



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 17 July 2023

4 pm

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Members present: Baroness Pitkeathley (The Chair); Lord Altrincham; Baroness Armstrong of Hill Top; Baroness Barker; Lord Kakkar; Baroness Osamor; Baroness Redfern; Baroness Shephard of Northwold; Baroness Tyler of Enfield; Lord Watts.

Evidence Session No. 24

Heard in Public

Questions 230 - 236

Witnesses

I: Rt Hon Lord Lansley CBE PC DL, Former Secretary of State for Health (2010-12); Rt Hon Lord Hutton of Furness, Former Minister of State for Health (1999-2005); Rt Hon Lord Warner, Former Parliamentary Under-Secretary of State for Health and Minister of State for National Health Services Delivery (2003-05).

Examination of witnesses

Lord Lansley, Lord Hutton of Furness and Lord Warner.

Q230 **The Chair:** Welcome, Lord Warner, Lord Hutton and Lord Lansley. As you know, this is the Integration of Primary and Community Care Committee. That is our main focus. We will all ask you questions. People might come in with extra ones. Our questions are to all of you. We probably want to get each of your opinions on them. You might have to decide between you who will go first. We will leave you to do that.

Governments in recent decades have introduced initiatives to improve integration. It is a word that has been familiar to all of us for many years. When each of you was a Minister, what were the main initiatives at the Department of Health? Why were those decisions taken? We would also be interested not only in the barriers you had to overcome to introduce those and how you went about overcoming them, but in your opinion of how successful they were.

Lord Hutton of Furness: I will just speak for myself in my time as a Health Minister at the turn of the century. The NHS then, as I am afraid it is now, was in a lot of trouble. People were routinely waiting 18 months or more for even basic operations. There was an obvious sense that the NHS was short of the funds to move it into a new area where it could meet patient needs much more proficiently.

It rapidly became clear to all of us that it was not just a case of money. The money had to be provided, because without the money there was not the resource in the system to grow, change and do things differently, but the service itself needed some pretty far-reaching and fundamental reform.

We started with secondary care as the service that really needed a pretty radical shake-up. We tried to get the expertise of the private sector to work alongside the NHS more systematically and effectively. That was a significant success. It was opposed by a lot of people, who felt there was a religious imperative to have the public sector and the private sector, and never the twain shall meet. We felt that was completely wrong. There was capacity there that was not being used but which could have been used for the benefit of NHS patients.

As time wore on, it was obvious to all of us that it was not just the secondary care piece of the jigsaw that needed fixing. There was a significant set of issues in primary care, and indeed in social care, which we began to focus on. For me, the high point of reform in my

time in the department was the *NHS Plan* in 2000, which set out how we would use the extra resource and what we wanted back from the NHS in return for that, which was a series of pretty fundamental changes in the way it did its business.

For me, again, there were key things that made that reform effective, and it was effective. By the time we left office, people were waiting maybe 10 or 12 weeks for an operation, not 12 or 18 months. There was significant change, which most people thought could not be made. People thought there was something impossible about that and the NHS could never respond to patient needs in that way.

I know I am going on a little bit. The glue that kept the money and the reforms working in the right direction was the sense from all those involved in the NHS and social care that these were broadly the right reforms to be doing. The unique thing about the *NHS Plan* in 2000 was the signatures on the front page from all the 20-odd organisations that were significant NHS stakeholders. They were basically prepared to say to the Government, "Yes, we like this plan. We're going to make this work. We're going to do everything we can to support the reform agenda".

Although some of the reforms proved to be controversial, such as foundation hospitals—most of the fuss about that was ridiculous and exaggerated; no one talks about that as a fundamental problem in the NHS now—there was the sense that this was a mission that we were all in together. Broadly, those reforms were successful. We grew the NHS, we met patient needs better, we got the service working more efficiently. Those 10 years of reform and investment in the NHS will, in my view, stand as probably one of the most significant periods in the service's history.

The Chair: You were next in time, Lord Warner.

Lord Warner: I was indeed. That agenda continued. The difference between my time and John's was that the money had been delivered to the NHS—shedloads of it. It was getting 6% or 7% a year in real-terms increases. That prompted us, led by the Prime Minister, to ask some questions about its delivery. It did not always like the questions that were being asked about its delivery, because the questions were about more patient choice, more competition, a new computer system and independent-sector elective care centres.

That agenda was not always approved of inside and outside the Department of Health, it would be fair to say. You basically had Ministers driving the agenda; it was a political agenda that was

beneficial, in our view, and it was being driven by Ministers. I want to mention, because this was the first time we really got into the issue of integration, the preparation of the 2006 White Paper called *Our Health, Our Care, Our Say: A New Direction for Community Services*.

You could say that we took a long time to get round to that, but we did. It had such a difficult time because it was trying to change the balance in what the NHS did and the way it spent its money, with much less emphasis on acute hospitals and much more on community services. It raised the issue, "How do you join up community services, including social care?" I think that was the first time the Department of Health and Ministers had to ask some quite difficult questions of themselves about how they had dealt with that.

We tackled it by having a massive public consultation, which ended up with 800 or 900 people voting on one Saturday morning in Birmingham. You could argue that there were better things to do with your Saturday mornings, but people voted. The interesting thing is what they voted for. None of them voted for acute hospitals. The Department of Health was focusing on acute hospitals, but, if I can put it this way, the punters were on some other agenda. It was a good agenda, but it was mainly about community services in some form or another. That is where I discovered integration. I had done integration outside the NHS in the criminal justice system and in local government, so I was partly prepared for what lay ahead.

Lord Lansley: Let me pick up my bit of the story. I will not elaborate on the circumstances, not least the financial circumstances, in 2010. My time as Secretary of State, you will be aware, had the smallest increase in NHS resources available year on year of any time since the mid-1970s, so there were inevitably constraints associated with that.

In part, what I was looking at, prompted by what Norman just said about Ministers having to drive it, was the concept that Ministers should not be driving the NHS; the NHS should be driving itself—hence the White Paper on giving the NHS greater autonomy and accountability. That was to be delivered through what is now NHS England and what became clinical commissioning groups, which are now incorporated into the integrated care systems.

Let me direct myself to your question. In my time in the department, what were we setting out to do that constituted integration? First, the 2012 Act required NHS England, as it

became, Monitor and the clinical commissioning groups to promote integrated care. It became a statutory requirement.

Secondly, the construction of commissioning—that is, NHS England as a commissioning body and CCGs as commissioners of care from any qualified provider—was designed to focus the minds of the NHS commissioners on how to deliver the best possible care and outcomes for patients. Almost by definition, one would say that integrated care is both welcome to patients and instrumental in delivering better outcomes.

It is up to you to say why you are pursuing integration. In my book, it is not an end in itself, but a means to an end. The means is integration. The end is improving patient outcomes. Just to digress for a moment, the Commonwealth Fund produced a full international analysis of this issue in 2014, which is the data that is relevant to my time, and again in 2017. It took the view that access to care and care integration in England was relatively successful, but the outcomes were relatively poor. That contrast is really rather important. We needed to use integrated care mechanisms to deliver better outcomes.

What sort of mechanisms were we looking at? We were looking, for example, at the construction of the NHS outcomes framework, which in my view is still a work in progress to which insufficient attention and effort has been devoted. If you want to make the service accountable, you must have data on outcomes as the basis for that accountability. As it happened, when I was Secretary of State we had the shortest waiting lists in history, in late 2012 and early 2013. I do not think that meant that we had the best outcomes in history. Outcomes are something completely different. They are the product of population health and NHS services. Both are equally important. In fact, you might say that population health is even more important.

We gave an additional public health responsibility to local government to work with clinical commissioning groups and now with ICSs. One question you should absolutely be looking at and seeking to answer is how well the ICSs themselves are working to improve population health as well as social care in co-ordination with local government. That nexus of integration is terrifically important, and it was designed into the system through the health and well-being boards. As you know from our debates last year on the Act, it is not clear to me how the Government see ICBs and health and well-being boards working together. They might be the same thing, but we need to see how they work together.

I will quickly mention the other things that we did. I tried to move tariffs—I will come back to tariffs—towards patient pathways, extending them beyond hospital episodes of care, and to introduce payment by results into mental health services. PCTs were being abolished, affording community trusts the opportunity increasingly to enter a new provider form with NHS partnership trusts, which had demonstrated themselves to be quite effective.

That led to better integration, where it happened, between mental health services and physical health services. You will recall that in the 10-year plan, integration, in the NHS England view, consisted of integration between primary and secondary care, integration between physical and mental health services, and integration between the NHS health services and social care. There were three axes of integration, not just one axis of integration, so we did push on that.

In my time, we asked the National Institute for Clinical Excellence, now the National Institute for Health and Care Excellence, to produce clinical guidelines. The first was in stroke, not least because of my interest in stroke, and now there are 150 or something. Those guidelines are terrifically important in enabling wise commissioners to look at how they commission for the best outcomes for patients. The guidelines make no distinction between primary and secondary care. It is about a patient pathway, and it necessarily extends across the two.

It is not just about primary care reaching into the commissioning process. I have some direct experience of this. I went to the University Hospital of South Manchester. Its cardiac nurses were spending 80% of their time in the community, because if you are looking after patients with heart failure, most of your time and energy can be delivered in the community. Many cancer hospitals and cancer services now recognise that patients should very rarely be in-patients, and out-patient services should increasingly reach into people's homes and deliver care at home.

One of the leading examples in my time, which I visited and saw, was at King's College Hospital. It was working on a design for diabetic care. It managed the diabetes care for a whole population, but there was a stratification of the degree of severity of one's diabetes. The less severe cases were managed in the community through GPs and with district nurses, and the more severe cases in the hospital itself.

The Chair: You are beginning to talk about the progress that has been made. Lady Osamor will ask a question about that.

Q231 Baroness Osamor: What progress has been made over the last two decades on improving integration between primary and community care and the wider health service?

Lord Lansley: There is progress, some of which is to do with data and technology. In interoperability terms, the exchange of data between GPs and hospitals, for example, is much more prevalent now than it used to be. We will not revisit the NHS IT programme too much, but it started there. Things like the NHS communication systems work well, as far as I am aware.

The whole redesign of emergency care is making progress. It is really important. We are overcoming this, but at times there were absurd efforts to delineate between urgent care and emergency care, in that urgent care can be handled in the community while emergency care must be in hospital. This is a spectrum of need that should not be divided at the front. You need to work across community and secondary care to deliver the best possible care. That is increasingly happening. It involves more outreach from emergency departments, more GPs getting into emergency departments, and more co-ordination with them.

Where primary care physicians are concerned, the Commonwealth Fund also looked at us and other countries in early 2019 and said that we had the highest level of co-ordination between primary care physicians and social services, which was interesting, because we would not imagine that to be the case in this country.

The Chair: Indeed not.

Lord Lansley: It also said that we were relatively poor at the timely exchange of information into and out of secondary care. Notwithstanding what I have said about the exchange of data, we have to be alive to that. Compared to others, our hospitals are not telling GPs sufficiently rapidly about the fact that patients have arrived at the emergency department or have been discharged from hospital—and vice versa: GPs are not telling hospitals about their own requirements.

Lord Warner: Could I offer a rather different view? My view would be that it has been very slow and painful. Let me explain why I say that. I just want to go back to the 2006 White Paper and then add two very quick points.

First, when we were preparing that White Paper, we consulted senior clinicians around the NHS, who told us that 50% of out-patients could be dealt with in the community and we did not need to drag patients to hospitals. It was not my view, it was not Patricia Hewitt's view. It was the clinicians' view. It was particularly loaded

in certain specialties. If you look at the White Paper, you will find the pilots that we did to try to test that hypothesis.

Secondly, all my experience of integration is exactly as Andrew said, in the sense that it is a process, not an outcome. It is about why you are doing it. My experience of it in local government, in the criminal justice system and in the NHS is that there are particular keys to success. One is a common budget, another is a common information system, a third is whether you have support for doing it from the top brass. Those three things will largely determine it, if you have a clear mission. It has not happened, and it will not happen, because not all those three things were in place.

Lord Hutton of Furness: I am basically with Lord Warner on this. When it comes to secondary and primary care in the NHS, there are plenty of examples of really good practice that has developed. The fundamental divide, and the fundamental problem, remains between the NHS and social care. We tried several ways to try to bring social care and the NHS together. Were they successful? Probably not. We legislated for pooled resources and pooled budgets. That hardly ever happened, because the process was so bureaucratic. It did not really work.

The fundamental divide is that one is a service free at point of use and one is a paid-for service with means testing and people contributing to it. Until and unless we resolve that fundamental divide, with the best intentions in the world—I do not query anyone's intention, either Conservative Ministers or my former colleagues—we are not going to get there. The divide between social care and the NHS remains the biggest fault line in our integrated care model.

Lord Lansley: This follows on directly what John was just saying. John will recall the announcements following the problems at the Bristol Royal Hospital for Children and the intention that there should be children's trusts. There were intended to be integrated services relating to children, but it did not happen, did it? What immediately becomes obvious from that, which we have all experienced, is that you can aim for institutional integration as much as you like, but if the professional integration never happens, the results will not justify the effort that has gone into the institutional changes concerned.

Where the relationship with social care is concerned, in my time we rested quite a lot of hope on the possibility of creating personal budgets whereby, if you are a recipient of social care, you have your NHS entitlement and you have your social care entitlement, which may be relatively negligible, so you may have to add your

own resources to it. I appointed Andrew Dilnot, and we had the Dilnot report, but nobody did much about that. The point is that there was an expectation that the structure of financing for social care that came out of the Dilnot report would itself substantially support the development of those personal budgets. People with those personal budgets can go to more integrated providers. That is quite important.

The Chair: As we have one of the Dilnot report members with us, we had perhaps better not go down that particular road.

Q232 **Lord Kakkar:** It is very clear from the discussion so far that, over the last 20 years, successive Governments have returned to the question of integration as a key determinant of the future success and sustainability of our health and care systems, but there must be a reason why Governments have had to keep on going back to do that. There are clearly great expectations about integration. As we have heard from Lord Lansley, the integration between primary and secondary care, between services for physical and mental health, and between health and social care is essential in that consideration.

We have heard some of the reasons why it has failed. Is one of them that the expectations may not have been matched by the impact, over the last 20 or 25 years, of relentless policy and commitment by Governments to achieve this? In particular, we have heard in this inquiry that there is no evidence that the current approach to integration will provide the opportunity to substantially remove resources from the hospital secondary care environment and drive them to the primary and community care environment. If that is the case, how, from a political point of view, will this be driven forward?

Lord Warner: I will give you one answer. There was an attempt to do that. I have always been very influenced, in every job I have done, by the history of the Audit Commission. That history was written by someone who called it *Follow the Money*. At the end of the day, this is about where the money flows go.

When we were doing the White Paper, there was a bit of a private bust-up at the top of the Department of Health, which was not a surprising phenomenon. Some of us—well, at least me—wanted to limit the budget for acute hospitals. As far as I could see, the only way to make the integration of community services work was to stop money being funnelled back to acute hospitals. Even when you allocated it out of acute hospitals, there was this amazing osmotic process whereby, when acute hospitals were overspent, the money flowed back from the other services to bail out the failing acute

hospitals. Unless you stop that, you cannot safeguard the Cinderellas in community services.

Lord Hutton of Furness: Leadership is very important in all this. It is not enough, in my experience, to will the ends you want. You have to make sure that the system delivers and that the behaviour in the system supports the objectives the Secretary of State and Ministers have set. At the moment, I do not see any sign that there is enough leadership in the sector to drive the outcomes that we are talking about here. That is a big issue.

I understand Andrew's point entirely. In a science-based service like the NHS, you would expect the leaders to be at the forefront of driving best practice and making the system work effectively. In many ways, particularly in this clinical space, that happens. It does not happen in the organisational space. There are too many perverse incentives in the system at the moment, particularly after the pandemic, with the ending of payment-by-results systems. Payment systems designed to drive good behaviour across the sector have just disappeared.

Until you get hold of the money and how it flows around the system, and you really drive that, I am afraid you can legislate until the cows come home and nothing is really going to change. We have seen that year after year. Norman is absolutely right. The money is king; it always is. But without the leadership to make the system work more efficiently and effectively as a system, nothing will happen.

With great respect to Andrew—I have a lot of respect for his time at the department—unless the political leaders of the health service in the Department of Health really put their foot to the floor and firmly grip the steering wheel, you will not get change. You will not get the sort of change that I suspect the committee is looking at by turning the mirror back to the system itself and saying, "Guys, come on. You must see that there's a better way of doing it". They will not see that. They will only see the resource implications for their own part of the system.

That, I am afraid, will not change unless there is a completely different political and leadership momentum that drives this like an electric current right the way through the system. At the moment, that is just not there.

Lord Lansley: I rather agree with my two fellow witnesses. I have a list of the things that I thought I should not have done, since there were too many things, but which I tried to do, and a list of

things that I tried to do insufficiently and would have done more and which I think continue to be very important.

John made the point about the loss of some of the incentives built into the payment-by-results system, which is deeply regrettable. If anything, we should have developed payment by results further so that it became, for example, payment for outcomes. There was a programme for the development of payment for outcomes; I think it has been killed now. There was the development of payment systems for mental health services, because there you are largely paying for approved pathways of care over time. You might have a Year of Care budget, for example, and key performance indicators in relation to that.

All of it is moving away from payment for activity and episodes and towards more payment for outcomes. That tariff development is completely absurd. We have 1.45 million people in the National Health Service. As far as I can tell, there are about half a dozen who understand tariffs and work hard on them. This is madness, because tariffs drive the system. Everywhere else in the world, people say, "We don't have competition, so we are all co-operating".

I have never thought that it is about competition; it is about commissioners using their budgets to get the best outcomes. How are they going to do that? It is not just by having nice meetings, but by having a payment system fixed on key performance indicators that are principally outcomes or processes and targets that are proven, evidence-based proxies for subsequent outcomes. That is what drives the system, and that is what we do not have.

Lord Kakkar: There is a consensus here. How, then, is the system to be designed to drive activity and to drive the focus in such a way that we achieve what everybody agrees are the very best outcomes for patients and an improvement in population health? Again, that must be predicated on the appropriate utilisation and distribution of resource between the hospital sector and the community and primary care sector.

Lord Lansley: Let me start, and then my colleagues will no doubt add to or subtract from what I say. For my purposes, I regret having agreed that the NHS would have no competition in its commissioning support units for at least five years, by which time it had effectively maintained control of the commissioning system, because most of the CCGs were too small to run a commissioning system. That is why the commissioning support units existed. They are relatively large scale. There are only about half a dozen of them. They should have been exposed to competition from the

outset, because that is where the competition would have had the chance to bite, with organisations like Xperience, Humana, Bupa and others coming in and providing commissioning activities for CCGs. From the patient's point of view, that would not have made the slightest difference, except that they would have been very focused on commissioning for patient pathways.

We have better data now. We have better opportunities for population health management than we have ever had. We have a better potential for analysis. But I wonder sometimes. Even in the new ICSs, where the commissioners are supposed to be bigger and all the rest of it, they are still not big enough to do this on their own. To make it happen, they need large-scale commissioning support with sophisticated population health management analysis. I want to see them doing that, because they will not get outcomes without it.

The Chair: Are you going to add to or subtract from that, Lord Hutton?

Lord Hutton of Furness: The commissioning role in the NHS has always been really undeveloped. From my time in the NHS, when I think back, it was more a case of asking, "What is the uplift in the budget this year?" Everyone gets that and it moves on.

In my experience, there has never been any really serious effort to sit down and design services properly from the perspective of patients, such as the number of journeys the patient has to make to get this treatment or that treatment. We do not commission health services effectively. To be honest, one thing that Andrew might reflect on now is that there was not much appetite from GPs to take the lead on it.

Lord Lansley: They said they would. When I was in opposition, they said, "Give us the chance and we'll do it", but they did not.

Lord Hutton of Furness: We found something broadly similar. With the benefit of hindsight—my goodness me, it is a fabulous thing, but you never have it when you need it—we never got the whole approach to commissioning services right. That will be a fundamental bit of trying to get the integration agenda moving again.

Lord Warner: I used to be a fan of commissioning, but I have come to the same conclusion as Ken Clarke: that it is a 30-year experiment that we are still awaiting a decision on. When I did practice-based commissioning with the GPs, that was Labour's way of disguising the fact that it was GP fundholding. My experience

was the same as John's. We got about 50% of them there. The other 50% wanted to carry on much as before.

My answer to the original question from Lord Kakkar is that you have to control the money. But you do not control the money just for the centre to decide and design community-based services; you have to get local people getting their hands dirty and doing the local services that you need for population health. You cannot deliver population health from the centre of Whitehall. It is impossible, because the communities vary so much.

That is why I have written a pamphlet—by a strange coincidence it was published today—in which I have argued for what I have been saying here: that you need to stop the leakage back to acute hospitals. You need to control the flow of money regionally and locally down—particularly locally down—with the agenda of using community-based services, including social care, to drive population health. If we want a health service, not an ill-health service, we have to do something like that.

Lord Kakkar: How do you prevent that leakage?

Lord Warner: My proposal is that, each year, you decide what percentage of the NHS budget—percentage, not a cash sum—you are prepared to run acute hospitals with. You put a central figure in charge of ensuring that they manage within those budgets. I would strongly want that to be very clinically led, in order to carry doctors with you, and shared out among the specialties and the hospitals.

I would then, possibly under regulations, set the percentage going outside hospitals, with a gradual build-up of that sum over time, to be used on community-based services—with the expectation, coming out of the 2006 experience, that a lot of that money, which is currently spent in acute hospitals on diagnostics of one kind or another, is spent in the community. You need to get communities commissioning the services for their communities much more quickly than we do now. That is a move away from command and control.

The Chair: If you do not have copies of your pamphlet about your person, Lord Warner, I am sure you can supply them.

Lord Warner: I have one. I can tell you where to get more.

Q233 **Baroness Armstrong of Hill Top:** I ought to declare the interest that my husband was the special adviser in the department when Lord Hutton was there and in No. 10 when Lord Warner was there—not that I knew what on earth was going on; I just had the responsibility of getting it through Parliament.

We have become really interested in accountability and in how the fine words actually work. John, you talked about delivery being almost more important than policy. You can have fine policies, but how do you make them actually work? The evidence we are getting about ICSs and so on at the moment is, "They're a very good thing, but you've got to give them time".

From your experience, what was that link between the policy you were committed to and the delivery of it? Where were the levers? Were there levers? If ICSs are good, what levers and outcomes should we be looking for?

Lord Hutton of Furness: You could approach that topic in a number of ways, but I agree with you: it is fundamental. We tried a number of devices in our time in government, including hauling people in and bawling them out, which generally speaking was not terribly successful. It did not change very much on the ground.

If you are going to do this, you have to do it from a systematic point of view. You might wonder, "What's he actually saying?" but every aspect of the system—the money, the local governance, what NHS England does and what Ministers do in the department—has to be focused on the key goals and objectives that have been set for the service. When we were in government, we used to get a lot of flak for setting targets: "You can't set targets, because it cuts across professional responsibilities. It gets in the way of the patient and the clinician".

With respect, there are not many people left who think targets in the health service are a bad thing. There have to be targets. The public pay for this service. Those of us who have been in the other place, in the Commons, will remember what it is like to meet a constituent who has paid for the NHS all their life and who, when it comes to the point of need, cannot get an operation—there is no prospect of it at all. We cannot tolerate that type of service.

The politicians have to be tougher. They have to be prepared to get the whole system pointed in a certain direction and keep it pointed in that direction. That brings levels of responsibility for all the key players, including the person who runs NHS England, the people who run local hospital trusts and Ministers. Ministers have to be properly accountable for what goes on in a publicly run service.

At the moment, that has got blurred at the edges. It is all too difficult. The pandemic has changed quite a lot of people's perspectives, but at the end of the day we should not settle for second best. I am afraid that at the moment we do: "It's too hard; it's too difficult. We can't get the system to work in the way we would like it". Yes, you can, but you really have to have a plan to

do that. I love the NHS and want to see it succeed. At the moment, I do not see anything that looks like a plan. There is no plan beyond how we get through to the end of the week, maybe the end of the month. There is no plan at all for that sort of outcome. That is pretty depressing.

Lord Warner: The real issue is what you will hold them accountable for. I believe that you have to have a structure where there is some accountability at the national level. Unlike Andrew, I do not think you can run the NHS without some kind of regional presence. It is simply too big. We have seen devolved Administrations run health services for even smaller units than any regions would be.

You have to have local accountability. You have accountability for things you care passionately about. We care about population health. We care— I learned this from local government—about people not ending up in a closed institution, a hospital or a care home. They prefer to be in their own home. They prefer to live and die in their own home.

We need to keep measuring patient satisfaction, as the British Social Attitudes survey does. What do the public think of the NHS? I can tell you, from writing this book, that in about 2010 70% of them were broadly satisfied with the NHS. On the last survey, 29% are satisfied with the NHS. It is even worse for social care, at 14%. Public satisfaction is important, as is delivering what people want, which is to be kept out of hospital or out of a nursing home. These are the things that you can try to measure, even if they are not perfect.

Lord Hutton of Furness: The irony today is that, despite 20 years of reform—to some extent, we have gone this way and then we have gone that way—hospitals are once again the kings of the jungle. They control everything. They suck everything in. There is no room for any other part of the healthcare system to flourish. There just is not. The secondary sector—the acute hospitals—rules the roost. That is wrong.

Lord Lansley: They do. Under the 2012 Act, the intention was that that would absolutely not be the case. I was criticised for it. The providers, the large hospitals in particular, did not have a formal seat at the clinical commissioning group table because they were the providers, and the commissioner's job was to secure from the providers the best available care.

That did not work. We have now arrived at ICSs and the providers are at the table. Many of you will remember the debates about

that. I am not now arguing that we must avoid that. I would not subscribe to Norman's view that you give them an allocated percentage of the budget, because I have seen hospitals that are reaching out into their communities. I have even seen hospitals, like the Great Western Hospital in Swindon, buying social care provision themselves in order to manage the discharge of their patients into the community. The possibilities are there. It may be that we are looking at integration through provider action rather than just integration from commissioner action, but integration is required.

Hilary's question was the accountability question. In my book, if you go back to my White Paper of 2010, accountability was for outcomes. If you asked me what I was involved in that in the long run was the best thing and could make the greatest difference, I would say that it is the development of the NHS outcomes framework.

With the greatest respect, the British Social Attitudes survey is not going to be a real-time method for determining patient satisfaction with the NHS, but within the NHS outcomes framework one of the five strands is patient experience. One of them is avoidable mortality, which is an internationally relatable measure of our performance compared to others. We have developed the measurement of quality of life for those with chronic conditions, and we can measure those populations and the changes in their quality of life over time. In my book, the one about the success of treatment is very interesting. That is another of those five.

We measured safety in our work on *Clostridium difficile*, as the Labour Government did in 2008-09 on MRSA and as we now have to on sepsis, and so on. You can work on safety for those things, but the patient treatment one is really interesting. In the past, people were paid per episode and they barely knew whether it worked. How many knee operations give people enhanced mobility after a period of time, for example? The NHS outcomes framework should be continuously developed so that you can assess not only the NHS's response and performance but how well the different parts of the NHS and the different places across the country are performing, and you can ask, "How well are your outcomes improving? If they aren't, what are you doing?"

Q234 Baroness Barker: This is all really helpful. I wanted to pick up one thing. Lord Warner, your phrase about safeguarding the Cinderellas has grabbed my attention. You also talked about patient satisfaction. Is there a danger that patients who are better able to articulate their needs are the ones who get the services and that it

is not really about patient need?

Let me give you an example. Over the last 40 years, for a variety of reasons, we have developed one of the best HIV and AIDS services in the world. Over that same period, access to contraception has decreased dramatically. We now have a frighteningly high level of unintended pregnancies. Something like 40% of pregnancies are unplanned. Something is going quite wrong with the service. Back when I was young, those two services were handled primarily in the same place by the same doctors. In the last 40 years, there has been constant reorganisation and a changing of budgets. I am intrigued to know—I will read your pamphlet—how you make sure that you are not just moving one set of problems around and ignoring another set.

Lord Warner: You cannot solve every problem. We are in a tough fiscal world, and it will go on for some time. You have to look at your priorities. Not everything can be a priority.

I was not suggesting that we should all be judged by the British Social Attitudes survey. I was trying to find things that the public would recognise whether the NHS was doing well or badly on. Many of them will be clinical. The more you get down to the detail, the more you end up with targets that are specific to a particular area and particular specialties, so you need that.

I looked at an overview of this. You have to face up to the fact that acute hospitals are the most expensive part of the system. As John rather graphically put it, they suck in all the money. If you want to stop that, you have to stop the money going there. There is no other way of doing that. You have to persuade clinicians that that is what you will do and what you want them to be engaged with. When we were doing the 2006 plan, we were trying to engage clinicians in a new way of working. You will nowhere without doing that.

I sat in your place in this room nearly six years ago to the day in a committee of the House on the long-term sustainability of the NHS. Four NHS acute hospital barons, if I may call them that, came in. We were all stunned when their opening remark was, "We need a real-terms increase of 4% a year". The whole committee froze. There was sheer disbelief at their arrogance about what they thought they were entitled to. A lot of that has not changed. With all due respect, Andrew, we can all find trusts that have done good things, but as a whole they have sucked up the money and denied it to community services.

Q235 **Lord Watts:** The acute hospitals are sucking in the money, as it has been described. What are they doing with it? There do not

seem to be any results coming out of that extra funding. Where is the money going?

Lord Hutton of Furness: They are using it to keep their heads above water. That is essentially all that is happening. There is no turnaround and there will be no turnaround on waiting times unless there is a fundamentally different approach to how we manage demand across the NHS. Let us not forget just how expensive an acute hospital is to run. One thing that is causing much financial distress across the service at the moment is the high cost of and continuing reliance on agency stuff. They are big, expensive organisations and their costs—their fuel costs, their labour costs, their drug costs, everything—have risen enormously. It is a really difficult space.

Chair, I should have declared right at the beginning that I am a director of Circle Health Group, the largest private healthcare organisation in the UK. I am very sorry that I did not do that. I really want to make that clear now, because the next thing I will say has direct relevance to that. We are all pulling our hair out trying to work out how we will manage this resource, because we are not spending effectively the money we have. Having been in the department, come out of it and worked across the NHS and in the private healthcare space, the one thing I know is that we are woefully bad at managing demand across the healthcare system. There is virtually nothing to stop GPs referring people to consultants for an out-patient appointment and then perhaps a surgical procedure. There is nothing in the middle that allows people to perhaps check that route out first before putting in a bill for secondary care at an acute hospital.

We need demand management. Whether it is in musculoskeletal or other areas—probably not sexual health; demand management will not work there, for obvious reasons—we can do a lot better with the resource we have. In the process, we can help to join up the disparate services that are more community-based, whether it is physiotherapy or whatever it might be. That will provide a better patient pathway for patients who go to their GP because they are anxious and want some form of treatment but do not know what.

It cannot just be the default position that a GP writes a docket and off you go to see a consultant. That is a completely hopeless way to run a healthcare system. We know there are many other ways and routes open to patients before they need to see a consultant at all. Some people clearly need to see a consultant as quickly as possible, and we have clearly established protocols and procedures for people who need an emergency referral into acute care. I do not want to get in the way of any of that. For a lot of the more

routine work across the service, if we are trying to find a way of using resource more efficiently and, in the process, integrating more community-based services into the patient pathway, we must look at how we systematically manage demand from primary care into secondary care.

At the moment, it is completely haphazard. Some parts of the healthcare system have really good demand management filters in place. Others have absolutely none. We should not have to have Ministers there to make sure that we have best practice across the NHS, but sadly we do. The service itself will not design this system to work efficiently and effectively. Why should it? Demand management is a critical thing. We do not pay enough attention to that in the healthcare space at all.

The Chair: Lady Shephard will ask the last question, which may give you all an opportunity to leave us with one idea.

Q236 Baroness Shephard of Northwold: We have heard a lot of ideas from everyone. It has been fascinating, I think we would all agree. Here is the question. What one change does your ministerial experience suggest would make the biggest improvement to the integration of primary and community care in England? We have ranged far and wide, but it is the integration thing we are interested in.

Lord Lansley: Can I just jump back and give Lord Watts an example of the problem they are facing? Based on each of our experiences, we had an idea of what the year-on-year increase in the number of presentations to accident and emergency departments would look like. Our experience was completely different from that of the NHS in the period since about 2016 when the number of people visiting A&E departments every year has been going up much more quickly.

Of course, that is what the acute hospitals are saying. When they read Norman's pamphlet, they might say, "If the patients are all arriving here and we have to deal with them, we should have the money to deal with them". The problem is that many of those patients could have been better dealt with—this is precisely John's point—through better demand management. Those patients, many of whom are relatively elderly and have comorbidities, are arriving in emergency departments and occupying hospital beds sometimes for weeks while they are trying to arrive at a point where they no longer have comorbidities, which frankly is never going to happen. We are talking about the management of antibiotics for UTIs in the community, for example, not sitting in a hospital bed while you are doing it.

Baroness Shephard of Northwold: Who does that management?

Lord Lansley: If I may, there is this idea that commissioning somehow has not worked or is not going to work, and that at the same time we must do much better at demand management. That is what commissioning is: the management of demand to deliver better outcomes with the resources that are available. That is what it means.

You asked me what my one thing was. My one thing—I will revert to it now—is tariffs for outcomes and patient pathways, if necessary just for simple stuff such as Year of Care budgets, according to NICE guidelines. Those are the things for which tariffs should be used. You have to get people at the centre, in NHS England, who are sufficiently focused on that and who have moved away from sending block budgets to hospitals. They have to send to the hospitals the budgets for the patients they deal with for the whole Year of Care patient pathway or outcome. Ideally it will be for outcomes, although in many cases they think that they cannot manage that, but it should definitely be for Year of Care budgets.

I will give you an example. Going back 10 more years, the Cystic Fibrosis Trust did this work itself. It is a charity. It analysed the structure of the provision of the best services for cystic fibrosis patients in hospitals and designed it all out. It analysed all the necessary costs and completely identified all the outliers in terms of poor quality or high cost. It forced the creation of a tariff for CF patients in hospitals. Creating the right tariffs seems to be critical.

Lord Hutton of Furness: I agree with a lot of what Andrew said. There are two ways to cut this. You have to look at the system and how it is working. At the moment, it is not working efficiently at all. The money is being pulled into one part of the system at the expense of all the others. Commissioning should result in that sort of outcome, but it does not because that is not really how most commissioners approach their job. They are managing a financial crisis on a daily basis. They do not really have time to think about some of those big picture things.

If I was in the department now, I would be really worried about the integration between emergency, primary and secondary care. It has just fallen over. We all know what is happening in A&E departments at the moment. It is a car crash. That is partly because there is no range of community-based primary care systems that can help people who otherwise just get sucked into A&E. If we are worried about where all the money is going, that is where a lot of it is going. It is the most expensive part of the system. If you think about it, that is where you treat people. I do

not know what the numbers are, but I would think that more than half of those patients do not need to be there. They are there because the system is not geared up to work efficiently and effectively. I would look very critically at how we cannot have more intermediate services between primary and acute care. That will cost money.

Again, my lesson is that it is almost impossible to expect any Minister, whatever their political colour, to take a big pot of money from hospitals and spend it somewhere else. That is never going to happen. Let us be quite honest. No one will do that. So if we are serious about it, we will need a pot of money to help the NHS to develop the service that will fill the gap. There is a huge gap. As I said, it is extremely unlikely that that money thing will sort itself out by shuffling the existing pack. Who wants to see acute hospitals close? I do not.

There is a very stark choice there. When Lord Darzi came into the department to help us redesign some of this, this is where we ended up in 2008-09. We would need a bit of double-running in the system if we really wanted to separate out what needs to be done in acute hospital settings and what does not. There is no cheap way of doing that. If you think there is, you have not learned any lessons from the last 20 or 30 years.

Lord Warner: I have not changed my mind during this hearing. You have to stop the flow of money to acute hospitals over time. I would do it by making an announcement. I agree with John that you have to have some money to make the announcement, but some of it might be capital. You have to choose a period, whether it is five, seven or eight years, and announce that you will move the NHS down this path by adjusting the budgets in a controlled way over time. You have to announce that you will spend much more of your capital investment budget on community and intermediate care services rather than pumping it in all into Boris Johnson's "build 40 new hospitals" project. The NAO is right: that is not a thought-out programme. It needs to be redirected to other types of facilities.

Ara Darzi never got his way, because polyclinics were killed. In part, polyclinics could give you a stronger out-of-hospital capability that would stop people going into hospital. Until this is the direction of travel you want to have politically, nothing will change.

The Chair: That is a very pessimistic note for this committee to end on. We are seeking to find something that we can suggest for change that will bring about more integration. I cannot thank you enough for sharing your ideas, your wisdom and your experience

with us this afternoon. On behalf of the committee, thank you very much indeed to all former Ministers. As you know, that this is a public session, and you will be sent a transcript to correct any errors. In the meantime, on behalf of the committee, thank you very much again for your wonderful contributions to us this afternoon.