Health and Social Care Committee

Oral evidence: The 10 Year Health Plan, HC 386

Wednesday 11 December 2024

Ordered by the House of Commons to be published on 11 December 2024.

Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Deirdre Costigan; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 1-55

Witnesses

I: Stephanie Elsy, Chair, Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board; Saffron Cordery, interim chief-executive, NHS Providers; and Melanie Williams, President, Association of Directors of Adult Social Services.

II: Beccy Baird, Senior Fellow, The King's Fund; Professor Kamila Hawthorne, Chair, Royal College of General Practitioners; and Professor Nicola Ranger, General Secretary and Chief Executive, Royal College of Nursing.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Stephanie Elsy, Saffron Cordery and Melanie Williams.

Q1 **Chair:** Welcome to this session of the Health and Social Care Committee. Today's session is part of our work on the 10-year health plan, looking particularly at the Government's ambition to shift care from hospitals into the community, and what needs to be done differently to achieve that. We are lucky to be joined by two panels. The first will run for roughly an hour, then we will move on to the second. Thanks to all our participants for being with us, and to everyone who is watching at home.

I am going to get cracking. In my lifetime there have been a number of different initiatives to make exactly this shift. In '87, there was the "Promoting Better Health" White Paper. In 1990, there was the National Health Service and Community Care Act. In 2006, we had "Our health, our care, our say: a new direction for community services". In 2014, the NHS "Five Year Forward View" had a go. In 2019, the NHS long-term plan also set out a vision for integrated place-based care, and here we are.

I will ask all participants to have a go at this first question, perhaps starting by telling us who you are and where you are from. Bearing in mind that we have tried this before, what do we need to do differently this time?

Stephanie Elsy: Thank you very much indeed, Chair. I am Stephanie Elsy, chair of the Bath and North East Somerset, Swindon and Wiltshire integrated care board. I suppose there are a couple of things that I think are very different this time. First, the changes that have happened since the '22 Act have completely changed the relationships between different parts of the system. Previously, it was competitive. That was the way it was set up. This time, we have a duty to collaborate. That is a really big change. Secondly, there is much better alignment of incentives for organisations within the NHS and local government to work together to achieve this shift. As you rightly say, Chair, everybody agrees that it is the right thing to do—I certainly think it is the right thing to do—so we have a much better context and framework for it to happen.

The final thing that is different, perhaps, to previous years is that we have a really significant burning platform, operationally and financially. You all know the enormous pressure that the whole system is under at the moment. As far as I am concerned, the only way that we will be able to continue to meet the demand, perhaps meet it more effectively than we are at the moment and, indeed, meet the demand that is coming down the track with the ageing population and so forth, is to achieve this shift. It is really important that we help people to stay out of hospital, and that when they are in hospital, we are able to get them out safely—back home, or to wherever the best place is for them to be.

The other burning platform we have is, of course, financial. Given the conditions the public finances are in now, we simply cannot afford not to

do this. It is essential. It is crucial to the future survival and health of the system that we get this shift.

Q2 **Chair:** I think we are all agreed on all of that, but we are trying to learn today whether there are any lessons from the past. I am hearing one around the duty to collaborate—it is really important that we keep that going. If we focus initially on the past, what have we learned and, therefore, what must we emphasise to progress this and embed it? Saffron?

Saffron Cordery: I am Saffron Cordery, interim chief executive at NHS Providers. We are the membership organisation for all types of provider trust in England. We encompass acute hospitals, mental health services and community and ambulance services.

I agree with everything that Stephanie said. In some ways, there is nothing new under the sun, as you said. We have a timeline of shifts to moving care out of hospital—if you want to define it like that—and trying to integrate local services more effectively. I was in local government in the 2000s, when it was all about local strategic partnerships, shared local targets and things like that. It has been around for a very long time.

We perhaps need to focus on what has not worked in the past. We know that a narrow focus does not work. In looking at this particular conundrum of moving care out of hospital into the community—moving care out of in-patient settings—we need to encompass mental health. It is absolutely fundamental. It is about broadening out and encompassing mental health in our definition of in-patient.

We also need to redefine the challenges and issues that we are trying to solve, which Stephanie set out well. When we look at the solutions, we need to look not just at how we achieve narrowly drawn targets. We all know about the 18-week target, which will be the big driver for the next four or five years. That is absolutely fundamental, but in thinking about how we achieve that, shifting care is fundamental to that. We must ensure that we do not just focus on a big, national, popular target without encompassing what needs to be done locally.

There are a host of barriers, and we have learned a lot along the way. First, I think narrowly drawn targets mitigate against looking at how we enable good quality of care and patient flow, which is fundamental. At the moment, there is a real lack of understanding of the nature of all the offers that are out there. I do not think there is broad understanding across the piece of what community services offer, from health visiting to speech and language therapy, and all sorts of services on the ground that help people to stay fit and healthy at home. When I say lack of understanding, I do not mean from the public, but from across local systems delivering local services.

We have a real challenge in terms of the nature of the funding. It is hugely fragmented and it is often short term. If you are in primary care, community services, mental health, dentistry or an acute hospital, you

have different funding streams and different types of funding. That is incredibly difficult to navigate if you are all meant to be focusing on a single goal and aim. The nature of block contracts, particularly for community services and mental health services, is that you only have a defined amount of money. Whether your demand goes up or down, you just have this money to work with. You would never see that in acute care. We have to remember that. For what is expected to be delivered in settings outside of hospital, the budget is not elastic.

Q3 **Chair:** We will certainly come back to that, so I might stop you to allow colleagues to dive into that later. Melanie Williams?

Melanie Williams: Good morning, Chair. I am Melanie Williams and I am here as the president of the Association of Directors of Adult Social Services, bringing a social care perspective. The other part of my week is spent as a director of adult services in Nottinghamshire, and I sit on the integrated care board. I have some reflection on that to share.

From a social care perspective, we have been working for probably about 15 or 20 years at three main initiatives, which have achieved some of that shift. We have had a better care fund for 10 years, which intended to integrate services and prevent admissions to residential care alongside emergency care; we have had the shift, which has been referenced, in mental health—the closing of campuses and moving away from asylums to community care; and there is also the community mental health transformation programme, to support more and more people in the community. Importantly, there are a lot of lessons to learn from transforming care and building the right support, which is why we are supporting adults with learning disability and autism, who have often had a very long stay in institutional care, to be supported well in the community. I think there are some learnings from that.

The first thing is to have a clear policy expectation—being clear about who we are talking about and what we want to achieve, based on their needs, rather than on care settings. That is a very important lesson. If we just describe settings, we are moving people around, rather than attempting to meet people’s needs in a different way, which, ultimately, is our goal.

We then need to make sure that the metrics and the measures follow the policy. I mention that because when we think about the better care fund, one of the tensions is that we have had incredible drift from its original purpose. We have added in metrics, levers and expectations, which have spread its focus. Having that clarity of focus on what you are measuring is really important, as is measuring the policy.

The funding flow has also been touched on. It has been very clear what your programme spend is—what is the spend in the areas that you are wanting to move away from, and how does that shift in practice into the areas that you deliver? If you want to do that at pace, that is what you need to invest in first—the outcomes. We see that in the transforming care work, where we had funding agreements that followed the individual. Unfortunately, it did not follow ahead, so we were not able to provide

different sorts of support in the community ahead of that. Certainly, that has not been maintained over time. In particular, capital is really important. If you want to support somebody in the community, they need somewhere to live, so having a home is central to that policy. People need a place of support. That is really important for learning.

It is then about burning the old models, if you like. One of the things we tend to do is drift back. If we think about community mental health transformation, we see the rolling back of investment in crisis teams and going into the acute sector in adult mental health. Rather than making sure that we close off those old models of care, we constantly drift back. It is often like a gravitational pull to building-based services in terms of status, safety and the feeling of comfort for professionals.

Chair: And you think the best way to do that is to decide to move away and then shut it.

Melanie Williams: Yes. When we have had successful programmes of moving people's support, it is about then closing off the old models—not just for financial flow, but so that we truly are committing to a new way of working. That is a thing for learning. One of our challenges and barriers is that when those things work best, it is because there is leadership that works in partnership, can mobilise a workforce, has a partnership culture, and has some local drive. That does not exist everywhere, so you will have variation. It is worth considering in the policy expectation how we tackle variation of leadership.

Q4 **Chair:** One of my questions is about local authorities' need in that area. Is it training or support? What do they need from Government in order to be successful and to deliver what you are delivering?

Melanie Williams: In terms of the shift from community hospitals, having a really clear remit for health and wellbeing boards, and having that local partnership and the public health approach, is going to be crucial to the success. One of the things to be considering is: what is the role of health and wellbeing boards? Local government partnership is much broader than just social care. It is about housing, debt management and a whole range of things that are available to people. That will be one of the things to consider.

Clearly, this session is not about looking at adult social care reform, but if we are not reforming the way that we work through the national care service and the other aspects of reform, we need to be really clear about how we achieve that in an unreformed social care system as part of that work.

The local accountability and leadership are really important. The initiatives work best when there is single accountability and leadership. It is worth considering how the local authority can play into that, but it will depend on the group of people we are supporting. Some people that I support in adult social care will not need any health input, and some will. People who are accessing treatment do not necessarily need a social care service, so

we have to be really clear about what solutions we need for what group. Like I said, that comes back to the policy expectations.

Q5 **Chair:** On the other side of the equation we have the trusts, who are running the acute settings. What do they need to help to achieve that shift? Saffron Cordery, perhaps you could answer that.

Saffron Cordery: I think I said it before in my previous answer, but it is about how we focus on the types of contract we are thinking about. At the moment we are in a situation where if you are in a community or, to a lesser extent, a mental health service, your services can be reprocured every few years. Think about that in terms of running a health service that is really critical to a local population: after three years all the investment you have put in could go somewhere else. Sometimes that is a good thing—if you have a failing service, the opportunity to be able to move it somewhere else is really helpful—but often we see massive disruption, and it is very wasteful in terms of investment of funds in reprocuring.

In terms of a shift from that model, we have seen proposals from both Amanda Pritchard at NHS England and the Secretary of State on a change to overtime and a different model for integrated care boards, so that they take on the strategic commissioning role. That is the bit that from my perspective and my members' perspective makes real sense of the integrated care system model. It is about health inequalities and understanding population need, and then commissioning on that basis. It is about making sure that we are looking at the wider things that Melanie was talking about, like socioeconomic development, and supporting in the broadest way. That is very important.

We also have to make sure—this is fundamental—that we have the right data systems in place. It might feel like just a nitty-gritty operational thing on the site, but it is fundamental.

Chair: What about them?

Saffron Cordery: If we cannot have interoperability with the right data infrastructure and digital infrastructure for every part of local services, we cannot offer the seamless service that we are talking about.

Q6 **Deirdre Costigan:** Stephanie, the idea is that integrated care systems would support long-term transformation in the delivery of health and care. The Hewitt review expressed concern that that might mean they become a "nice to have". You mention the burning platform of the pressures that face the NHS. In that context, how can we ensure that ICS leaders get the support to drive the shift we are talking about into the community while they are facing all those intense short-term pressures? In particular, how can we drive forward into public health and preventive work?

Stephanie Elsy: In a sense we have a good start in the fact that the Government have articulated this ambition, which is the first time it has been said as loudly and clearly as that. The NHS is very good at doing what it is told. If it is the priority of the Government that there is this shift

into community, that needs to be followed up with, "What does that look like in terms of the kind of targets that Government are setting for us as part of our planning?" If the Government and NHS England support that through the planning system we have, that will of itself drive that kind of change. In a sense that is some of the leadership that we are talking about, and that leadership needs to happen at all levels, not just nationally but regionally and locally as well through ICSs. Actually, everyone is up for it. In my system everyone totally supports this agenda. That is why we recommissioned all our community services with this as the focus.

To pick up the points that Saffron made about the contract, that is really important as well. We are trying to make sure that our contracting is outcomes-focused and has the length of time in it. Our contract is seven plus two years, so the provider knows that they have this contract for that period of time and can put the investment in up front to do the transformation of services that needs to happen over that period of time and can get their return on investment. We have guaranteed what the funding envelope looks like.

The other thing that is really helpful across the board is to have some kind of certainty of funding. Any sort of medium-term funding settlement is really helpful. I am hoping that the spending review will help with some of that so that, again, you have the certainty of knowing where you are going to be and can plan for that. Those are some of the drivers that will help us to deliver that. I hope that helps.

Q7 **Deirdre Costigan:** You mentioned certainty of funding; my question is about voluntary community and social enterprise providers. I declare an interest: I am a Unison member, and Unison is one of the unions involved in the discussions on that. On funding, if the community stuff is done in that way with an outsourced contract, is there any disincentive for the acute services to take part in the shift of moving services and patients to the community? Would that then impact the funding of acute services in terms of the point you made about the fragmentation of funding?

Stephanie Elsy: It certainly wouldn't any time soon, because the acute services are absolutely overwhelmed, frankly, with the volume of demand they are having to deal with. Anything that community services can do to help people to stay out of hospital in the first place and to leave hospital as quickly as their treatment allows would be regarded in the acute services as really helpful. Certainly, in my system, our acute trusts are absolutely supportive of the approach we have taken in this commissioning round. I think it is supportive, but Saffron may know more about that than me.

Saffron Cordery: It is really important that we think of this as a paradigm shift. I do not think we are in the territory now of acute trusts saying, "You're taking our business away." We are absolutely in the paradigm of saying that we fundamentally need a way to be able to provide high-quality care, to minimise risk, to encourage patient flow and to give people the experience that they should have. That is absolutely about admission avoidance. It is about, as Stephanie said, getting people

out of hospital as quickly as possible. It is about anticipating their needs and stopping them from deteriorating at all.

I can write to the Committee to give you some examples of where this is working really well in different places. Hertfordshire community NHS trust in particular has a fantastic left-shift programme called minus 9. It anticipates what someone might need nine days before admission. It stratified all its population to understand who is most at risk and at what they need.

There are some great initiatives out there, but there is absolutely no sense from our acute members that community is out there prowling around taking its income away. It is absolutely about how we get really good flow, because really good flow enables us to move forward on the bits that are top of mind for the public. If we think about the 18-week target and all the constitutional standards, that is top of mind for the public, trust leaders and everybody working in the system. I would say wholeheartedly that this is enabling and not undermining.

Chair: Thank you. We will come back to that point.

Q8 **Ben Coleman:** It is very good to see you all. I declare that the questions I ask are partly based on many years sitting on the council as the cabinet member for health and adult social care and sitting on North West London integrated care board. Given that, my experience—I wonder whether it reflects your experience—is that, for the NHS to achieve its objectives, it has to work extremely well with local councils, and we have been talking about that. Local councils in my experience—again, I would like to know whether the same is true in your experience—understand the NHS rather better than the NHS understands them. How much of a challenge do you think it is that the different parties do not necessarily understand each other very well, and how can we overcome that? Maybe I can come to Melanie first.

Melanie Williams: One challenge to integration is that we have two completely different systems. Adult social care is, in the main, locally funded with local oversight. It is 153 councils that deliver those functions—I am talking from an adult social care perspective, but it is equally true of any local government function—and then we have our partners in the housing authorities, some unitary councils, some district and borough councils and then we have the vast array of NHS organisations. There are thousands of different ways that people work well and do not work well locally. That is my experience. There are some amazing examples of integration and positive working: a care home and a paramedic, or a community nurse and a social worker. Equally, there are examples of leaders not speaking to each other and failing to agree on a way forward. There is a huge variation.

Q9 **Ben Coleman:** I understand that at a local level, individual services can work well, but at an ICB or a system level—you come from an ICB that has only three councils; I come from north-west London, which has eight—how much is there a system understanding of local authorities,

and vice versa? How much does a lack of understanding have an impact on what we are trying to achieve?

Melanie Williams: Again, there is huge variation. In my own system, I play a very active role in my ICB. I sponsor some of the integration workstreams and we share intelligence, so we feel like we have a seat at the table. But unfortunately, as I said, we have these two competing systems. Our financial planning and organisational planning systems do not align, and they do not align centrally. I was asked what Government can do, and aligning our planning and financial systems would be really helpful.

Both the local government system and the NHS are under huge fiscal pressure and we do not have the resources that we want to deliver the things that we are doing today. That is a huge pressure, which has led to command and control behaviours, particularly in the NHS, and moving us away from funding decisions that achieve our vision of the shift from hospital to community. Those are the sorts of things that can be tackled nationally to enable those things to happen.

I am not dodging the question, but there is huge variation. When I talk to directors of adult services, some will say they have amazing relationships in their system, and some will say that it is really difficult and tense. As I say, there is lots of variation.

The ICB is great in terms of ideology, but the practicalities get in the way. Things like having discussions about how we are meeting our duties under section 117 of the Mental Health Act where we have to jointly commission packages of care, and the interface between continuing healthcare and the Care Act ability to place somebody, are real tensions because we lack the resources to fund them. They are essential mechanisms to be able to support people well to have a good life in the community.

Ben Coleman: I see Stephanie wanted to come in on that.

Stephanie Elsy: To reinforce some of what Melanie was saying, it really does vary from system to system according to the discussions I have had with my peers across the country. I feel extremely fortunate that, generally, our relationships in my system are very good between our local authority colleagues and the NHS, and for that matter with the voluntary sector. On my board, I have the voluntary sector as well.

Q10 **Ben Coleman:** What is the voluntary sector and what is the community sector? I looked at your board and that position is vacant at the moment. Is that because it is challenging to fill?

Stephanie Elsy: Yes. The person who was the board member left, and because of the procurement, we have left it vacant while we work out what to do with that position.

Getting back to your earlier question, that goes back to the point I was making about the fundamental change in the way that we are now expected to work together, which is about collaboration and having the

duty to collaborate. That is something I frequently remind my board members of. It is tough—let us not pretend otherwise—it is really difficult and everyone is under enormous pressure, which inevitably creates tensions. But you have to have those difficult conversations, because we are all working for the same community.

Q11 **Ben Coleman:** To come back to my original question, where are the greatest tensions? Are they between different parts of the NHS that do not want to work together, or are not used to working together, or are they between an NHS that does not understand the local authority and vice versa?

Stephanie Elsy: For me, there are two separate things there. The lack of understanding, if you like, between the different sectors is probably present to some extent everywhere. This is a challenge that we all face. I say to people, "We've got to find out about each other's perspective and understand each other's perspective. It's your job as a board member to make the effort to do that as part of your role as a member of the ICB board." Interestingly, when I have seen people do that really well, it makes a massive difference to the way that those organisations work together for the benefit of patients, which is who they have to do it for.

Q12 **Ben Coleman:** That is very interesting and helpful. To follow up on that, you have appointed a private sector provider to bring together everybody and do something new in children's services. Is that because you could not get skills locally, or was it simply that bringing someone in from outside who was neutral was an easier way of dealing with things, given that you have three systems locally that you are bringing together?

Stephanie Elsy: That has nothing to do with it, I have to say. We ran a commissioning process—a procurement—so who ended up winning it was entirely determined by the process that we went through. That was not a factor. It would be illegal for us to do that, to be frank. That is just the way it has ended up. That company won the contract, and of course they have worked in our system for quite some time already, so they know the patch. Now that you mention it, I need to decide how we are going to fill that place on our board. Because they are a privately owned organisation, I will probably not make them a full member; I will make them a participant. But it is important that they are in the room, except when there is a clear conflict of interest, so they can contribute to our discussions about how to achieve this shift. I hope that makes sense.

Q13 **Ben Coleman:** Thank you very much. Saffron, do you want to talk about how we can improve the understanding between the different parties?

Saffron Cordery: The variation point is really important, and there is something about what we learn from where it works well. One of the fundamental elements is the longevity of relationships. Think about how ICBs and ICSs came about: they were created, and in some places they naturally fit a footprint where people had been working together for a very long time. In other places, they were new, so people were building whole hosts of new relationships. They were building that trust and really seeking to develop that. We need to remember that.

Everywhere is challenged, but some systems are facing additional challenges, perhaps because they are in rural areas with a sparse population, so it is very difficult to get people to go and work there, or they are in coastal communities, and those kinds of things make it even more challenging.

Q14 **Ben Coleman:** Thank you. That is very interesting. I shouldn't pick out your board, Stephanie, because there are how many ICBs in the country now?

Saffron Cordery: Forty-two.

Ben Coleman: And they all operate in their own sweet way. There are a couple of things that I would like to bring out. One is the role of councillors, and the other is the better care fund, because we talked about the funding. I will ask Melanie to pick that up and talk about the agony, from the local authority perspective, of having to deal with the NHS coming in late—very late—deciding on the better care fund and requiring changes at the last minute. That can feel simply disrespectful. Is that your experience, and do you think other people feel that?

Melanie Williams: The better care fund is quite a small part of the money that both partners spend, but it has an extraordinarily disproportionate emphasis because it often a point of tension. It has completely moved away from purpose. You are right that it is incredibly bureaucratic. The planning guidance comes out after the time that we should have agreed it, which therefore means that we cannot do meaningful engagement through health and wellbeing board partners to look at the plans, because you are doing retrospective authorisation every year. It feels very difficult, bureaucratic and almost futile. It has lots of levers and expectations.

Q15 **Ben Coleman:** Why do you think it comes out so late? All the local authorities are waiting for it—they are waiting and waiting and waiting, and so are local NHS partners—and it comes out so late. Is there something systemic at the centre that needs to change?

Melanie Williams: We need to review the way it operates and its purpose, and we need to be clear about that. Over time, we have changed bits of it. Parts of it were about protecting adult social care. Bits of it were to do with the Care Act, which we implemented 10 years ago, so those things have got lost through the channels of time. The key learning for me is that it does not work for both partners. If you asked local government and the NHS, they would both say that it does not work. There are examples of really great things that were due from it, but as a mechanism it is not fit for purpose. I cannot imagine why the planning guidance takes so long. It would be unrealistic for me to say, because I am not close enough to it to comment on what they need to do to shift that. I am just commenting on the impact it has on partnerships such as health and wellbeing boards.

Q16 **Ben Coleman:** Thank you. I am sure we can come back to what the challenges are with the other witnesses.

Stephanie—sorry to put you on the spot again—I want to come back to the new community care partnership that you have appointed. You went and commissioned the services, but how easy was it to get agreement among all the partners when you wanted to do that? You wanted to commission somebody to do that, rather than have somebody from within one of your local authorities to lead it. As a commissioning exercise, why was that essential? There may be very good reasons. How are you going to learn from it? Are they going to have to achieve clearly specified outcomes? I find that in all these things, the specification of outcomes, which one or two of you referred to, is often lacking.

Stephanie Elsy: Okay. We had to recommission the services because the contracts we had were going to run out at the end of March next year. There was a timing issue, so we had to recommission them. We base the commissioning process on the care model that we developed in consultation with system partners and with the public, and on our integrated care strategy, which the ICP agreed. Again, that was based on all the strategies from our three local authority places and the consultation that had come through that process.

We defined our three objectives for the ICP strategy, which are prevention and early intervention, tackling health inequalities, and providing excellent services. Within that, there would be this shift into the community. Everybody agreed that that was the right thing to do—it was absolutely unanimous across all system partners—so the commissioning framework was based on all that.

What is interesting and innovative about the contract that we have now awarded is that it is outcomes-based. We have nine transformational priorities within it. I have the grid here and I am very happy to share it with the Committee; it is really interesting and impressive. That was the process. We went through the usual process. We had to use all the public procurement rules and regulations, all the legalities and all the rest of it—

Q17 **Ben Coleman:** Brilliant; that sounds very impressive. When it is done, how will you evaluate and share the learning?

Stephanie Elsy: That is all built into the whole thing. As you can imagine, this is of great interest to us so we will monitor it—to death, actually. It is not just the ICB; it is the three local authorities, so it is jointly commissioned. We have a commissioning board and a governance structure that will monitor the contract and see how it is going. All that will be in the public domain. I am very happy to come back at a future date and tell you how it is going.

Q18 **Ben Coleman:** I have a final question, which is for you, Saffron, although it could be for anyone. I have noticed that on some integrated care boards you have a chair who is from a local authority background and a chief executive who is from the NHS. On other boards, both positions are from the NHS. Some integrated care boards have councillors on them—cabinet members; others have chief executives. When it comes to the NHS taking one position and councils taking another position, is there any

particular model that seems to work best, or that seems to work least well? Which model might be most helpful in terms of driving care from hospital into communities?

Saffron Cordery: It is a really interesting question, but I do not think we are actually seeing a difference in the nature of operation due to the different types of leadership. I would want to turn that on its head and say that we know that different individuals will bring different elements to the table. A council leader or a councillor chairing an integrated care board will bring something very different, but also really important knowledge to the table, versus someone who is an ex-chief executive of a trust—running the whole shebang will give them a different perspective. It is about the opportunity for those two things to meet.

But I do not think we are seeing huge differences; we are seeing different perspectives being brought to the table. I think it is undeniable that bringing that local elected representative voice to the table is critical, just as having the operational nous is critical. As with any organisation, it is about where you put all that and how you use it. The skill is in the leadership using the resources they have, and people will have different backgrounds. Indeed, councillors have different backgrounds and different things to bring to bear when they step to the table.

All those roles were competitive and interviewed for. I suppose it is particularly about thinking about local areas and local patches, what they need, and what individuals understand about them.

Ben Coleman: They were interviewed for? In local councils, they are not all interviewed for; the council just puts up the person it thinks is best for the board.

Saffron Cordery: But to lead—to be the chair or the leader of an integrated care board.

Ben Coleman: Oh, to be the chair. Thank you.

Q19 **Chair:** I have a related question about accountability, and I speak from my own local experience. With my trust, there is a frustration that there is very little local accountability in the ICB. For example, MPs raised the issue of the place-based person for Oxfordshire being removed. That seems to be quite unusual around the country. We wrote to them; we tried to meet with them. The local health and wellbeing board said that it was not the right thing to do, and yet ICB went on and did it anyway.

That is just one of many examples of MPs feeling that they try to get into those decisions but cannot. There is a general feeling of a lack of accountability. How do we introduce this into the system? It strikes me that there is a democratic deficit in the way that ICBs are currently set up. I would love your thoughts on whether doing that would be a help or a hindrance. I hope we all agree that accountability is a good thing, but if it is going to be there, how should it be there and how can it be meaningful? I will ask Saffron Cordery to start, but if anyone has any other thoughts, I would welcome them.

Saffron Cordery: That is another interesting question. Stephanie may well have views about her own relationship with local politicians, because as an ICB leader you have your own relationships on your local patch. Certainly from a provider trust perspective within the ICB, the core element that trusts are ultimately accountable for is the quality of care within their organisation and that they provide to their public. But they see themselves as very much embedded in and influencing the system. They will prize their own relationships with local MPs and councillors to ensure that people are aware of what is going on and what the challenges and needs are. But that does not necessarily need to be at odds with the broader structure that they sit within.

Q20 **Chair:** Who do you fear the most?

Saffron Cordery: Who do trusts fear the most?

Chair: Yes. If someone came along and said, "Right, I am going to come and have a look at you," which part of the system is it that you would fear?

Saffron Cordery: There is definitely accountability to the quality regulators, and NHS England offers—or demands—oversight. But it is worth remembering that trusts also feel deeply accountable to their local communities. A trust will fear bad publicity locally and the reaction that they get from their public. If you think about everything we go through in making changes to services, that is where the real rub comes. It is the trust's job to convince the public that they are doing the right thing, for a multiplicity of reasons. So there are a number of accountabilities.

Ben Coleman: Can I come in on that question?

Chair: Sorry, we need to move on to finances. We've got to get on.

Q21 **Gregory Stafford:** I will not ask a new question, but I will follow up on the point that has just been stated. My constituency of Farnham and Bordon is covered by three ICBs, and the variation of quality in the service delivery and—to the Chair's point—in communication and accountability between those three ICBs is extraordinarily large. There does not seem to be anyone who is able to hold ICBs to account on their overall performance and engagement.

I will move on to finances and follow up on the question from Deirdre. Saffron, I want to say thank you to your colleague, Layla McCay, who has been in contact with me since I spoke on the same panel as her on these issues at the Conservative party conference. It has been helpful, so please pass that on. I listened to your answer about how moving funding from the acute sector—the hospital sector—into the community setting is happening already and is all okay. That is certainly not my experience of it. How do you ensure that you move the money, funding and resources without detriment to the acute sector?

Saffron Cordery: I am not sure I said it was okay; I think I said it was happening. Those are two different things. You light upon a really important point, because we are talking about the transformation of how

we deliver services. There are a number of factors that come into that, whether it is pace, managing risk or the scale of investment. We have to look at those, because you can go fast, but that could be risky. You could invest more and double-run, which will give you the pace you need. If you do not invest more and double-run, you need to do this more slowly. That is some of the challenge that we are grappling with at the moment. The burning platform is there and we are all very aware of it. However, it is absolutely incumbent on those leading services at the centre, and those delivering services, that we do this in the safest way possible.

We know that issues with double-running are tricky. I do not want to, but we could go back into the history of why we are here. There are all sorts of issues, but I will highlight the fact that, probably 10 or 15 years ago, we made a decision to take out a number of beds from in-patient settings, with the intention that we would build up the community side. What we did not do was put that resource into the community side, because there was a resurgence in demand—for a whole host of demographic, population, public health and health inequalities reasons—which meant that demand also shot up. We see a gravitational pull towards acute, so I think that that is really important to remember.

Q22 **Gregory Stafford:** That leads on neatly to my next point, which is about political imperatives. Governments of all colours have obviously set targets. We see that getting operations done and reducing waiting lists is a priority for the Government, and that is obviously all at the acute end—or a significant part of it is at the acute end, if you are talking about waiting list operations. How does it help or hinder this ability or aim to move things into the community, when all the targets that the Government put in are essentially trying to funnel the money resource back into the acute sector?

Saffron Cordery: In my opening remarks, I said that we need to see what contributes to our ability to get that waiting list down. One of the things that really contributes to that is improved patient flow, as well as reducing the demand on acute services. That comes from shifting resources from an in-patient setting into a community setting. We need to look at that aim from end to end.

Q23 **Gregory Stafford:** I understand that and completely agree with you in terms of the policy position and how you would work that out, but the reality does not seem to be matching that. How do we break the cycle where we say we want to do this, but winter pressures then come up and waiting lists go up? While we say we want to do it, the money actually gets pulled to deal with the acute. How do we break that cycle?

Saffron Cordery: We need to look at the reality of where we are investing, and we need to take on board the raw fact that, over the last 10 years, we have pulled money out of some areas that would have stopped us being in the situation that we are in. For example, the public health grant is one area where we have seen a huge undermining of the level of investment in public health. Public health is our tool for preventing ill health, and it sits in local government. From the moment it was moved

into local government, that grant was pulled away and it was, I believe, almost halved straightaway. It had a whole chunk of money pulled out from it, and that was about 10 or 15 years ago. If we had seen a gradual increase in that funding, we would probably be in quite a different place now, with communities and individuals being much more resilient, both physically and mentally. We have to remember that we are dealing with some of the consequences.

To answer your question directly, we need the political imperative and the operational leadership to move us to a place that says, "Yes, we want to achieve this target, and we understand the steps that need to be taken to do that." That is end to end, looking at stopping people going into hospital and at how we discharge them quickly. It is also about looking at how we organise our services. Hospitals are doing great things with hot sites and cold sites, protecting surgical units, and using hubs in the community, so that they can get through stuff faster. But at the end of the day we have finite resource and finite workforce, and that is not elastic.

Gregory Stafford: Thank you. It is always nice to hear things about my former role in GIRFT.

Paulette Hamilton: Good morning. Can I start by declaring my interest? I know one of the panel members really well. I worked with Melanie for a number of years; she was my chief officer when I was a cabinet member in Birmingham.

Chair: Noted. Happy to facilitate the reunion.

Q24 **Paulette Hamilton:** My question is predominantly for Stephanie and Melanie. There have been multiple reviews calling for a move away from that single financial year settlement. I know, from when I was there, that this would have long-term impacts on the service. We have talked a lot about prevention, moving away from analogue to digital and all this stuff, but you need to have a more long-term financial plan. How do you feel we could make this happen? Can I start with Stephanie, because we are look predominantly at ICSs and at local government.

Stephanie Elsy: I can only repeat what I said earlier: it is about the financial settlement. If the spending review coming up can give us a clear indication of what multiple-year funding is going to look like, that really does help financial planning for the future. It helps us to say, "Okay, this is our envelope, and this is what we need to do within it. This is the challenge we have, and this how are we going to tackle it." Does that answer the question?

Q25 **Paulette Hamilton:** No, it does not, because as an ICS you have lots of targets, haven't you? You have your funding—you have the multiple in-year funding settlement—and you have your targets, but if you want to make a difference in the long term, what would strategically help you as an organisation to develop practices, develop new services and really move into that preventive space if you were able to have a longer-term financial window?

Stephanie Elsy: Are you talking about things like ringfencing?

Paulette Hamilton: I asked you the question. You tell me what you think.

Stephanie Elsy: My view is that we should not have ringfencing, because the way the funding is spent should be for local determination. Having said that, I do think it is important, certainly in the short term, to protect funding for things like mental health and community services. I do not know if this is a true statement, but one of my views is that part of the reason we have separate organisations for community services and mental health trusts is to protect the budget for those services. Otherwise, it will get sucked into hospitals—there is this gravitational pull, and funding just goes towards the acute sector. That is obviously contrary to what we are talking about today, and it is not in the interests of the patients of the future.

Possibly in the guidance we get, the Government could decide to say, "X percentage of you allocation should be used for mental health and community services. If you are not going to do that, you will need to explain why." I am reminded of the recent example where there was some ringfenced funding for health inequalities, and then the ringfence was removed. Of course, a lot of systems then just took it straight to the bottom line to help with their deficits, which is a tragedy. If we think things are important, then there needs to be a strong steer from national Government and NHS England. I would suggest that these things are actually important, and critical to the success of systems, so you need make sure that those funding streams are catered for.

Q26 **Paulette Hamilton:** Melanie, as you know, my biggest bugbear in local government was that we only had single-year financial settlements, so we struggled to plan ahead. Sometimes we made that plan not really knowing if we had the funds to carry it out. We were trying to develop services and bring them forward. I will ask you the same thing: how do you feel that we could make this happen?

Melanie Williams: We need a radical shift in our financial and managerial incentives. A really good example is that we set up integrated care systems and immediately there was a pressure on ICBs to reduce the leadership at place. That is what happened. Many ICBs reduced the inequalities fund and the leadership at place, moving us away from that shift of hospital to community. I assume that when we are talking about that shift, we are talking about a vision. We are investing in preventive, proactive, personalised care. That is a very different set of investment propositions to the ones we currently have. That would be the really important bit—to think about how we do that. We have mentioned some of those mechanisms, including the ringfencing and protecting. Whatever vehicle there is, there would have to be a bold political action to make that shift. If we are not going to do that, the shift will not happen, from my experience.

You have referenced the very good reasons why we struggle to align the planning cycle. The NHS and local government settlement cycles are different and do not align. The planning guidance does not align. We referenced the better care fund with that, and the planning guidance comes out late. Aligning that mechanism and having a multi-year settlement would help, even if it is not the whole of the financial settlement. Like I say, it is about having that programme budget, if you like, and knowing what this hospital to community shift that we want to see is and what we actually want it to achieve. If we just had that as a multi-year settlement, it would support that.

I think we need to be really imaginative in how we use the policy levers to rebalance the investment, and we are talking about non-acute services, aren't we? Let us be honest. I know that Saffron will have to take a more diplomatic perspective, but that is what we are describing. We are talking about primary care, social care, and voluntary and community services. We need to be able to have those levers following that investment shift.

The bit we really struggle with is moving funding that is allocated nationally to healthcare into other things that are not the NHS, whether that is public health, social care, community support or accommodation. It is seen as an NHS budget rather than a health budget. Starting to see that as a different, radical shift in the way we think about that resource would enable us to feel more comfortable about the money moving into other forms of support that are not necessarily NHS led. In proactive, personalised care there is a whole range of things we need to build around communities to make that a reality.

Q27 **Paulette Hamilton:** Just before I ask my last question, do you not feel at the moment that, going back to what Ben said, we are still very much the NHS and local government, and are not doing that systems approach that will effect that change?

Melanie Williams: It is very difficult to do the systems approach locally, with the national constraints. I think colleagues on the panel have rehearsed a number of those, not least the fiscal challenge and this grip, whether within local government or the NHS nationally, to try to control demand and spend. We are really up against it with that.

We have not talked about some of the other barriers, such as workforce strategy and the fact that we do not have one for adult social care. The data is really challenging. Data and information sharing is really challenging. Some of those things we could resolve nationally in workforce strategy and planning and data, and that would enable us to do these things more effectively at a local level. We really need to focus on how we can enable local leadership, because you cannot do national community care. That is one of the paradoxes.

Paulette Hamilton: I am going to get into trouble with the Chair, but I know you were desperate to get in, Saffron.

Saffron Cordery: It is really important when we are thinking about funding and funding allocation to think about what we are seeking to do. Funding community services of whatever type, including mental health services, is critical in and of itself to deliver the right kind of care. If we see the end of something like the mental health investment standard right now, we will see the marginalisation of people with severe and enduring mental illness. We will see more crises turning up at our A&E departments.

We will see more challenging situations that impact not just acute care and the individuals themselves who are suffering, but other bits of the public service, like the police, education and so on. We need to make sure that we are building on some really good progress that we have made to continue that and build that into the funding framework. Funding services in the community, mental health, social care and primary care are steps in and of themselves to shift the demand, but they are also important to provide the right kind of care that people need.

Paulette Hamilton: Thank you. Am I allowed to ask the last question?

Chair: Yes. You have 30 seconds.

Q28 **Paulette Hamilton:** I have one more question, so I will ask you each to answer with one point, Stephanie and Melanie—that is the only way I will get away with it. The question is, how could the Government or NHS England better incentivise ICBs to invest, to deliver and to prioritise services in the community? What is one thing that you think could help?

Stephanie Elsy: Include it in the planning guidance, and measure what we are doing on it.

Saffron Cordery: I agree.

Melanie Williams: Me, too.

Chair: I thank all three of you sincerely for being here. You gave us lots of food for thought. You are very welcome to stay for the second panel. Thank you again.

Examination of witnesses

Witnesses: Beccy Baird, Professor Kamila Hawthorne and Professor Nicola Ranger.

Chair: We now come to our second panel. Thank you so much for being here. We will look at workforce, structures and all sorts, building on the excellent first panel. I welcome all three of you to our session. May we start with very brief introductions?

Beccy Baird: I am Beccy Baird, senior fellow in health policy at the King's Fund.

Professor Ranger: I am Nicola Ranger, chief executive and general secretary at the Royal College of Nursing. I was previously a chief nurse for 10 years in acute trusts.

Professor Hawthorne: I am Kamila Hawthorne, chair of the Royal College of GPs, and a working GP.

Q29 **Chair:** Thank you. To start with something topical, we have had the announcement from Government of the 2.8% pay rise. I think it is fair to say, Nicola Ranger, you were sceptical about that this morning. First, you have said you want talks with the Government—I found that an interesting statement. Have there not been talks already? Are you not talking to the Government?

Professor Ranger: We absolutely are. That is why there was genuine disappointment. We can see, I think, that this Government are genuinely interested in the NHS, and we as a college absolutely believe in the priorities, particularly the shift from acute to community. But there is a golden thread here that has to make it absolutely essential: workforce.

The largest workforce for all of this, whether community or acute, is nursing. In England we still have 32,000 nursing vacancies. We are incredibly reliant on international nurses and, while we absolutely welcome our colleagues, we are destabilising the rest of the world with regard to their nurses. I am disappointed that there has still been no structural reform of nursing in this country. As a college, we feel that is an extreme disappointment.

It is no longer just about a percentage pay rise. Nursing in the UK has got so many challenges that that will absolutely not work. There has been a 21% decrease in people coming into nursing, and there are those leaving. I have listened this morning with real intent, but the underlying conversation that was not mentioned is exactly as you said: workforce. Without nursing, whatever the Government want to do, they will not be able to succeed.

We are disappointed that there is still no structural reform for nursing, and that will make it very difficult for this Government to achieve. That is what we want to talk about. It is no longer just about a percentage pay rise; it is what we are doing, particularly in England, to make sure that we both retain and recruit brilliant nurses in every single sector. That is what we are disappointed about.

Q30 **Chair:** This morning, you mentioned talks in the context of needing to avoid further disruption and ballots. I think there is an acceptance in this place that the disruption and ballots we have had over the last few years—understandable as some may feel they were—have also played their part in increased waiting lists and stresses on the system as a whole.

What is the better way to ensure that these conversations take place, without that further disruption? As a Committee, we are very mindful of the stresses on the profession at large. Isn't a ballot and disruption just

going to make it worse?

Professor Ranger: No one wants that. It is always a failure on both sides when it gets to that. But you cannot have 10 years of real underfunding—the least amount of funding for the NHS in its entire history—and then go into a pandemic and not wonder why we are in a very difficult position, which we are. The people who suffer most for that are the patients.

Of all the things that were talked about this morning—when you have extra patients on a ward with no oxygen, no suction, no call bell, no privacy, no dignity, and extra patients in a corridor in A&E, that is not a great place for professionals to work. That, in the end, is also making people feel, "Can I do it again?"

Although I absolutely understand the timetable of trying to ensure that there is a pay award in April, the real disappointment for many NHS staff is to hear this right before the winter, when they have already escalated all over the place in acute hospitals. I met a group of district nurses a few months ago who are seeing 26 patients a day on 15-minute intervals. That is not going to make people feel great about another winter.

No one wants it to be difficult but there is something about giving at least some kind of hope for the future. We need to recognise the real financial difficulties. If we do not invest in the workforce, all of us worry about the future. Patient satisfaction is the lowest in NHS history. More people than ever are seeking private care. It is on all of us to make it work. All we want is a plan. At the moment, certainly for nursing, we have had no structural nursing plan to see how it is going to get better in future.

Chair: Well, we have got Wes Streeting in front of us next week, and I am sure he has heard what you have had to say. We will come back to the GP point later, because I appreciate that not only nurses are facing this issue. Briefly, Greg Stafford has a question.

Q31 **Gregory Stafford:** We could have a discussion about this, because in real terms the NHS has had more money than it has ever had, but I am interested in the funding point. What you are talking about for nursing is Agenda for Change. Nurses are not the only ones on Agenda for Change; there are others, like the allied health professions and, let us be frank, all the managers in NHS England who are on Agenda for Change. Would you see a benefit in disaggregating or separating the pay streams or bands for what one might call the professionals—nurses, allied professionals and so on—and the management side?

Professor Ranger: The college recently put out a separate pay spine. There is something around nursing being generally weighted to the bottom of that Agenda for Change. For example, a band 5 nurse could have years of experience, yet never see their pay go up. Inevitably, to get more money in the NHS, if you are a nurse, you sometimes have to move that little bit further from the patient.

Whereas, I think what we put forward is a bit of a difference between promotion and pay progression. I spent several years in America, where

they absolutely incentivise pay progression for those closest to the patient. The experience for the patient is outstanding, because you get brilliant nursing care from someone with years of experience, but they can earn $100,000. The difference for patients is enormous.

Nursing is 62% of band 5. We are the only ones who will start as band 5 and retire as band 5—the only ones. You would not find a manager or any other allied health professional who would both start and end their career in band 5. That is something that has to be corrected. When shifting from hospital to community, we need an incentive that is different, and it is not just a percentage pay rise.

That is the disappointment: it is so fundamentally broken. England is the only place where you have to pay your tuition fees; in Northern Ireland, Scotland and Wales, you do not. That has not worked—treating nursing students as regular students—because of all the practice hours. That is the kind of thing I am disappointed about, because this is not just about a percentage pay rise.

I absolutely believe that this Government believe in the NHS, as do we as a college, but where is the structural change that will genuinely make things better for patients? At the moment, I cannot see it.

Q32 **Chair:** We are touching on themes that we are going to come back to. Before I turn to Andrew George for the next question, the King's Fund has done quite a lot of work in this space over the years on the lessons learned, so I want to ask Beccy Baird the same question that I asked the first panel. As we move forward with this 10-year plan, what are the key lessons learned for what we have to ensure happens so that the shift from acute to community actually gets followed through on? What insight can you give us?

Beccy Baird: We published some work last year looking at why we have not achieved this over the past 30 years, and it is complex—if it was easy to do, we would have done it. Just after Christmas, we are going to publish some new work looking at what national policy levers are available to Government to make this happen, so I am slightly pre-empting that work here.

One of the key things is focus and political leadership, because the system will do what the system is incentivised to do. If we say that we are going to move care closer to home but incentivise improved care in hospitals, we will focus on improved care in hospitals. Both those things are important, but I think that the Government might need to think about a review of the constitutional standards and how quickly they are likely to be achieved in this Parliament, because it will be very hard for the system to both achieve all the constitutional standards for waiting times and deliver care closer to home. Political prioritisation will be absolutely key. I think that that is probably the No. 1 for me, in short.

As workforce is key, again, we can incentivise the workforce to move into community. We reward people who work in hospitals because we pay

managers by the size of their budget, and clinicians want to work in acute hospital. We do not attract the best clinicians and managers into the community, partly because of the pay, as Nicola has talked about, and because we do not train people in primary and community settings. The NHS management training scheme does not have routine placements in general practice, for example.

There are lots of things that we could do to really incentivise people, but the key thing for me would be keeping that focus on primary and community services, because the minute that we prioritise hospitals, that is what we will do and we will continue to see what we have seen for the last 30 years.

Chair: That is incredibly helpful; thank you very much.

Q33 **Andrew George:** Thank you for your earlier remarks. Nicola, for the benefit of the Committee, what is the pay at the lower and higher ends of band 5?

Professor Ranger: That will start at about £28,000.

Andrew George: That is £28,000 for a fully trained, degree-level clinician?

Professor Ranger: Yes.

Q34 **Andrew George:** I suppose this question might apply to Kamila as well. On the issue of the longer-term workforce planning and trying to achieve larger numbers within the service to fill the 32,000 vacancies and so on, there has been a move—one might say a clever move—towards finding other ways of recruiting nurses, such as using nursing associates and apprentices. Is that a clever move, or is it dumbing down standards? Is it a way of filling the gap?

Professor Ranger: With nursing associates, much as with physician assistants with GPs, there is something about substitution—there is a concern there—but I think apprenticeships can be a pathway. We have genuinely no difficulty with the route in, as long as, at the end of it, it remains a degree-educated profession. What is not always understood is that although the apprenticeship route is a great route, there is still a cost to the organisation because it does not fund the entirety of their backfill. That still costs most trusts £18,000 per nurse.

The NHS workforce plan talked about a large-scale incentive, but until that is funded, that still is a cost to the organisation. That is part of the difficulty. If the apprenticeship levy, particularly for the NHS or nursing, could fund the backfill cost, what a difference that would make. If an exception were made for nursing, that would be the kind of thing that would make a difference. Currently, you have the same as every other apprentice, but there is talk about taking it away at level 7, which would be a disaster for nursing, so I urge this Committee—

Andrew George: What is level 7? Please explain.

Professor Ranger: That would be for a nurse—it is a slightly more degree-educated apprentice route. There is a question about whether that funding is going to move slightly more to the diploma and other things that are not a degree. If that is changed, that will also make it harder for nursing.

Q35 **Andrew George:** There is presumably an opportunity for you to have a big say in next year's review of the Long Term Workforce Plan, to put a lot more emphasis on retention and recruitment, and to address those issues. Maybe we can start with Kamila.

Professor Hawthorne: I have a lot to say about that.

Andrew George: Maybe you would like to use the opportunity of the review of the Long Term Workforce Plan as your route into the subject.

Professor Hawthorne: We were delighted to hear Wes Streeting talk about a review only a few days ago. A few weeks ago, we sent in a letter that had been signed by nearly 10,000 of our members, urging a review of the Long Term Workforce Plan. The National Audit Office, having looked at the modelling, could see that the number of GPs was projected to rise by the mid-2030s by 4%, whereas the number for hospital consultants, as you probably know, was 49%. That was despite the fact that the number of GP trainees was going to increase by 50%.

When you look at it, you think, "Well, two and two are not making four." It took us a while to get to speak to the authors of the Long Term Workforce Plan, which we did a few months ago, and it became very clear that within their modelling, they had not included retention. We said, "This is crazy because you've got a sink with a tap that's full on, but no plug in the sink." People are leaving the profession faster than they are entering it. We are still about 100 full-time equivalent GPs short of where we were in 2019, while we have an ageing population with more chronic illness and bigger numbers. When I first qualified as a GP back in 1988, the average was about 1,800 patients per full-time equivalent GP; now, it is 2,300 patients and they are sicker than they were back then.

We are pleased that there is going to be a review. We need to get in there. We are urging for a national retention scheme with local flexibilities. We are seeing GPs leaving at all stages of their career progression. New ones are emigrating, mid-career ones are leaving early and late-career ones are leaving as soon as they can. The reason behind all that is workload, burnout and stress. That is really the bottom line, although there are, of course, different personal factors for everybody. Different retention schemes are needed at each stage. We really want to try to retain some of our older, more experienced GPs so that they can mentor the younger ones—bring them in and show them the joy of general practice, because it is a fantastic career when you get a chance to do it properly.

Q36 **Andrew George:** Retention is clearly a very important issue. Finance to enable retention will be a big constraint. Are there actions that the Government or the system can take to address retention matters without

that becoming a large financial burden on the Government?

Professor Hawthorne: Money for retention schemes was available. It was announced at the beginning of the year that it would be withdrawn by the end of March, which really upset us. These are new-to-practice fellowships to encourage young, newly qualified GPs to get settled into a practice, get their feet under the table, understand what continuity of care really means, and develop their own professional interests. The money for those schemes was devolved to ICBs; as we have heard, it was not ringfenced and it has disappeared into a black hole somewhere else, so it is very patchy. There are some places where it is happening, but many where it is not. The same has happened to mentoring schemes.

We need to be thinking about emeritus GP schemes, so that we can encourage some of our older GPs to stay on. We need more flexibility in how people work, because that is what the workforce is now asking for. They are not willing to work in the way that I was working 36 years ago.

Q37 **Andrew George:** To deliver the shift from acute to community—a mantra we have been hearing for decades—the assumption is that social care needs beefing up to tackle delayed discharges from hospital, but as far as I can see, in a large proportion of such cases, the majority in Cornwall, there is a need for ongoing medical oversight. I believe the RCN has put out figures showing a 45% reduction in the number of district nurses in the last 10 years. How can the community sector build its medical capacity with that level of failure to retain staff?

Professor Ranger: You are absolutely right. The number of school nurses has declined by 31% since 2009, learning disability nurses by 44.9%, and health visitors, who are key, by 31%. That is why I think the Long Term Workforce Plan needs to look closely at what the issues are. There is something really important practically about incentivising or finding a way to make that shift from hospital to community. It might sound very operational, and I hope it is not too low level, but this is something that the public find it really tough to understand.

If someone has come into an acute hospital setting—say your husband or wife has just had a massive stroke—you are thinking that is a healthcare need and it is the right of the patient or their family to have that need assessed, but that can take up to 28 days while they are still in that hospital setting. One thing I would ask ICBs to do is look at the data on how long it takes to get the continuing healthcare need assessment done.

We nurses often know that the patient is not going to meet that threshold, and this is now means-tested; they look to see whether the family has over £23,250 in either assets or savings. It is a very practical thing, but the impact on families is massive. They do not understand the system and think, "How, when it's a health need, can that possibly be means-tested?" All of that goes on in the acute sector, and in many cases, up to a third of patients in the acute sector could be cared for in another setting.

Things like discharge to assess all require funding shifts, because we will never do what we need to do with the constitutional targets that are right

for patients unless there is genuine public understanding and changes are made to the way the assessments are done and to the funding. I recently went to a ward in the south of England where I met a patient who had been in hospital for four months. When I asked the ward, I was told that 26 out of the 28 patients on the elderly care ward had been there for over four months, primarily because of funding issues. This is a real and practical problem and it needs to be sorted.

Chair: Perhaps this is a good moment to plug our "Adult Social Care Reform: The Cost of Inaction" inquiry. For those watching, let me say that we are keen to hear from everyone, but today is the last day they can submit evidence. Thank you very much for raising that. We are keen to look at the impact on families and carers as well as the financial and economic side.

Q38 **Josh Fenton-Glynn:** Professor Hawthorne, what support do GPs need to do more work in the community?

Professor Hawthorne: We need more GPs, essentially. We do not have enough. If you are on call, for example, you may have between 50 and 70 patient consultations in a day, and it is really not safe. Quite a considerable number of GPs in our surveys are telling us that they feel it is unsafe, and that they are having real symptoms of stress and burnout as a result. That is the first thing.

The second thing is infrastructure. We will need better premises than we currently have. We know that that will cost money, and I know that the whole conversation is about how we keep within the same envelope, but there is going to be a need for that, particularly if we are training more. More and more people need to be trained in generalism, and the best place to do that is in general practice. That is not just medical students and GP trainees; it is nursing students, physician associates and clinical pharmacists—the whole raft of the team need to come out into general practice and we do not have the room to train them properly, nor do we have the trainers. Those are the two big things.

As GPs, we are absolutely up for the three shifts that Wes Streeting is talking about. People have been talking about services coming from hospital into the community for decades. Of course, a lot of chronic care now—with the old QOF system that started about 20 years ago—has come out into the community, but resource has not really been following the patient, and I think it will have to follow the patient for this to be done properly.

We are also going to need some sort of shared data for patient care—otherwise, I do not know what my pharmacist in the local pharmacy down the road has said to somebody, and they do not know what I have said to them other than what the patient is saying to them. The same goes for the local optician and the local dentist. As well as being able to see whether somebody has been to out-of-hours on a Saturday night, I need to know straightaway what is in their medical record and how it has been dealt with. That is another thing—and yes, I could carry on.

There are quite a lot of things that we need, aren't there? I think those are the three main things: infrastructure, more GPs, and of course more members of the primary healthcare team. I completely agree with Nicola. If we really want to do prevention well, we need to have the headspace to be able to do it, and then the ability to share patient records.

Q39 **Josh Fenton-Glynn:** To follow up on that, the state of medical education and practice report that the GMC does every year came out at the end of last month. One of the most alarming things in it is the rise in the number of doctors who are ending up in SAS and LE roles, which are primarily hospital roles. I think that has gone up from 23% to 26% of the workforce—about a quarter of the workforce. What can we do to get those doctors on GP training pathways? I am not sure if that question is for Professor Hawthorne or for Beccy.

Professor Hawthorne: It is a difficult one, because within the society of resident doctors, as they are called now, some of this seems to be what they are expecting to do. They finish their foundation posts and some people want to look around for a bit. Some people go down to the Antipodes; nearly all of them come back, thank goodness. That seems to happen as people are trying to work out where they want to work and what specialty they want to work in. On top of that, there are some real bottlenecks in postgraduate training, meaning that some people cannot get on to the training schemes that they want to get on, so they hang around doing bits and pieces until that happens.

Q40 **Josh Fenton-Glynn:** Can I just interrupt? Does that mean that they that cannot get on to the training scheme in the area they want to or for the specialty that they want to?

Professor Hawthorne: It is both and it depends on the specialty. Some specialties are much more difficult to get into than others—so it is a bit of both. For general practice, there is a bit of a bottleneck as well—not as bad as in other specialties—but we are also finding that we have large numbers of international medical graduates coming in too. We are very grateful for them, and they do a fantastic job, but we need to treat them and value them well. Sometimes that is not as good as it could be.

Q41 **Josh Fenton-Glynn:** Absolutely not. The other thing that came out of the report was the huge levels of dissatisfaction among GPs. I think it said that 53% of GPs were dissatisfied with their work. Obviously, that is not sustainable. I think when we had Andrew Dilnot here a couple of weeks ago, he said we have to train two GPs to get one person in practice—sorry, I meant Lord Darzi, not Dilnot.

Chair: That was another time.

Josh Fenton-Glynn: Yes. I was thinking of reports. You have hinted at a lot of these things to make GP services better, but more generally, what would be the top three things we could do to improve the satisfaction that GPs feel?

Professor Hawthorne: The real problem underlying it all is stress and burnout. I am sorry to be repetitive, but we need more GPs. Every practice needs more GPs, including my own, and some practices have real difficulty recruiting them—not just because there are not GPs to fill those shoes, but because they do not have the core funding to pay for them. That has been a real problem, because over the last 10 to 15 years the proportion of the NHS budget coming out to primary care has gradually gone down and down, while the workload has gone up and up. There is a real issue with being able to pay for GPs to come in to practices to work, and there is also much less locum work than there used to be.

Q42 **Jen Craft:** Beccy, you aptly said at the start that the system does what it is incentivised to do. How do we incentivise NHS providers to effect that shift from hospital to community care?

Beccy Baird: There are a few things. One is that this is not just about shifting care from one place to another; it is about shifting the focus of care. Sometimes it is appropriate to shift things from one place to another but, as Nicola and Kamila have both alluded to, this is more about shifting the focus. The proportion of the money spent on primary care has gone down, yet activity has gone up. That cannot be right. Part of the incentive is to rebalance where we are putting new growth, in particular, and where we are investing any new money.

I am very wary of micro-financial incentives. As a nation, we rely on them hugely compared with other countries, particularly in general practice, with QOF and IAF and all kinds of three-letter acronyms for funding. The danger of all those small, disconnected pots of money is that they stop practices and communities being able to really address the needs of their patients.

We saw that with the additional roles in general practice—a fantastic scheme that has put loads of extra workers into general practice. That is a wonderful thing, but if we do not also fund core general practice, you end up with a really unbalanced team: "These people come for free through the additional roles in general practice scheme, so we'll have more of them, but we won't have the GPs because we don't have the money to pay for the GPs." I would rather see a much more devolved system that trusts general practitioners to use the money that is given to them on a capitated basis, and where they are held accountable, as other local commissioners are.

That brings me on to another thing: if we are going to incentivise the system, we need people within the system to keep an eye on it, to do the commissioning and to really think about how we invest in primary and community services. At the moment, integrated care boards in most places in the country do not have very good infrastructure at all for holding primary and community services to account or for doing the strategic planning that is necessary. Their entire focus is on hospitals and emergency care, because that is what they are judged on.

Professor Hawthorne: I have two things to add—thank you, Beccy. First, we need to have a louder primary care voice at the top of the ICBs. It is just not enough. There may be somebody from primary care, but it may not be a GP, and we need a stronger voice so that ICBs understand what is happening in primary care. I think quite a lot of the time they do not.

My second suggestion, which is a recommendation I would like you to make, is to introduce a general practice investment standard, similar to the mental health investment standard, so that ICBs have to report on an annual basis the percentage of budget that is coming out into general practice. That should also be increased funding year on year over the next few years, to get us back to where we were some years ago.

Professor Ranger: I would like to see an incentive to genuinely get this right, so that services offered in the community are 24 hours a day, seven days a week. We can no longer have a model that is 9 to 5. Otherwise, the acute sector will continuously be the catch-all, because it is the only thing open 24 hours a day, seven days a week. When you commission community care, make it 24/7. You need the workforce that can do that.

Q43 **Jen Craft:** Moving away from micro-budgeting or ringfencing, how do you get the financial incentive in place that achieves your aims? For example, on the GP investment standard, do you have a budget that goes directly to GPs, which it is up to them to spend, or is a ringfenced budget given to an ICB, which is told, "You must spend it on this"? Are there mechanisms? Where is the perfect balance between saying, "This is where you must spend money," and saying, "Over to you"?

Beccy Baird: Every OECD country and EU country is looking at exactly the same issue. What are the right payment mechanisms? How do you incentivise this kind of shift? There is a combination of things. We collect a lot of data in the health and care system. I think we did an analysis of community services a few years ago where we found that there were more targets than staff in most community settings—something like 4,000 key performance indicators—yet what are we doing with that money?

I think somebody said this in the earlier session, but you cannot nationally prescribe community services. It just cannot work like that. Every community is different—from Wigan to Fleetwood, to Frimley. We see it all over the place. Giving a budget to a place and an ICB, commissioning services for that community, makes sense. It is about having good outcome metrics that hold them to account for what they are delivering with the money, but allowing them to decide how they use that money to deliver the care.

The interesting thing about the mental health investment standard, a community investment standard, and a primary care investment standard is the overarching proportion. Can we say, "You need to maintain or increase the proportion of money that is going into those services compared with the proportion going into acute, because we know that the balance is wrong at the moment," rather than saying, "You must use this

money to fund X, Y, or Z—very prescribed, specified services"? I think trust in the system has disappeared a little. There is a definite sense of, "We will not fund general practice too much because what if they don't spend it right? What if they don't do what we want them to do? What if they do the wrong things?"

Actually, people in the health and care system want to do right by their patients. The people who know the patient community's needs are largely the people closest to them on the ground, so giving them the flexibility to deliver what is necessary but holding the ICBs to account, and having people within them to hold to account, is absolutely critical.

Q44 **Chair:** Who is that? What does that look like?

Beccy Baird: It is commissioning staff, essentially. Without wishing to dredge up history, in 2012 we lost a lot of capacity for primary care commissioning particularly, because CCGs were not allowed to commission primary care because of a perceived conflict of interest. It went up to NHS regional teams. A lot of the staff left, and in many places that capacity and expertise in primary care has not been replaced. ICBs have seen 25% headcount cuts, so they focus on what they are judged on. They have people who are expert in waiting times targets and the performance management of acute hospitals, because that is where the focus is. There are exceptions, and there are places that do this really well, but it is essentially good strategic commissioners who really understand how to do good community engagement, and how to commission services.

Q45 **Chair:** That is the strategic commissioning bit. What about the accountability bit?

Beccy Baird: Again, it is held the same way.

Professor Hawthorne: May I come in with an example that I think might be helpful? Leicester, Leicestershire and Rutland ICB has been distributing its health inequalities pot, which is not very large, to general practices in the ICB's most deprived areas. This has been happening over the last two or three years, and it has allowed those general practices to use that money the way they see best. What is happening is that access is improving in those practices, so it does produce improvements but there has to be an element of trust and leeway, so that people can be flexible in what they do and how they do it.

Q46 **Jen Craft:** I guess it is about removing some of the strangleholds on services. How do you stop ICBs being tempted to the acute sector, when it is very pressing and very noticeable?

Professor Hawthorne: By having some strong primary care voices up at the top, from the top table.

Beccy Baird: That is definitely important. If you think about an ICB board, there will be a chief exec from every hospital trust in the patch, but there won't be a GP from every practice, because that is not how it works. So how do we think about representation? Equally, I think it is about the messaging that comes from national politicians, national policymakers,

NHS England and the Department of Health, because what they signal is important—it is what the ICBs will focus on. If they signal that primary community services are important, that is what they will focus on, but they cannot also signal that waiting times are as important. You cannot prioritise everything: at some point, some hierarchy or some conversation with the public about trade-offs will be really key.

Q47 **Joe Robertson:** Professor Hawthorne, how does the GP contract need to change to better support a shift from hospitals into the community?

Professor Hawthorne: That is really a question for the BMA rather than for us in RCGP, where we are upholding professional standards. However, it is quite clear that funding for general practice has been undershot for some time now, so my call would be for the Government and the BMA to get together and sort out the new core contract going forwards. Within that, we need to create an ability to make an account for deprivation, because in deprived areas we are seeing that practices are working with more patients with more serious chronic illness but are able to earn less according to the targets that they are being set. That is a real problem that needs to be sorted.

Joe Robertson: It sounds like it is more a funding thing than a change in the way we contract and commission.

Professor Hawthorne: We are obviously thinking a lot about the QOF system, which I think has now run its course. We need different incentives now, perhaps including some sort of quality improvement type incentive on continuity of care. We know that good continuity of care keeps people out of hospital, reduces morbidity and mortality, and improves compliance with management plans, as well as patient and professional satisfaction, so what's not to gain? So we need to be looking at the old QOF system, and reducing bureaucracy and red tape as we go along, and at giving people the head space, because we are going to need a lot of head space if we really want to be thinking about preventive services and how we develop prevention.

Chair: Beccy Baird, do you want to jump in on this point?

Beccy Baird: I will make a couple of extra points, if I may. There is lots of opportunity for reform in the general practice contract, but it will also be very important to think about harmonising across the different primary care contracts, particularly the community pharmacy contract. At the moment, there are lots of competing financial incentives for pharmacists and general practitioners, who are chasing the same money. That makes no sense at all, so some work to harmonise those two contracts feels important.

I absolutely agree that deprivation is not well reflected in the formula, but estate reimbursement is one thing I would very much urge the Committee to think about, if you get time to think about the primary care estate. It is not just about extra funding for primary care estates, which may well be needed; there are also some arcane rules around estates reimbursement

and the way we are allowed to flexibly use general practice, which I will not go into because it could take a long time.

Professor Hawthorne: It is entirely labyrinthine.

Chair: Noted. We will go and do some homework.

Professor Ranger: It is also important to look at the investment that the GP can put into workforce in their practice, such as senior nurses who can do some of the patient interaction, freeing up the GP. It is extremely difficult for many GP practices now to invest in that senior nursing support.

Beccy Baird: Again, that is partly because of all the small, interlinked pockets of money—or unlinked pockets of money. They are chasing different pots of money for different things, rather than having an overall budget.

Professor Ranger: And the nurses in a GP practice get paid less than in the NHS, so it is difficult to incentivise nurses to come and work with GPs. All these small things add up to a difficulty for GPs.

Professor Hawthorne: If you think about messages that go out to the health profession, the recent Budget message was that £1.5 billion will be invested in hospital infrastructure and £100 million in 200 GP practices, but that is only 3% of the 6,000 or so GP practices we have in England. That message does not land easily, because it implies that, again, it is the acute care sector that is getting the lion's share.

Chair: Paulette Hamilton has a quick supplementary question, and then I will come back to Joe Robertson.

Q48 **Paulette Hamilton:** My question goes back to the point you made earlier, Nicola, about the RCN and the problems within the nursing profession. I have been a nurse for many years. I was a district nurse and I consciously chose to leave the profession because I could not do it any more—it is as simple as that. I was quite upset when the nurses gave up when they did last year, because—I should not say this—I backed them all the way.

This year, you have rephrased it—I know you were not in charge of the negotiations or anything last year—and said that we need to look more at the workforce and changing the way things are done. Why do the nurses need to go on strike to do that? I understand about the finances, but are you striking because the finances are not enough and the nurses are saying, "We want more money," or are they talking about striking because they do not feel the Government are listening on how nursing is run at the moment and how it wants to be developed in the future? I was not clear on that, to be honest.

Professor Ranger: To be really clear, we have not said we are taking strike action, neither have we had a ballot. What we are trying to say is exactly what you said. I have met the Secretary of State several times,

and I genuinely believe there is listening. There is an understanding that nursing needs to change. The difficulty we had is that we know that, with the 5.5%, we were the only professional body and trade union where our members—48% of them—said, "This still isn't right for nursing; we are rejecting it." All we are trying to say is: "Avoid that." No one wants strike action—not us, not the patients. We are saying that in all this shift from hospital to community—you made a point about district nursing—whether it is acute care or mental health, without nursing, nothing will work.

At the moment, one in five nurses in the UK—30% of the UK register—have been internationally educated. It is fantastic that they are here, but what is the long-term support for an amazing profession? You know yourself that nursing is an amazing job, but you said you got to the stage where you could no longer do it. People still love nursing; the problem is the environment in which they are being forced to practise. We want to support this Government, but we need something tangible so that we can go back to our over half a million members and say, "Nursing is valued," particularly in England. We are not saying that at this moment in time. We are talking, but we need something more than talking. We need action and, particularly in December, when everybody knows winter is going to be difficult, we need some hope—and we need it quite urgently.

Paulette Hamilton: Thank you.

Q49 **Joe Robertson:** Going back to incentivisation, I am concerned, in terms of public understanding, that "healthcare" and "NHS" are used interchangeably. You mentioned nursing, where of course it depends on the setting—where you are and who employs you. There is an issue with successive Governments sticking with some very simple messaging around money for the NHS. That is always an attractive way of presenting and budgeting, but it leaves GPs, pharmacists, dentists and so on in what might be called the funding slow lane, or left out. The national insurance contributions announcement is an example of that, in my view.

How do we tackle that? Professor Ranger, you have made some comments about the new Government really wanting to improve the NHS. How do we get over this problem of Governments wanting to improve healthcare across the board but continuing to return to acute hospitals, probably because it is politically easier? How do we get over that?

Professor Ranger: You are absolutely right. That is why there has to be some shift to incentivise. Why not say, "If you become a nurse in the social care or community sectors, your university fees will be paid if you work for us for three years"? There is something tangible around incentivising, whatever sector you are in. I talked earlier about being weighted to the bottom. We want to do for all nurses in every sector what we do with paramedics and midwives. They are band 5 for a year or 18 months and then move to band 6. All of that would incentivise all sorts of sectors, and we would at least be able to get that stability, because turnover and retention are a huge part of the problem.

I would think about some proper incentives, particularly in social and community care, and particularly around 24-hour care. For a patient or someone in a social care setting, things do not stop going wrong at 5 o'clock. What is the incentive to genuinely get 24-hour, seven-day-a-week care? I was recently in Belfast, which has an amazing district nursing service, 24 hours a day, seven days a week. The difference that makes is huge. Wherever the need is, we should ask, "What is that little bit of incentive to do things differently?"

Professor Hawthorne: It is also about leadership. It has to come from the top and permeate all the way down. We need to ensure that we are training our youngsters in leadership as well. That needs to come through, because they are going to be the generation that will be looking after us, sooner or later, and we want them to do it well. It is about the messages that come from the top. If the ICBs are told that they have to have a strong primary care voice at their top table, then they will do it; otherwise, they will not.

Professor Ranger: Also, particularly in social care, so many of the workforce are unregistered. When you are competing with other sectors that pay way above minimum wage, and with all the stress and accountability of the job—as well as how amazing it is to work with people, which is always fulfilling—people will say, "Do you know what? I just don't want the stress," especially when they are not paid for their petrol or their travel time. I think people still love the job; it is about the environment in which they are working. If we sorted out some simple things, like parking, travel time or petrol money, they might sound small, but they are big things for the workforce.

Joe Robertson: Thank you very much. Hopefully decision makers are listening.

Q50 **Danny Beales:** I was going to ask about the investment standard, but it sounds overwhelmingly like you are in favour of an investment standard for primary care, general practice or a combination, so I will take a different tack.

Beccy, you mentioned the frustration with QOF. There seems to be endless discussion about the adequacy of QOF, while we continually add new measures to it to try to deal with issues of variability in care, and patient expectation about the consistency of what they are offered from practice to practice. I have worked for patient organisations previously and it seems that each one is desperate for a new QOF measure to address some of their concerns. How can we strike the right balance between moving away from prescription and those elements, while still dealing with what we hear from patients and carers about the variability they experience from primary care across the country?

Beccy Baird: Variability is a really interesting one. We need variability. It is really important that services in Fleetwood, north of Blackpool, look different from services in St Albans, where I live, because the communities are different and the needs are different.

Q51 **Danny Beales:** Sorry to challenge you on that, but if you are living with diabetes or a heart condition, would your local circumstances mean that you should not have a care plan or preventive education?

Beccy Baird: Absolutely not, but what that care plan looks like and how your care is managed might be different depending on what resources are available to you in your community. What I think is more interesting is thinking about what local people think they want, and how they hold their local services to account. If you ask local people what they want their service to look like, as plenty of places have done, they will be clear about what they want. Wigan is a great example of where they did an interesting change, as are Frimley and Fleetwood. I use Fleetwood as an example a lot because it is one that I know well. The danger with national prescription and QOF is that Blackpool has a population with huge mental health, drug and alcohol issues, yet that is not prioritised through QOF. Yes, they have diabetes and heart disease, but that is not where they want to put their prime focus. They need to put their prime focus on to drug, alcohol and substance misuse and child and adolescent mental health problems—that is where they want to put their energy.

There is something about setting basic standards, which is where regulation comes in. We know what the basics are, but what the service looks like and how it delivers care for those populations needs to vary. The quality does not need to vary, and that is different.

I would argue that although QOF is supposed to be a quality and outcomes framework, it does not really measure quality or outcomes; it measures process. Yes, let us have some basic quality standards and collect patient outcome data, because the outcomes need to be the same wherever you are, but the way you might achieve those outcomes could well be different and that is a good thing.

It is very hard to have an organisation that is not an organisation. The NHS cannot be run like an organisation. It is a very, very complex system, and in many parts of it, it is provided by independent practitioners, voluntary services and private sector companies—the provision is all over the place. It is a great thing to have a real plethora of providers, but you cannot run it like a single organisation. That is when I think things go wrong. We need to allow communities to determine and hold to account their local services.

Professor Hawthorne: If we are really looking at patient outcomes, which I think everybody around this table is interested in, we have national organisations that already produce standards—NICE guidelines—which need to be far more about the holistic patient. We also have the CQC and other bodies that can check that patient outcomes are being achieved while allowing different regions to concentrate on what their locality really needs.

Q52 **Danny Beales:** One of the challenges to that point is that NICE care guidelines are not implemented. You speak to anyone—fundamental, basic care standards are not implemented, time and again. There is huge

variability in care. I am sure that there are good reasons for that and challenges.

Professor Hawthorne: It is very difficult in a 10-minute consultation, but having said that, certainly GPs are looking at NICE guidelines all the time and all of our updating CPD is based around NICE guidelines. It really depends to what degree you are expecting guidelines to be implemented down to the last full stop. A CQC-type inspection, if it was properly organised and properly implemented, could check that patient outcomes were being beneficially affected.

Q53 **Danny Beales:** I suppose that would only be if the data is captured on whether the NICE processes are implemented. That is the point: if we are not measuring or collecting that data, you would not know, necessarily, that one practice in an area offers a very low level of its patients a foot check, for example, which is a NICE care standard.

Professor Hawthorne: Each practice gets its own individual CQC inspection—so you can inspect each practice. At the moment, CQC has been pronounced not fit for purpose, and it does need a huge reorganisation, which I hope we will get an opportunity to be involved with. But you could be looking at patient outcomes within each individual practice.

Beccy Baird: The other really effective thing that we have seen is peer review. The clinical effectiveness units in south London and west London, for example, publish all that data between practices and they hold each other to account. That is a far more powerful way of looking at things; you can see that you are an outlier on flu vaccination or on diabetes care, for example. Most clinicians, if I may say this, are very competitive and they do not like to be the outlier, so publishing that data has seen real success. Holding each other to account locally, rather than relying on punitive inspections, seems to be very effective.

Professor Ranger: That is when the CQC works. Under Professor Mike Richards' leadership, the CQC inspections were peer review. They were clinicians who did your day job, who then came and inspected your GP practice, your hospital or wherever. Now that has stopped and you are not peer reviewed; you are primarily reviewed by CQC employees, who always look through a slightly different lens. Peer review is how cancer standards got up when the Labour party was last in power. That is how all the reforms with CQC were done in the beginning. That process has gone down and down and down, and I think it is no longer fit for purpose, because that peer review element has disappeared.

Q54 **Danny Beales:** That is really helpful. My final question is about the role of patient and peer review in accountability and dealing with variability at primary care level. How could patient voice and patient experience be used? Patient participation groups seem in some places to be a genuine engagement tool, but many are not particularly effective, from what I have seen. Would this be a place for peer review? Do you have other thoughts about that?

Professor Hawthorne: Every GP, as part of their appraisal system, has to undergo a degree of patient review as well as peer review. Of course, I think we should be encouraging our PPGs to do more with practices, in co-production with patients. Some of this is about the public understanding how to use the NHS, as well as being involved in developing and designing services that suit them and work for them. That is where that flexibility has to come in, with the difference between Fleetwood and Farnham, for example. It is a huge potential that we are not using well enough yet.

Beccy Baird: We did some work with the Grenfell health system not long ago, where we talked to them about their experience of health and care after the terrible tragedy. What we found is that doing community engagement is not a token exercise. Too often across our health system, we see community engagement as, "Well, we've sent a leaflet out to our patients, so we've done it." Actually, really listening to communities takes skill. It takes working with communities, real investment and head space—all things that are quite hard to find. There are amazing examples of how to do this well, but it is not easy and it takes time and effort.

Chair: Jen Craft has the final question.

Q55 **Jen Craft:** I am not sure we have lots of time—we might be out of time entirely. My question was generally going to touch on the primary care estate and the Government's ambition to have a neighbourhood health hub in every ICB area, but I feel like we have opened the door to something massive. What needs to happen to the primary care estate, basically, to deliver that?

Beccy Baird: Part of this is about investment. The cost of one new hospital is probably £1 billion. That would go a long way in primary and community services. There is more to do to think about how we can make it easier for local authorities and other public settings to combine and use their estates together, because there are so many competing incentives that stop them working collaboratively around estate. The Institute for Government published a very helpful document on primary care estate, which I commend, to look at some of these issues. Some of it is more technical than it is about finance.

Professor Hawthorne: This is a back-of-an-envelope calculation, but we have calculated that it would cost approximately £2 billion to bring primary care estate in England up to scratch from the surveys that we have done on our members. I think it will be vital if we want to deliver the new Government's vision.

I see a neighbourhood health service as having general practice at its core, with a primary healthcare team and a multidisciplinary team around it, together with the additional services that we now get from pharmacy, optometry and dentistry. Around that, there will be housing, social services, social care, citizens advice, benefits and so on helping people get back into work when they are ready. But that could be done virtually; you do not need an actual hub.

I see the hub bit as a diagnostic place where services can come out from hospital to do out-patient clinics—hopefully there will be plenty of free parking for patients. There could be endoscopy, colposcopy, some women's health hubs, some community paediatrics—all of that—with the practices around the hub feeding in. That would be my vision.

Professor Ranger: And mine. You no longer want to diagnose in hospital. Diagnosis should happen outside. We should not be admitting patients for diagnosis. If they are well enough to go home, they should be absolutely confident that they can have a diagnosis via a community setting. At the moment, we admit for diagnosis, which many other countries do not do.

Chair: That is very helpful. Thank you so much, all. As you can hear from the bells, MPs are being called away. I thank all our panel members for contributing today—it is much appreciated.