well. So if people choose to spend more on it, why do we say that because it happens to be publicly funded it is a bad thing and a burden? It is worth thinking about it like that. If it was an entirely private sector business, more was being spent on it and we were getting more for it and employing more people, we would say, "What a success!"

Professor Richard Horton: For every job you create in the health economy you create two jobs outside it. That was work released by the International Labour Organization that looked specifically at the UK.

Lord Scriven: I am unusually suspicious of journalists, but I am warming to you guys. You have said that basically a paradigm shift has to take place here, and a question like "How do you save the NHS?" will not work. You have absolutely hit the nail on the head. If that is the case, what do you think is going to be needed, not just in funding but in policy, particularly where you are experts, and engagement and discussion with the public to get that paradigm shift, rather than a short term "We have to save the NHS"?

John McDermott: Let us remember the political context. You have a Government whose existence will be defined by getting out of the European Union and the desire to mutualise the National Health Service, which they have done since 2010. The difficulty facing those who would want to persuade the Government about the importance of tackling the social care funding crisis is that the Government will be aware that by

raising the salience of the issue they potentially attract criticism at a time when they believe that they do not have a lot of money and are busy trying to extricate themselves from the biggest mess in British political history since Suez. It is important to remember that context. Given the bind politicians will feel themselves to be in—that they are only ever being attacked on the basis that it is their fault for this and their fault for that—they might be more inclined to bury the issue than tackle it.

Alastair McLellan: To build on what John says, for the first time in 20 years we have a Government and a Prime Minister who do not consider the NHS to be a priority. There are perfectly legitimate reasons, including practical political reasons, for that. This is a Government who do not prioritise the NHS and are slightly irritated by the NHS's sense of self-entitlement that it has grown used over the past 20 years since new Labour came in. The Government have said, "On the one hand, we can put more money into the NHS because we realise it is an important topic, but we have no idea whether we will get any return on our investment, because it seems to us you can put a lot of money into the NHS and some good things happen but not everything does. What it does not do is stop people asking for more money—they carry on asking for more money—and we are not very confident in the NHS space; it is not our area of skills and expertise. Therefore, we will put our chips into Brexit and deal with immigration and concerns about that and the economy, because we are more likely to take that action and get this result"—that may be foolish, but that is what they think—"and it is also our skill set; we know our way round that". In summary, the debate that we are talking about, as John was saying, will probably not come from the Government.

Lord Scriven: We can put things in a report that will hopefully kick-start it, or at least light a fire. It is those kinds of issues that I am interested in, because clearly you are on that page in your understanding. What are the key issues or messages?

Professor Richard Horton: Can I give you one example of where it works very well but not in the context of the UK health system? I refer to the sustainable development goals for 2030 mentioned earlier this morning. That has transformed, as the MDGs for 2015 did, the entire global conversation about human development, specifically health, because of specific targets that have been set. All countries—194 nations—have signed up to those targets, and they have to be delivered. Suddenly, you have all these agencies and Governments running around thinking about how they are going to meet those targets, because you have league tables that show where you are and you do not want to be shamed in front of your neighbours.

In the UK context we have fantastic data. We can do forecasting, but we do not do long-term forecasting; it is very, very short term. Why can we not have a national SDG for health? Why can we not think out to 2030? There are all these nations that disagree about so many things, yet we cannot do it within our nation. There must be a way to do that. I do not think you can do it easily from the Department of Health; it is not independent enough. But why can we not create an organisation that has technical credibility and can set those long-term goals and keep a running commentary, and in the public mind, even when, as may well be right,

Governments do not want to talk about it. The Institute for Fiscal Studies does an incredible job in being able to keep issues in the public consciousness because it is independent, credible and technical. Why can we not do that for health?

Q331 **Baroness Blackstone:** Can I come to the whole question of long-term planning? A lot of the people who have given us evidence have suggested that one of the current failures is that there is no long-term planning. We do not know what is going to happen after 2020.

Nicholas Timmins: I think long-term planning sounds great; it is very warming and all that sort of stuff. It is incredibly difficult to do because stuff happens. I am not saying that you should not do it. You should try to do a bit of it. You have to recognise that you will be wrong all the time. Look back at NHS history. If you had been trying to do long-term planning in the 1950s, it would never have occurred to you that over 30 years we would shut all the lunatic asylums because the drugs were not available to allow us to do that. If you do long-term planning in the 1980s, along come day surgery and keyhole surgery. You would need to be a genius to see these things coming. Clearly, it is sensible to do some broad forecasts about where we are going and what it looks like, but you need to be very wary about being deluded that you will get it right. Good stuff happens, bad stuff happens. Think about dementia for a moment. If someone comes up with a new drug that makes a significant difference but is not a cure, that will be incredibly expensive because of the numbers. Supposing someone comes up with something that halts it in its tracks. That will be incredibly cheap. It could be either; we do not know.

Lord Willis of Knaresborough: To follow that up, every major corporation in the world, including major supermarkets in Britain, works by having a database that is swift enough to move for market trends. Surely, a starting point in long-term planning has to be the sophisticated use of data that is fast and responsive so that whatever comes along, be it new disruptive technologies or whatever, you can respond to it because you have all your data there. Surely, we could all fight for that one.

Nicholas Timmins: I am not saying that you should not do it at all. I worry about putting too much faith in where it says it is going.

Professor Richard Horton: I broadly agree with that. It is absolutely true that there are new things that come along very quickly.

Lord Willis of Knaresborough: And you do not need data for it.

Professor Richard Horton: I am thinking of discoveries: new drugs or techniques that come through the pipeline.

Lord Willis of Knaresborough: But they will apply to people.

Professor Richard Horton: I absolutely agree, but there is planning that you can do. We have known since 1990 that we were building up multimorbidity in both mental and physical health. We have known since 1990 that dementia would become a huge crisis for us. Did we start planning for in 1990? No, we did not. Why are we talking only now about parity of esteem? Why are we talking now about dementia? We knew this a generation ago. The point is that there is no long-term planning, and we

do not use the data we have because nobody is charged with it; nobody is given the locus of responsibility to do something with it. Nick is right: things come along, but for a lot of stuff we do know today where we will be in 2030.

Lord Willis of Knaresborough: The first question is: who should be doing that?

Professor Richard Horton: It should be Public Health England; it should be the Department of Health. Multiple bodies should be doing it, but they are so locked into short-termism and not given the political responsibility to do that. They should be doing it, but I do not know why they are not.

Baroness Blackstone: When you have a workforce, some take many years to be trained, but you do need to have some long-term planning to think through how you are going to divide up roles in the workforce and think through different ways of approaching how you prepare them for their jobs in the longer term.

John McDermott: You clearly want to think about what is going to happen in the long term when it comes to health needs, but that is different from having a plan to address individual policies. That can be dangerous, because sometimes if you have a plan and it is not a very good one sticking to it becomes more important than meeting the objective. I think a lot about how technology could change the health labour force. Like Nick, I do not know what is going to happen in 10 or 20 years, but even if a modicum of what some of the more techno-evangelists say will happen does happen, for example with diagnostic intelligence, it could utterly transform the role of the general practitioner—in essence, it could make its current form redundant—so we do not want to get into a long-term plan for X thousand number of GPs and prioritising that over a more efficient technology that could bring benefits to patients in the future.

Lord Warner: Is not what Richard was saying right? You do know what the demographic and disease profile will be in 20 and 30 years, and you know what your workforce does now, and you could make some reasonably intelligent judgments about whether, if you carry on that workforce trajectory, it is likely to be a practicable or an inexpensive or very expensive way of dealing with your disease profile. We do not see anyone doing that and telling the public they are on the wrong trajectory for what is now inevitable. There is something pretty inevitable about the disease profile and demographics—they are going to happen, so that is a reliable area you can start from—and your point about goals seems to me important. Would you guys be writing about that if there was another body? You write about the OBR; you are interested in what it is saying and the Government are doing. Would you be interested in writing about whether an informed body was talking about this and whether governments were on the right trajectory to meet those goals?

Denis Campbell: I want to make a point about the potential of creating an OBR-style body to set goals and targets and monitor progress towards agreed health goals, acting as an honest broker with the NHS England, already atomised as it is, more so since 2012. I am loath to suggest the creation of a new body to add to the baffling, confusing array that we

have already, but a body like the IFS that has clout, credibility and complete independence could also go alongside the great investment in more public funding, wherever it comes from, that Jeremy Hunt has said repeatedly will be necessary after 2020. That could all be part of the mission of renewing and repurposing the NHS for the times that we know we are soon coming into.

Alastair McLellan: I cannot think of a system that has as much scrutiny as the NHS already. You have Anita as your adviser; she produces incredibly good work on the long-term funding needs for the NHS. We know the answer; we do not need another body to create the answer. It is there; you have been presented with the evidence over and over again.

One of the advantages of the world in which we now operate is that we can see which articles get most read. We would all write articles about a health OBR. They probably would not be that well read, apart from a relatively small bunch of health policy geeks. I do not think it would have an enormous impact on policy decision making because of the political nature of the NHS. I realise that might not be an answer you feel comfortable with, but that is what I think the impact would be.

The Chairman: Surely, there must be a difference if an opinion given by a body set up through legislation and is independent rather than very efficient think tanks.

Alastair McLellan: You would think so, would you not? Just because something is created by legislation does not mean that anybody pays any attention to it. I refer to the Health and Social Care Act passed only a few years ago and now widely ignored by everybody, including the Government that created it.

Professor Richard Horton: I do not agree with this.

Alastair McLellan: I thought you might not.

Professor Richard Horton: This has to be framed with the word "accountability". What is accountability for the NHS? There are three parts to accountability. First, you need to have accurate monitoring and reliable data, metrics and indicators to be able to track progress in various dimensions of what we say our NHS is. It is true that we have multifarious sources of that data, but there is no one place—an independent, authoritative technical body—where it is pulled together, so we do need an institution that is for monitoring. Secondly, there has to be transparent and participatory democratic discussion about what the data means. We do not do that because we do not have that monitoring centre. Thirdly, we have to act and do something about it, which is a remedy function. The three dimensions of accountability are: monitoring, reviewing and acting. We can start with the monitoring bit.

Lord Lipsey: The discussion about long-term planning is very interesting. I am thinking about what this body would have done 15 years before the Black Death. Would it have seen that coming? To take a perfectly realistic example, in 10 or 15 years' time we may well as a society opt for widespread voluntary euthanasia. Some people think that is a good thing, some think it would be a bad thing, but given that two-thirds of health expenditure is incurred in the two years before death, it would clearly

make an enormous difference to the economics of the health service. Do you not think that some of this planning idealism should be taken with a very large pinch of salt, because very large disruptive forces can come along and turn this into nonsense?

Professor Richard Horton: But if we are planning for, say, more people living with dementia in 2030, 1,500 extra doctors a year is not going to solve that problem, as wonderful as that might be. We have to train a completely different cadre of people who will be able to respond to the physical and mental health needs of that group of people. We should be planning for that now because we know it will hit us. It has already hit us. Are we planning for it? Nowhere near enough.

Q332 **Lord Bradley:** Do you see that as the biggest threat to the long-term sustainability of the NHS and social care, or are there other factors that you would want to put on the table? Can I abuse my position by asking you, as we are coming to the end, whether you see devolution, such as in Greater Manchester, as an added fragmentation of the NHS and social care, or an opportunity to reconnect and make coherence out of a fragmented system?

Alastair McLellan: If you look at what is happening across the NHS through the lens of the STPs, although not a perfect lens, there are parts of the country forging ahead. Manchester is one of them and there are various other parts of the country where that is happening. I will not list all of them. They are parts of the country that always seem to do well under any kind of system, and it is good. Therefore, for those parts of the country you should devolve to them as much as you can to. If you do not mind my saying so, that is not the problem. The problem is those parts of the country—take the M25 ring for example—that are not high-performing health or social care economies, and never have been. Devolution is unlikely to be the answer in that particular case, because effectively you are likely to be endorsing poor practice.

I think that for the best and most high-functioning healthcare economies devolution is the answer and we are seeing that happen now, but the really difficult question is what you do with those areas like the M25 ring which are not high-performing where devolution is not the answer because you are not starting from a good place.

Q333 **Baroness Blackstone:** If you had to pick out one proposal for change that this Committee might make, which would support the sustainability of not just the NHS but, to use Alastair's earlier phrase, the health and social care system, what would it be?

John McDermott: Before answering that, can I return to the question about whether we want an OBR for health? I implore you to think that analogy through properly. It sounds nice and reminds me a little of what people tend to do when it comes to a problem, which is to say, "Let the schools deal with it". If we are saying, "Let us hive it off into an independent technocratic body"—at a time when, by the way, the public seem to be getting quite annoyed with such bodies—it would seem to me quite an odd thing. Experts propose more experts.

On the OBR analogy in particular, it is an annual almost falsifiable judgment on decisions that are made and can be quickly interpreted as right or wrong, or dangerous or not. If we are talking about health, what is the equivalent of estimates of the deficit here? What is that body going to do? Saying we should have an OBR for health might make a nice headline for three people to read, but what does it mean?

On what this Committee can do, if there is one good thing it can do is probably be specific and raise the salience of the crisis of ignorance and funding in social care and not repeat the same clichés about there being a sustainability problem in the NHS more broadly.

The Chairman: Nick, let us start with you.

Nicholas Timmins: On the "OBR" bit?

The Chairman: We have probably killed that cat.

Nicholas Timmins: If you have killed it, I will shut up.

The Chairman: What would you like to say quickly about OBR?

Nicholas Timmins: On sustainability, I would echo a lot of what the previous witnesses have said. The big drivers around cost in the NHS do not lie within the NHS but within exercise, obesity and all the things the NHS picks up the pieces for without being responsible for getting it right in the first place. If you want to make the healthcare system more affordable, clearly one of the most important drivers lies outside the health and social care system.

The Chairman: As it is Christmas, what were you going to say about OBR?

Nicholas Timmins: You have to be very clear about its remit. Someone mentioned setting targets. First, politicians will not let an independent body set targets for health and social care. Secondly, I worry about its actual influence. Can I give a parallel? Take NICE; its remit is that when it says that the NHS should adopt a new technology, it has to. Therefore, there is a direct connection between what NICE recommends and something happening on the ground. It also has responsibility for social care. It produces guidance on social care. It has no mechanism for implementing its guidance; it just sounds nice. In its previous report it said that we should not have 15-minute visits, which we should not, but there is no mechanism to translate what NICE says about social care into action.

If you take all the big issues that we have been talking about, we know what they are. The problem is getting people to do it. Clearly, it is a huge challenge. We have known about the social care problem for 20 years; we have known about mental illness. One goes back to Barbara Castle and the Cinderella services in 1975. The problem is getting something done about them. It is not that we do not know about them, so I am not quite sure what another body adding all this up would bring to the party.

The Chairman: Denis, what do you say in response to Baroness Blackstone's question?

Denis Campbell: There needs to be a recognition among politicians of all parties that ill health is starting to overwhelm the health service. Therefore, the prevention of that should self-evidently be regarded as an absolute key priority of government, whoever happens to be in power, and should be treated as such. The gap between the evidence and necessity for provision is wide and growing in the wrong direction. That should be the No. 1 priority. The NHS is visibly, almost on a weekly basis now, straining uncomfortably to keep up with the demand. We know from the demographic projections and so on that trends in COPD, obesity, cancer, diabetes and the whole slew of things we know about will continue, and yet the NHS's capacity to give people what they need when they need it, and as good as they need it, is, sadly, increasingly found wanting. We need to make the prevention of ill health an absolute national priority. I am not going to propose a body, but we need someone in government to progress chase it and assess almost every government policy. Will this improve the prevention of ill health? Otherwise, we will be overwhelmed.

Professor Richard Horton: Do not give up on a post-fact world. Facts are still important. More importantly, we need radically to change the economic arguments about health and social care. Health and social care are not costs to the economy; they are investment opportunities. Use the new economic evidence to show that by investing in the NHS and social care you will accelerate inclusive economic growth for the whole population. The best way to build sustainability is by making the direct link with the economy.

Alastair McLellan: I agree with all my colleagues. I make one plea. I am sure you will not do it, but please do not produce a report that bashes the NHS. Produce a report that recognises that, while the NHS faces many challenges, there is also an enormous amount of innovation, endeavour and improvement going on within the service.

The Chairman: We are not here to bash the NHS. Remember, we are the Lords Committee. We are here to help.

Alastair McLellan: Like us journalists. We are health journalists who are here to help.

The Chairman: Thank you all very much for coming today. We very much appreciate it.