

Health and Social Care Committee

Oral evidence: NHS Pilots, HC 1612

Wednesday 4 February 2026

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Gregory Stafford.

Questions 1 - 121

Witnesses

I: Dr Jennifer Kilcoyne, Clinical Director & Director of the National HOPE(S) Collaborative, Mersey Care NHS Foundation Trust; John James OBE, Chief Executive, Sickle Cell Society; Professor Solomon Tesfaye, Consultant Physician and Honorary Professor of Diabetes Medicine, Sheffield Teaching Hospitals.

II: Dr Claire Fuller MRCGP, National Medical Director, NHS; Dr Kathy McLean OBE, Chair, NHS Confederation ICS Network, and Chair, Derby and Derbyshire, Nottingham and Nottinghamshire and Lincolnshire ICBs; Professor Kath Checkland, Joint Director, NIHR Policy Research Unit, and Professor of Health Policy and Primary Care, University of Manchester.

Examination of witnesses

Witnesses: Dr Jennifer Kilcoyne, John James and Professor Solomon Tesfaye.

Q1 **Chair:** Welcome to this one-off session of the Health and Social Care Select Committee on NHS pilots. Let us begin with some quick introductions, so very briefly, please tell us your name, what you do and why you are here.

Dr Kilcoyne: Hello. I am Dr Jennifer Kilcoyne. I am a clinical director at Mersey Care NHS Foundation Trust. I am also the director of the national HOPE(S) programme. I also work for the World Health Organization, delivering equality rights training across Europe.

John James: Good morning. I am John James. I am the chief executive officer of the Sickle Cell Society UK, which is the national charity for sickle cell.

Professor Tesfaye: Good morning. My name is Professor Solomon Tesfaye. I am professor of diabetes medicine at the University of Sheffield and I work at Sheffield Teaching Hospitals.

Q2 **Chair:** As you were warned, we are going to give you four or five minutes, if it is all right, and no more, to outline these three pilots, what they were about and anything else you want to say about them. I will be quite strict about the time though, because we have lots of questions for you and we really need to get through them before we can then question the Department, so please forgive me if I start to look at you intently.

John James: The sickle cell emergency bypass unit pilots came about because the Sickle Cell Society produced a report in 2021 called *No One's Listening*. It highlighted the real problems with investment and care provided for people living with sickle cell, particularly in accident and emergency departments, where there are guidelines but they were not met. You should get your pain relief in 30 minutes. The vast majority of trusts in the country did not meet that at all—and did not really care about meeting it, if I am perfectly honest.

That report, which was done by the society and the all-party parliamentary group on sickle cell and thalassaemia, went to NHS England, which accepted that there were real challenges and underinvestment in what is, essentially, the country's biggest genetic blood condition. It decided to establish a sickle cell improvement programme, recognising that it needed to do something to improve the care for people with sickle cell.

It implemented a sickle cell improvement programme. As part of that programme, it decided to set up seven emergency department bypass units. The problem it was trying to resolve was the fact that experience in accident and emergency was appalling. That was what patients were saying, and it was what health clinicians were saying. That is what it was



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trying to solve by having these bypass units, 24/7, which would allow those patients to be seen by experts in sickle cell.

There are seven pilots, four in London and three outside London, in Sheffield, Leeds and Manchester. The interim evaluation was completed in October. It says that this is good for patients, because they are now getting their pain relief in about 15 minutes, and it is good for the healthcare professionals who provide the service. In the wider context of the NHS, it is saving money.

I am going to give you a brief example of Lewisham, where I think the data goes up to November of last year. It is saving, through reduced admissions and reduced lengths of stay when people are admitted, somewhere in the order of £800,000. It takes about £600,000 to deliver the service, so in net terms we are talking about a £200,000 saving. It is good all round for patients, the NHS and the healthcare professionals providing the service.

Q3 Chair: You have a specific issue, though.

John James: Yes. The specific issue is that these pilots were for two years. We are now in February. There is no certainty about the funding of the pilots going forward. We have a situation where these units are working well, the interim evaluation confirms that they are working well and there is no clarity from NHS England about the future funding. That is complicated further by the fact that integrated care boards and the NHS are in—

Chair: They are in disarray.

John James: They are in turmoil with change. That complicates the matter. I will give you one example. In October, we visited and talked to one of the new nurses delivering the service at one of these pilots. She has been appointed until March and is worried about the future, because nobody can tell her whether the service is going to be continued. That is unacceptable for hardworking healthcare staff.

Q4 Chair: Thank you so much. Well done; you kept to time. Solomon Tesfaye, thank you so much for your slides. We have seen them and digested them, so over to you.

Professor Tesfaye: Thank you for this opportunity. We are in the middle of a diabetes epidemic, described as the greatest health challenge of the 21st century. In the UK, one in five adults have either diabetes or pre-diabetes, and this figure is rising. Each year, the disease causes more than 48,000 strokes, 34,000 heart attacks and 155,000 cases of heart failure. Diabetes is also the commonest cause of kidney dialysis.

Honourable Committee, among the doom and the gloom, our eye screen service shines brightly. Twenty years ago, diabetes was the commonest cause of working-age blindness. However, since the establishment of a separate high-uptake—greater than 80%—community-based national eye



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screening programme, using digital cameras, with early referrals for sight-threatening diabetic eye disease and early treatment, the UK is the only country in the world where diabetes is no longer the commonest cause of working-age blindness. It is a great success story.

A robust screening service that does not rely on extremely busy GP practices reduces blindness and was a gamechanger. This contrasts with diabetes-related amputations, which have been rising to an all-time high of 180 every week, most of which are preventable. Amputations are devastating physically and emotionally. Many patients do not receive annual foot screening and present with diabetic foot ulcers to massively expanded foot clinics. Unfortunately, five-year survival after foot ulcer is only 50%, which is worse than most cancers, such as breast, prostate or colorectal cancers.

The cost of the diabetic foot, at over £1 billion a year, is more than the combined costs of three of the most common cancers. Sadly, most of this cost comes from hospital expenses, amputations and ulcer treatment, with only 10% dedicated to prevention. What a missed opportunity to prevent in a developed country such as ours.

Honourable Committee, current GP-based screening is not fit for purpose because GP practices are often extremely busy and have competing demands. The practice nurses are unable to have enough time to do this screening. The solution is a neighbourhood-based one-stop screening service.

We conducted a hospital and community feasibility study of combined eye, foot and kidney screening, including all nine care health checks, funded by Sheffield Teaching Hospitals, and published our results in a peer-reviewed journal. When patients come to the eye screening service, eye drops are put in. While the drops are working—it takes about 20 minutes—patients are taken to a second room where they have all the screening processes, including blood tests, done. They leave 35 minutes later, so it is a one-stop shop.

This was followed by piloting this in four large general practice hubs in Sheffield for nine months during 2021. The flow was excellent. The uptake was the same as eye screening at over 85%. Patients loved it because it reduced six appointments with GP practices over a year. It has high uptake and is very well received by patients. It aligns with the NHS 10-year plan of moving care into the community. This is the perfect opportunity to introduce this one-stop shop to these neighbourhood hubs.

Q5 **Chair:** Thank you for that introduction. Dr Kilcoyne?

Dr Kilcoyne: The HOPE(S) programme was a nationally commissioned clinical and human rights-based model specifically designed to end long-term segregation—I will call it LTS for brevity—and to reduce restrictive practices for autistic people, people with a learning disability and children and young people. Long-term segregation is one of the most restrictive



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and harmful practices in mental health. Many people are living in isolation for not weeks or days but months and years. In fact, the average in our programme was 415 days in long-term segregation.

People in long-term segregation are often in bare rooms with nothing but a waterproof mattress on the floor. Food may be passed through a hatch. Access to fresh air, meaningful activity or family contact is often very restricted and sometimes absent. The evidence is absolutely clear that LTS causes psychological, physical and social harm. Families tell us that it feels like watching their loved ones disappear. Staff describe moral injury, compassion fatigue, burnout and feeling stuck and hopeless in a system that is trapping people.

Following a series of national reviews, we were approached by NHS England to look at a fundamentally different approach. Because of our work at Mersey Care, they asked us to roll out the HOPE(S) programme at scale across England. The national programme began in 2022 and we took referrals from May; the national funding concluded in March 2025. Since then, we have shifted to local ICB funding, and that has significantly affected the programme's reach.

HOPE(S) is human rights based and is a co-produced model. It is delivered by highly specialist practitioners who are relentlessly positive and values driven. To illustrate with a brief case example, we worked with an autistic 16-year-old boy who had been in hospital for a year with escalating distress and harm. By the time HOPE(S) got involved, he had been in long-term segregation for five months. He was severely underweight. He was having three nasogastric feeds, under restraint by five agency staff, each day. He had stopped walking and speaking. He spent most of his day rocking in distress.

The HOPE(S) practitioner worked with the team, providing training and practice leadership and demonstrating a low-demand relational approach. Using our barriers to change checklist, she was able to work with the staff team to develop three key intervention targets that focused on building trust and communication and access to an outdoor space. Within weeks, he began to communicate. He started to write first. One of the first things that he wrote was, "Please make the people in the white suits"—the agency staff—"go away". As trust developed, he re-engaged and LTS was ended. Six months later, he was discharged to the community and has got back into education. This is what the HOPE(S) team does. It works with teams, the person and their family to try to remove the barriers that are keeping people stuck in long-term segregation.

In terms of impact and outcomes, to date the HOPE(S) programme has supported 174 people in segregation across 77 hospitals. We have trained 4,000 staff. An independent evaluation by Manchester Metropolitan University of 122 cases showed that with 68% of the people we worked with LTS was ended. One in three of those people moved to the community. Meaningful activity went up by over 100% and access to



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fresh air by over 80%. Seclusion was reduced by a third and physical restraint by over 20%. The impact on staff was also very significant. There were reductions in burnout and secondary trauma. The most powerful evidence comes from the people and the families themselves, such as a young man who hugged his nan for the first time in four years, a daughter who was at home for Christmas after eight years, calling it the best day of her life, and a young woman who left LTS and is now living her best life in the community.

Very quickly, on return on investment, LTS is very expensive—the CQC estimates between £800 and £3,000 per day. Our independent return on investment that we commissioned showed a return of 12 to one for the HOPE(S) programme. Thinking of the earlier case example alone, the costs for the agency care commissioned were £3,393 per day for that deeply traumatising and harmful care, a total of £1.2 million per year. That sum alone would almost fund the entire national programme.

This is just to show that change is possible. It is possible at scale. Profound outcomes can be delivered. The return on investment is significant, ethically, clinically and financially. I am here today to discuss the end of the national funding. The move to ICBs, as other people have mentioned, has left us with a postcode lottery, in effect, in terms of access to this proven evidence-based approach.

Chair: Thank you, all three of you. That was exemplary. Let us carry on as we started.

Q6 Ben Coleman: It is very good to see all of you. Mr James, can I start talking to you? I should say, Chair, that I had the pleasure of visiting the sickle cell emergency department bypass unit at St Mary's Hospital recently. I talked to patients there and I was very impressed by what they told me about the support they were receiving and how it made their lives much easier. That was just as a declaration of interest there. You explained the pilot very well. Can you briefly—we are always asking for brevity because we are all so pushed for time—explain the steps that were taken to get funding for the pilot initially?

John James: Thank you very much for the question. The steps that we took initially were to highlight to NHS England and the Department of Health and Social Care how bereft sickle cell, the country's biggest genetic blood condition, was in terms of comparable funding to other red cell conditions. The *No One's Listening* report was stark in its evidence. That evidence came from patients, families and healthcare professionals, some of whom are in the audience today. The evidence was something that they could not dispute, so they said, "We accept the argument and we will set up an improvement programme."

Q7 Ben Coleman: Who is "we"?

John James: "We" is NHS England.

Q8 Ben Coleman: Which bit of NHS England?



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John James: The health inequalities department of NHS England.

Q9 **Ben Coleman:** When it set up the programme, and obviously there is a lot of detail, out of interest, did it tell you that it would be building evaluation in from the beginning?

John James: Yes.

Q10 **Ben Coleman:** There was a plan for that.

John James: Yes, there was plan for evaluation from the very outset.

Q11 **Ben Coleman:** Why was it delayed? I assume it is delayed because it is not finished yet.

John James: It is not finished yet and it is not due to finish until quarter 4 of 2026. That is what we have been told by NHS England. Why it was late is that not all seven of the pilots started from the same starting position. There were delays in some places in recruiting staff. There were some delays in logistics about the space in which the bypass unit would be located at the trust. The delays for the evaluation were primarily linked to some of the logistical elements with those trusts.

Q12 **Ben Coleman:** Were you told at the beginning that the pilot would continue until the evaluation had completed? Was that just an assumption or was it explicit?

John James: We were told that the evaluation would be an important part of continuation or otherwise of the pilots.

Q13 **Ben Coleman:** The decision making—you were told that explicitly.

John James: It is very rare that you get anything explicit like that in writing from NHS England, but that was the impression that we got. That is why we pressed for the interim evaluation results to be made available before the end of March this year.

Q14 **Ben Coleman:** Yes, I understand that. Do you think that the interim evaluation results are sufficient for the Department, or ICBs, to take a decision on whether to continue and even extend the pilots?

John James: I believe so, yes. The evaluation is independent and is from the National Institute for Health and Care Research. The indications, as I said in my opening statement, are that it is good for patients. Those pilots are now meeting the National Institute for Health and Care Excellence guidance on giving pain relief within 30 minutes, and in practice it is much better than 30 minutes. If we have a situation that says that this is good for patients, the healthcare professionals think that it is great in supporting patients and there are wider benefits for the NHS in terms of efficiency and savings—that is reduced length of stay and reduced admissions—what else would you need?

Q15 **Ben Coleman:** You said that, overall, at this stage, it saves about £200,000 per pilot, so £1.4 million, if you take the seven pilots, is being



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saved. Part of the thing that we have been discussing as a Committee is that often the NHS will say, "We will do a pilot, because we have money for three years for something. We can scrabble that together," but it does not necessarily think about the long-term financial sustainability of the pilot. If it is as successful as the pilots we are hearing about today have been, you would expect the Department to plan on the basis of taking the pilot forward to permanent status afterwards. Do you think that that sort of financial sustainability was sufficiently taken into account, reflected and thought about enough when they started the pilots?

John James: I do not think that it was taken into account, and I will pick up your comment about planning. I accept that NHS England said that we need to do something because of where sickle cell sits in the scheme of all these other red cell conditions, but I do not think that there was a plan beyond the pilot. If there had been, we would not be having this conversation now. I do not think that the sustainability and extension, because it is only seven units across the country, was fully taken into account by NHS England and the decision makers.

Q16 **Ben Coleman:** I would like to ask the same question to Jennifer. It is very interesting to hear and read about what you have achieved. Do you think that the NHS thought about the longer-term funding from the beginning?

Dr Kilcoyne: No. There was funding for a pilot and my understanding originally was that, if the pilot was successful, it would be continued as a national programme, because there was a national concern and were national issues.

Q17 **Ben Coleman:** Forgive me for interrupting you. How was that your understanding? On what basis was that your understanding?

Dr Kilcoyne: It was just because it was a three-year pilot and then it was in the Department of Health and Social Care's response to Baroness Hollins' report, for example. It mentions that it is looking at the outcomes of the HOPE(S) pilot. I suppose I read into that that if the pilot was successful, people would continue to fund it.

However, halfway through the programme, at the beginning of 2024, NHS England came back and said that there would not be any national funding in 2024. March 2025 was when the programme was ending. Actually, it was ending in December 2024 but it extended it to March 2025 because it was no longer doing the national funding. It said that that would enable us to get ICBs on board. However, the difficulty was that many people had made their plans.

Q18 **Ben Coleman:** When you are punting everything down to ICBs, inevitably, unless the ICBs are all required to do the same thing, one will do it and others will not and you get this postcode lottery. We are talking about diabetes, sickle cell and the issues that you have been addressing. Are there some issues where it absolutely does not work if you leave it to ICBs? What would you say on diabetes, Professor Tesfaye?



Professor Tesfaye: I would agree with that. You need national certainty for diabetes. We need to build on the eye screening programme, which has been absolutely successful. It has very high uptake, so why reinvent the wheel? Patients come for eye screening and we do the screening at that point. That is immediately taken away from ICBs, because ICBs have to cater to so many things. We have something that works. We have the space and the manpower and it is cost-neutral. That is why we aligned ourselves with a very successful eye screening programme.

- Q19 **Ben Coleman:** Do you think that the NHS supports piloting new initiatives more than actually thinking about their adoption or long-term roll-out? I would even go as far as to ask whether you have the feeling that the NHS thinks, "We have a bit of money. We will stick it into a pilot and then we hope in three years' time, if the pilot is successful, we will be able to find a bit more money but we might not be able to." Do you think that it is as chaotic as that, or is it more thought through?

John James: I do not think that it is more thought through. I think that it is exactly as you say. I am using sickle cell as an example.

Dr Kilcoyne: We had a three-year programme. People were committed to do something. There were a lot of issues in the press, but I think that not a lot of thought went into how we would sustain it.

Professor Tesfaye: I agree. We need a national strategy. The move to the community provides absolutely the perfect opportunity to implement the one-stop shop.

- Q20 **Jen Craft:** Jennifer, when you first undertook your programme, what support was available nationally to roll it out?

Dr Kilcoyne: When we first undertook the programme, we had support from the national team in NHS England. We made connections with the regional leads in NHS England as well. They were responsible in terms of helping us develop the KPIs and the things that were of concern to colleagues and frontline teams out across the country.

- Q21 **Jen Craft:** I should have said this at the beginning—apologies, Chair. I meant to declare an interest, which is that I chair the all-party parliamentary group on learning disability. Thank you to my colleague here for reminding me about that. What kind of support do you wish would have been available? What would have been more helpful if you had had it?

Dr Kilcoyne: It is that sustainability in the future. We ran a very successful pilot. There was a query on whether there was going to be further funding. It became clear in 2024 that there would not be further funding and we would need to go to ICBs, but there was no plan about how we would do that. There was no infrastructure or contact information. By region, there was massive variation. Some of the regional leads invited us to programme boards, some did not. Some of them shared our information, some did not. We are very grateful to the ones



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that did an excellent job in co-ordinating it, but we have had this patchwork engagement.

We had probably 500 meetings with ICB colleagues to present the programme and data from their systems, et cetera. Quite often, we would go to a follow-up meeting and it would be completely different people again. Then we were not even sure whether the decision makers were aware of the information we were presenting. It was very difficult to get that follow-on funding.

Q22 Jen Craft: Is that taking away from time that you would be spending making clinical interventions?

Dr Kilcoyne: Yes, it is.

Q23 Jen Craft: You said that there is quite a lot of variation. When you go to different regions, do you find that there are any cultural differences in how to adopt a programme that is so unique and different and embodies such a different approach?

Dr Kilcoyne: In some regions, the ICBs worked together as partners and shared the costs, shared everything together and could recognise the benefits of the programme. Some regions said, "We will develop our own team," which is negating the amount of development work and the rigour of the approach. Some had lots of cultural issues about an independent team continuing and wanted to embed it in their own system. While that is an overall gain, we want to make sure that the model is delivered with integrity and the rigour that it has been developed with.

Q24 Jen Craft: Would you say that there is something in having highly specialised staff carrying out the programme that perhaps you might not be able to find at a hyper-local, regional or local ICB level?

Dr Kilcoyne: The highly specialised staff are really helpful because they support the teams. It is the teams in the end that do the work, but they do reflective practice and practice leadership. We select people who have been lead clinicians and have that real values-based, relentlessly positive approach that is needed, and have clinical credibility. We eventually want to spread the culture wider and get that culture change around long-term segregation, but at the moment we need that independence. We have found with other restrictive practice leads, for example, that they get sucked into the system in terms of "how things are done around here."

Q25 Jen Craft: Is it that, within an organisation, you need an outside perspective to break that almost cultural, institutionalised way of doing things and that is what a national approach helps to do?

Dr Kilcoyne: Yes, absolutely.

Q26 Jen Craft: Going forward, what would help? Would it be a continued national roll-out of the programme or even on a regional basis? What would work?



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Dr Kilcoyne: It would be better if it was in specialised commissioning nationally, because it is a national issue, but these are a small number of very high-cost, both personally and financially, people. When you break it down to ICBs, it is one, two or three people per ICB. We are now finding that many of the areas that have not commissioned are now approaching us with very distressing cases to say, "Can we spot purchase this?," but we have lost our practitioners in that area. We have lost the capability. You cannot run a cultural change programme on that kind of piecemeal, short-term funding.

Q27 **Jen Craft:** You cannot just be parachuted in to solve a brief thing. Do you think that there is an issue around the type of people who are served by the HOPE(S) programme, almost because it is such a low prevalence per ICB, but also perhaps it is people who are not always at the forefront of commissioners' and planners' imagination?

Dr Kilcoyne: Yes, that is absolutely an issue. Some of the people who we are working with are the most traumatised people in mental health services. They are highly invisible. In fact, the CQC called its report, where it reviewed LTS, the *Out of sight* report because people are often locked away. Particularly if they do not have families advocating for them, a kind of clinical complacency sets in and there is not that motivation for change. That is why my colleague and I developed the HOPE(S) programme. We really felt that things had to change.

Q28 **Jen Craft:** To clarify, one standout thing for me in Baroness Hollins' report was that there is no therapeutic benefit to long-term segregation. I wanted to make that clear to the Committee as well. The results you have had from HOPE(S), you have said, have been highly successful for patients, professionals and the wider NHS.

Dr Kilcoyne: Yes, absolutely. We concur that there is no therapeutic benefit from LTS. It is harmful and traumatising and often leads to increased distress, self-harm and suicidality. It is a very negative intervention. We have shown that relational care, where you create understanding and communication, really works and has measurable outcomes, as you described.

Q29 **Jen Craft:** It needs a highly specialist service to do so.

Dr Kilcoyne: Yes.

Q30 **Paulette Hamilton:** Good morning. Before I start, I have to declare an interest. I have met and worked quite closely with John through the sickle cell stuff that I have done. I have worked in sickle cell and I have also led the sickle cell voluntary service in Birmingham, chairing it. I have a lot of history in the area, and that is how my colleague got involved.

Anyway, let us move straight on. Can I start with John? I am always sceptical about evaluation processes. As you know from conversations we have had privately, there have been some real issues with these projects and many others because they have been put there just like a sticking



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plaster-type thing, but there has not been any real evaluation. They have not costed it properly and they have absolutely not looked at the effectiveness that you guys have talked about today. Did the ICBs really want to secure adoption? If they did, what did you think they needed to do to ensure that adoption of these projects happened?

John James: Thank you very much for the question. The first thing to clarify is that the seven emergency department bypass units are funded centrally by NHS England, not the integrated care boards. That is an important distinction to make.

Q31 **Paulette Hamilton:** For it to be funded by the integrated care boards, what was the evaluation process like for them to say, "We are now going to take this on"?

John James: I do not think that we have got to that position yet, because the national position over decades—you will know this from the west midlands—is that different ICBs in the country, as Jennifer has said, take a very laissez-faire view about some specialised services, sickle cell being one of them. As far as I am concerned, it has not got to a stage where ICBs are engaged in a conversation about how emergency department pilot units could be rolled out and funded by them. We have not got to that stage yet. The important thing for us as a charity was ensuring that the patient and family voice in that evaluation was strong and vibrant alongside that of clinicians.

Dr Kilcoyne: We were a nationally funded project. We had, as I said, quite a number of meetings with ICBs in relation to the evaluation. We also presented at various boards in relation to that and broke it down to the impact on the particular citizens in the ICBs to show the cost impact in terms of who we worked with and who we got out of long-term segregation.

I think personally that the ICBs needed some kind of national mandate to engage in this programme. If, for example, reducing long-term segregation was in the NOF for providers or they had some national mandate around that, I think that they would engage more. There are lots of competing demands and often the people at the meeting are quite divorced from the frontline clinicians who are asking us for support and help and can see the benefits. Often it is the decision maker in a finance board somewhere who is making the decision about whether to continue with HOPE(S), with competing priorities and the flux in the system.

For example, in the midlands, we had 11 ICBs that we were trying to work with to gain funding and commissioning. Originally, there were seven people who were interested in funding the HOPE(S) programme. When the changes to NHS England and the ICB announcement happened, it dropped down to four. Eventually, only one of those part-funded some of the programme. It is also being compounded by the commissioning landscape at the moment.



Q32 **Paulette Hamilton:** Do you feel that these projects are ever going to be rolled out, Jennifer?

Dr Kilcoyne: I hope so. I think that they came from a very good intention. Because we had such robust evaluation—we had an interim evaluation, then a full evaluation—I thought that they would be continued and it would be fairly compelling evidence. The difficulty is that ICBs are not working in partnership together. It is such a fragmented system that it has created so many barriers.

John James: Without the sustainability of these pilots, we go backwards for the people who live with sickle cell. That will increase health inequalities for that group, without question. From the beginning, I saw this as part of a journey to sustain and improve the care for these patients.

Q33 **Chair:** Solomon Tesfaye, one-stop did not ask for an evaluation. Is that correct and why is that?

Professor Tesfaye: We did our own internal evaluation, but it did not have an external independent evaluation.

Q34 **Chair:** What drove that decision?

Professor Tesfaye: It was because of funding, really. To have an external evaluation, including health economics and statistical analysis, requires an appropriate degree of funding. We struggled with that and so we had an internal evaluation.

Chair: That is helpful to understand. Thank you.

Q35 **Alex McIntyre:** Before I start, I should declare that I am an officer on the APPG for diabetes. I had a fantastic visit up to Sheffield to see Solomon and his team and the work they are doing in Sheffield on diabetes.

Some of the stats you shared at the start, Solomon, are pretty terrifying. Today is World Cancer Day. I think it would shock many people to know that diabetic foot disease has a worse survival rate than the average of all cancers.

As a type 2 diabetic myself, I know the pain of trying to find time to go to the GP on several occasions to have all these different tests. Everybody goes to their eye screening because you are terrified of losing your eyesight. My eyes are starting to deteriorate because of my diabetes. As you say, the foot test is often not picked up on. The one-stop shops that were piloted in Sheffield saw a massive uptake in that, did they not?

Professor Tesfaye: Yes.

Q36 **Alex McIntyre:** Most people, when they get their feet checked at the GP, have a filament test, do they not?

Professor Tesfaye: Yes.



Q37 **Alex McIntyre:** That picks up on diabetic foot disease at quite a late stage, does it not?

Professor Tesfaye: Yes.

Q38 **Alex McIntyre:** Can you tell us a little bit about the work that you have been doing in Sheffield to pilot new technology that detects foot disease earlier?

Professor Tesfaye: As the Committee will appreciate, foot disease and amputations are devastating. They are the most feared complications, together with eye disease. The methodology of using this monofilament is that we stick them on the patient's feet and say, "Can you feel that?" A lot of these patients may be cognitively impaired and it picks up the disease when it is advanced. Because people can feel it, we give them a false sense of security. Actually, the neuropathy is progressing.

In Sheffield we are developing new point-of-care devices that were developed in Harvard Medical School. We test them because of our interest in neuropathy. They detect early peripheral neuropathy using DPNCheck, which measures nerve conduction within three minutes, and SUDOSCAN, where you scan your hands and feet, which also detects small nerve fibre damage very early.

The one-stop shop is conducive to trying new methodology. You cannot adopt this in every GP practice, but if you have hubs, expertise can be developed in these hubs. This one-stop approach targets prevention and enables digital stratification, so that if patients are perfectly normal, they can come in two years' time. There is no need to follow people. The ones with early changes need to be stratified so that they have early management and treatment so that everything is normalised.

A patient said to me, "Professor Tesfaye, we have MOT in this country for our cars and we do not take the brake to one garage and the engine to another garage. Everything is done in one garage. If the brakes are faulty, you cannot drive it until it is roadworthy and fixed. Why is that not happening for me as a patient? I want not only to be told that there is something wrong but for that to be fixed." At the moment, we are not doing that properly in primary care, which is extremely stretched. There are competing demands.

The people who lose out are people who are disadvantaged, people with mental health issues and people who are economically and socially deprived. These are the ones who cannot attend six times for appointments in highly stretched GP practices. If we align this service to eye screening—the eye drops are put in at the start—we have shown that this works and flows beautifully. It can be done by healthcare assistants. They are not expensive like practice nurses. They can be trained to be really good at this, because they will have a critical mass in GP hubs, which you do not get in individual GP practices. This is the perfect opportunity to introduce this one-stop shop in community hubs.



Q39 Alex McIntyre: Given the stats you shared about the NHS spending £1 billion a year on diabetic foot disease and the wider complications of diabetes and the cost of that to the NHS, prevention is always cheaper than cure. From your perspective, why do I, as a Gloucester resident with type 2 diabetes, not have a one-stop shop? Why have we not taken that best practice and rolled it out across the country? What is stopping the Sheffield one-stop shop being in Gloucester and in all of our constituencies?

Professor Tesfaye: We need to see the facts. We have piloted it. We have evaluated it. It is patient-friendly. The patients love it, because they do not have to have six appointments. A lot of these people are disabled and have a lot of difficulties. It meets the sustainability agenda. The nurses love it because they become good at something. GPs love it because they get a report. The patients also get a record of their risk and become drivers of their own management. We give them an app.

It has not been taken up, because, like everything else, it takes a long time. I think that people are now waking up, because prevention is now the agenda of the Government. I hope that it fits in with that. It will target prevention and people adopting a healthier lifestyle. It can be done. With the medications we have nowadays, we can normalise every person with diabetes, which we did not do before because it caused hypoglycaemia. We did not have the drugs. We have weight-loss jabs now that target weight and exercise programmes. In one of our studies called the OCEANIC trial, we have normalised every person with diabetes within just a few weeks, so we have the tools.

Q40 Alex McIntyre: I am conscious that we have NHSE and DHSC colleagues sat at the back. If you had one message to give them about how we can get that model rolled out tomorrow, what would be your message to the people with the power to roll this out? What is stopping us? What would stop you from rolling it out further across the country tomorrow?

Professor Tesfaye: Absolutely nothing. We have a system that works for eye screening, which is brilliant. Align it with that, which is what we did in Sheffield. The eye screening programme is running. The patients are sent an appointment through the eye screening programme. Everybody attends that. We warn them that it is going to take a bit longer. We have space. Already, many GP practices have plenty of space, although not all of them. We have the bigger hubs for PCNs. It can be rolled out tomorrow.

Of course, we need to look at the barriers. What are the barriers? Are there people who live in remote areas? Implementation science is required. A new science of implementing this and scaling it up is required. We need a task force that looks at this and that can be rolled out very quickly.

It is cost-effective. It will save money. It will de-stress the GPs who have too much to do. It will really be a game changer, in my opinion, because



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the investment is very little. 10% is invested in foot care at the moment. We have a massive expansion of foot clinics. We have 12 foot clinics in Sheffield. That is not a mark of success; that is a mark of failure. We need to take off the cost of expensive hospital care. Look at you or me. If I have a healthier lifestyle and I do not get ill, I am not going to cost the NHS a lot of money. I am going to have a longer lifespan. This can be done and the evidence is there. We have done it in Sheffield and it can be rolled out tomorrow.

Q41 Paulette Hamilton: Good morning. My next question is a really interesting one. How much influence do you think media attention in these areas and pressure on Ministers and MPs had on these projects being launched in the first place? Has it just been used as a sticking plaster?

Professor Tesfaye: That is a very good point. When we had APPG for diabetes visit—Tom Gordon and Alex McIntyre very kindly were the honourable Members who came to visit us—that is exactly what I said to them: “Please drive this.” There is a new Government and then another Government come. This should not be a Government agenda for one Government. Appropriate funding needs to go to it. It has to be independent of that, driven by all parties and implemented. It needs investment. We should not just have discussions and meetings. Action is required now.

John James: The media plays an important part. The all-party parliamentary group report *No One’s Listening* identified that, without the investment that Solomon talked about, without the investment in sickle cell, you will have more preventable deaths. That was one of the reasons for the *No One’s Listening* report. Why is it that, for the country’s biggest genetic blood disorder, we are still having preventable deaths in accident and emergency and in wards? That was a real big drive and of course the press picked that up. There is a role and patients are very vocal about asking, “Why is our care so poor compared to other conditions?” It plays a role.

Credit goes to the all-party parliamentary group under Pat McFadden and Janet Daby. As Solomon said, they drove this and that resulted in the question that Ben Coleman raised about NHS England saying, “You make a good point. We need to do something about this,” but the doing something about it is short term.

Q42 Paulette Hamilton: Do you not think that the doing something about it was finding some money at the back of a drawer, shutting you up, putting you in a corner and then doing nothing with it?

John James: They cannot shut us up, first of all. We are very vocal. It comes back to having a bigger plan, because you cannot have these pilots that clinicians and patients are saying are making a difference and then say, “No, we cannot sustain it. You cannot roll it out.”



Q43 Paulette Hamilton: I have known you a while and I am going to beg to differ. What happens is you get the money, you go away to do that piece of work, hoping that it will be rolled out and, while you are doing that work, it is out of the spotlight, as happened in Birmingham, as you saw. Then things deteriorate and the money is removed. I am going to beg to differ. I am doing it for a reason.

Dr Kilcoyne: The HOPE(S) funding came on the back of a very high-profile, serious case review that was overseen by the Secretary of State. There were a number of pilots that started at that time. There was the IC(E)TR programme; Baroness Hollins was leading that. There was the senior intervenors and there was HOPE(S), which was the clinical aspect, in terms of reducing long-term segregation. There had been a number of CQC reviews. As I say, Baroness Hollins had produced a report.

People set up the programme with a genuine desire to address the issue. I do not think that it was just to get it out of the spotlight. I think that people really saw the trauma and the human rights breaches that were happening. Then, as you say, people move on and the problem remains the same. The cultural change and the improvements still need to happen. That is what we have been struggling against now. In terms of moving this forward, we were offered a webinar with other people. We need some action-orientated implementation and infrastructure to do that.

Q44 Paulette Hamilton: My final point is that, if there was a way forward that you would like this Committee to recommend to the NHS to help scale up these pilots, what would that recommendation be? I am only looking for one recommendation, so I am going to be awkward.

Dr Kilcoyne: For HOPE(S), personally, rather than any other pilot—obviously they are all great pilots—it needs to continue to be nationally funded. It is a specialist programme that needs to be nationally funded for a few years until we get the cultural change across the system

Q45 Paulette Hamilton: You are clearly saying that you do not want ICBs taking over the funding.

Dr Kilcoyne: No, we don't.

Professor Tesfaye: We need to build on a great British success story, and that is the eye screening programme. Within 10 years, diabetes, which has been for 50 years the commonest cause of working-age blindness, was completely demolished when we had a separate eye screening programme where every person with diabetes had their eye screen, with earliest changes referred to an ophthalmologist and early treatment. That was a game changer. That is what has happened within 10 years.

If we adopt neighbourhood hubs aligned with eye screening with all the other health checks and early management, aiming at prevention, this will be a game changer. The only country in the world where diabetic eye



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disease is not the commonest cause of working-age blindness in Britain. Let us build on that. Let us have neighbourhood hubs doing one-stop shops properly, implementing and using state-of-the-art screening tools. It can be done. We have done it in Sheffield. It can be scaled up.

John James: For the sickle cell emergency care pilots, the solution must be found to have a plan that sustainably funds these pilots going forward, and that should be funded centrally. The reason it should be funded centrally, not dissimilar to Jennifer, is that we know, and you raised the point yourself, Paulette, that, with the integrated care boards, there is so much variation. There is so much chaos. It would be unacceptable to add that to ICBs in the current climate and say, "You sort this out, ICBs, in terms of the funding". That is a solution that ensures that these pilots are sustained and funded as part of a bigger sickle cell improvement programme.

Chair: Thank you so much, all of you. Your passion for your area shines through this morning and gives us plenty to talk about with our second panel. Thank you.

Examination of witnesses

Witnesses: Dr Claire Fuller, Dr Kathy McLean and Professor Kath Checkland.

Q46 **Chair:** It is lovely to meet you all and thank you for your time. As with our last panel, we are here to discuss NHS pilots. We have a slightly different perspective now, with representatives from the bodies who are here to deliver and commission these services. Can we start with, as before, quick introductions?

Dr Fuller: Good morning. I am Claire Fuller. I am the national medical director. I am a GP by background and have a history of being a chief exec of the ICB in Surrey.

Professor Checkland: Hi, I am Professor Kath Checkland. I am professor of health policy and primary care at the University of Manchester. I am not here representing NIHR, but I have sat on NIHR funding committees and been in receipt of NIHR funding, both as an evaluator and as director of a policy research unit. I am therefore here, I think, because I have a good understanding of NIHR evaluation infrastructure and was the lead external evaluator for the vanguard programme. I should say that my comments today do not represent the views of NIHR. We are always expected to say that.

Chair: We are excited to therefore hear them.

Dr McLean: Good morning. I am Kathy McLean. I currently chair three integrated care boards: Derby and Derbyshire, Nottingham and Nottinghamshire and Lincolnshire. My past includes being a clinician.



- Q47 **Chair:** Thank you very much. Before we start, can I ask a very quick question of you, Claire? Much of the documentation that we have been looking at around this talks about the innovation and adoption strategy, but we cannot find it. Has it been published and is there a timeline for that?

Dr Fuller: I will come back to you on that.

Chair: Adoption, as you heard, is a big old theme and we cannot find this document, even though there is reference to it in all sorts of plans. Yes, that would be really helpful as soon as possible.

Dr Fuller: Yes, I will come back to you on that.

- Q48 **Andrew George:** Dr Fuller, the NHS is about to go through, or is going through, a process of very significant rearrangement. How are innovation and continuous improvement currently managed within the system?

Dr Fuller: They are really important. When we talk about NHS pilots, we need to be really clear what our definition is. We heard some brilliant examples in the first session around change that was initiated because of poor outcomes that were highlighted and need for change. Some of the most powerful innovations and pilots that have been led from the NHS have been based on new developments. If you think about things such as FIT screening, covid vaccines and covid testing, those are things that were led nationally and spread really effectively out across the entire country. Some things we lead nationally and some things need to be led locally.

In terms of how we do that currently, we have the NHS IMPACT board, which leads learning networks around the country based on specific needs. At the moment, one area that is being closely worked on is the frailty collaborative. That is working with seven areas that are leading the way and making sure that the learning from those sites is then spread, so that the seven sites maximise their opportunities, but also we take that learning and spread it more closely.

You have the national neighbourhood health implementation programme. My colleague earlier gave the most beautiful case for why neighbourhood health should happen, in terms of diabetes and how we manage it. At the moment, the way we manage innovation is through being really clear what the outcomes are and then making sure we spread and learn from best practice as we go around the country.

- Q49 **Andrew George:** That begs the question of whether innovation is better developed through central dictat, as it were. Do clinicians at the front line operate too much within a straitjacket of what the centre is dictating and not have sufficient freedom to, as you say, identify where problems are and innovate at the frontline, rather than wait for the centre to permit them to undertake a pilot?



Dr Fuller: We have to do both, do we not? That is at the heart of quality improvement. As clinicians, we always want to deliver the best possible care we can for our patients and we are constantly evolving and changing how we deliver that care. Nationally, our job is to identify new technologies, identify innovation that we know will help, set the parameters and set the outcomes and monitor those outcomes.

To dictate in detail how every place and practice should deliver that will not work because they are all so different. We have thousands of GP practices and hundreds of trusts and they are all different, for very valid reasons. Nationally, we set the parameters, identify the innovation and identify the new technology. NICE, 10 years ago, was authorising two new drugs every month. We are now doing two new drugs every week. The pace of new things coming through is extraordinary.

Q50 **Andrew George:** Kathy, you are closer to the frontline, but still somewhat distant from it. Do you perceive that the environment is sufficiently enabling for innovation to happen without it having the okay from the centre?

Dr McLean: Yes. I will take the opportunity to say that the overarching role of an integrated care board is to arrange health services for the population. It needs to do that based on an understanding of the health of that population and what its needs are.

As Claire says, you need both. There are some things that have been proven to be effective and would be great to roll out everywhere and to have a national indication to do that. Otherwise, it is going to take ages for everybody to learn about it.

There are lots of things, and we have some great examples across my patch, where provision is developed much more locally based on the needs of the particular communities and populations, the clinical leadership that there is and the buy-in from the partners, quite often in changing the way that services are delivered. The challenge there in this business of pilots is that they suffer sometimes from the same challenges as others. There is a bit of money to begin with, but there are various things, which I can go into at some point, as to why it will be successful and lead to substantive funding later on. I agree that it is both/and that we need.

Q51 **Andrew George:** Can I challenge on one example? In, I think, 2010, the NHS Confederation produced a report, which was a form of innovation, saying why we need fewer hospital beds. That was quietly rolled out and now we end up with corridor care and ambulances queuing outside hospitals. It is not a great innovation.

Dr McLean: Not all innovations end up working. In that instance, we have heard a little already about the potential for neighbourhood care, so shifting to prevention, as with Solomon's really great description of diabetes and so on. If we can do those things, we will end up with people



not needing to go to hospital as much. You have to look at it in the round and join up with social care and so on as well.

- Q52 **Andrew George:** Of course, yes. Dr Fuller, we are going through change. Do you see the merger, not only of NHS England and the Department, but also the ICBs—quite a lot of turmoil will be happening—as an opportunity to promote innovation or as a challenge?

Dr Fuller: The changes are going to bring greater clarity of purpose for what we are doing nationally and across ICBs and bigger geographies. The clarification of the role of an ICB as a strategic commissioner is really important. What you see, in terms of the brilliant examples we had earlier on and the roll-out of new innovation, is actually really good basic commissioning.

I started my life running a CCG. When CCGs were created, there was an awful lot of learning around what commissioning was and how to do it. One thing I am really pleased to see is that, as we move into ICBs becoming more strategic commissioners, we will provide increased support to ICBs so that there is appropriate capacity and capability to do the things that we know that they do best. This is about a return to old-fashioned commissioning.

- Q53 **Andrew George:** NHS England's innovation ecosystem programme report indicated that innovation has been stalled by concern about factors such as intellectual property and data-sharing creating barriers to effective collaboration between the NHS and industry. Also the NHS Confederation has identified problems of duplication and a competitive environment that stifles innovation. When you throw in reorganisation on top of that, is that not going to create too many obstacles?

Dr Fuller: The changes we are going through mean that we will need to do fewer things better, which helps to focus the mind. The reliance upon innovation, and actually on changes in technology, will come to the fore.

- Q54 **Andrew George:** The innovation and adoption strategy, which the Chair mentioned—

Dr Fuller: We will come back to you, yes.

Andrew George: We need that, so thank you.

- Q55 **Danny Beales:** Claire, in terms of deciding which pilots or trials to prioritise, what is the decision-making framework that NHS England uses?

Dr Fuller: I will go back to what we mean by pilots, because that influences how we make decisions and choose. If you are talking about an innovation that is a quality improvement because we have highlighted that there are poorer outcomes for the population, it is very clear where you are going to go. We have the support programmes that run things such as the "getting it right first time" programme and the provider support programme that will go into support providers, actually



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improving their outcomes. That would be nationally chosen based on poor outcomes.

Then there are things such as new technology that is coming through that we want to try. I am thinking of things such as the FIT testing, which has now allowed us to identify 600 more cases of colon cancer. We started that in eight sites where we had leadership, capacity and willingness to make it work. Because it was successful, it was rolled out and we are now lowering the threshold, so we will find even more cancers at an earlier stage.

When you look at things such as how we selected people to become part of the national neighbourhood health implementation programme, we had 141 applications from across the country—some 80% of the country applied to be part of that programme. We selected 41 sites, prioritising areas of health inequality, because we know that the changes will have impact.

Q56 Danny Beales: Rolling back on my question, those are examples of things you decided to prioritise. My question was about why you decided to prioritise those things to pilot or trial, or whatever word you wish to use. Presumably there are many other innovations or options that people in the health and care system might want to see innovated or piloted. Why did you not choose them? Why did you choose the things you did? What is the decision-making framework that allows you at NHS England to decide what to prioritise for GIRFT or other programmes and what to not?

Dr Fuller: That is the difference between local and national decision making. Nationally, we were driven by national policy, so by a previous long-term plan and now by the 10-year health plan. That is why there is the focus on GP access, reducing non-elective admissions and the neighbourhood health programme.

Q57 Danny Beales: You pilot the things because they are in the 10-year health plan. Is that the view: that whatever is in the 10-year health plan has to be piloted? How does it get identified as something that should be in the 10-year health plan?

Dr Fuller: The 10-year health plan was drawn up from looking at the evidence internationally and around the country around best practice, what works and how we can do it better. In part of the delivery of that, we need to work with local systems and providers to make sure we are delivering that, but it needs to be based on outcomes. One thing we are doing as part of the 10-year health plan is the modern service frameworks, which are really important because they will give us the outcomes. We will then be able to make sure care is being delivered in the right way.

Q58 Danny Beales: Are you saying that, from NHS England's perspective, unless it is identified as a priority in the 10-year health plan, it should not



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be piloted or trialled?

Dr Fuller: No, because the other side of this is making sure we address poor outcomes. That is looking at variation in outcomes around the country and then stepping in to support providers to make sure the constitutional standards are met.

If you take things such as the GIRFT programme, which has been one of our most successful roll-outs in driving change, that started by looking at variation in delivery of orthopaedic outcomes. It now covers multiple surgical and medical pathways, but is driven by benchmarking and looking at current performance, and then going in with clinical voices and experts to work locally to bring about the change. It has to be driven by new technology coming down through the pipeline and things that we can now do that we could not do previously, versus looking at the outcomes as to where places are not doing well, as well as looking at national policy, so things such as the shift to neighbourhood health, the focus on prevention and the fact that we need to do more screening.

Q59 **Danny Beales:** That is a very complex picture, is it not? There are a lot of moving parts there. It is not simply the 10-year plan. Is there an overarching framework for all those inputs, so new technologies, the 10-year plan, the other priorities and programmatic input? Is there an overarching framework of decision making that guides determining what should be piloted? I think that there is a clinical priorities advisory group. Is that the key input into decision making?

Dr Fuller: The clinical priorities advisory group sits around the specialist commissioning piece of it. It is actually individual directorates that set their outcomes and what we need to do through the year. Then we come together on the executive team as a board to bring the whole thing together in its entirety.

Q60 **Danny Beales:** Is there any political input, bearing in mind the previous panel's discussions? Is there political direction about what should be piloted or political views about priorities or problems? Does that lead to discussions about whether something should be piloted as a result?

Dr Fuller: Media and political attention can shine the light on where poor practice is happening. You have to come back to, "What are the acceptable outcomes? What is the best international and national evidence for how we should be delivering care?" That is what we need to make sure we are holding people to account for delivery.

Q61 **Danny Beales:** That is very nationally focused. Looking at the broader health system, which is a multitude of providers, local commissioners, ICBs, et cetera, do you have a sense from the centre of how many pilots are happening, at various levels in the NHS, of new or innovative practice?

Dr Fuller: No, I could not give you a number at all. If I go down to my actual practice, we would be trialling and doing things on a daily basis in



a different way, from trying to improve the number of people who are accessing their prescriptions via the app, rather than putting them in the box that sits outside, to reducing people who are waiting in queues. It is how you define pilots as being about quality improvement as well as the roll-out of new technology and interventions.

Q62 **Danny Beales:** There is no central oversight of locally commissioned pilots.

Dr Fuller: No, because it is happening within providers and sitting across ICBs as well.

Q63 **Danny Beales:** In terms of budgeting for piloting, the 10-year health plan discussed—perhaps your colleague with an ICB hat on might also have a view about this—ICBs dedicating 3% of their budgets to invest in transformation and innovation. Is your sense that that is happening? Is that achievable?

Dr Fuller: It is not happening at the moment. It is definitely something that is aspirational. We have more work to do, given the amount of change that is going on in stabilising ICBs. That is something that we will do in the future.

Dr McLean: The answer is that it is variable. I can give you an example from my Nottingham and Nottinghamshire ICB, in which we decided that prevention was really important. We put aside—it sounds a small amount—£4.5 million in the first year of doing this. In the second year we doubled that, to align that to prevention. People came forward with plans.

A really good example of how that has helped is that we have a really effective severe multiple disadvantage programme that started out as a pilot in Nottingham city. It did all the right things. It got the evaluations, the measurements, the partnership, the clinical leadership and everything, all from the start. When the money looked as though it was running out, it was able to apply to that fund. Now it has recurrent funding and that can go on into the future.

There are some local examples, based on the local needs. As Claire said, nationally they could not possibly know all of the pilots because they are literally going on inside providers, inside general practice and across places and systems all the time. Some of them are not successful. If they are not successful, we refer to “fail forward fast”.

Q64 **Danny Beales:** If things are not successful, but no one is aware that they have not been successful, is that not creating a system that continues to make the same mistakes in different ways?

Dr McLean: They are locally known about. As ICBs have clustered together, they are covering much larger populations now, so there is a great advantage of being able to share across a bigger patch. NHS Confederation does some work to do peer learning and sharing across the whole country.



Q65 Danny Beales: We are hearing that the 3% is not necessarily happening in many places. It is a patchwork. Do you think there is scope, potentially Claire or Kathy, for greater co-funding of pilots with industry or academic partners? Does it have to be NHS-led piloting?

Dr Fuller: No. The HINs, so the health innovation network, are doing some really exciting and interesting models of driving change and driving. Manchester is an excellent example of some things that are going on there. We need to look more broadly at how we can do this.

Q66 Danny Beales: That is a very helpful example. In terms of industry, we have talked about new drugs and treatments. Innovation is happening. As you said, new drugs are being approved all the time now by NICE, weekly rather than monthly. Is there any view about, if industry has a case to make about a new innovation or treatment, whether it should co-fund the piloting of it to demonstrate its value? Is that something that NHS England has explored?

Dr Fuller: It is something that we have looked closely at, yes. You can think of the roll-out of the GLP-1, so tirzepatide, at the moment. It is really important because there are new medications that are coming out. We need to look at what the appropriate support is for people as they go on to those medications. We are looking at the wraparound services for that, which might be digital or face to face. As an example of a pilot of a new medicine that has come out, we will go on to make sure we nationally procure an offer that is available to everybody locally, should they choose to use it.

Q67 Danny Beales: Do you mean nationally procuring, so that would be the NHS buying it?

Dr Fuller: We have had great success with the digital weight management programme in terms of the support for people to access. The GP refers in and it is an offer that can then be accessed. We are using a similar support for people on the GLP-1s, making sure that you are not just having the medication. You are getting the support to make sure your weight loss is sustained. We need to make sure that there is a consistent national offer as part of a framework, so that we avoid the postcode lottery of distribution.

Q68 Danny Beales: Finally, the innovation ecosystem programme report recommended budgets for innovation that span multiple years, ideally spending review periods. Do you think that it is possible or realistic to have budgets for piloting and innovation that go beyond three years, so beyond spending review periods?

Dr Fuller: You know the power of the political cycle in terms of needing to have results within the spending review. Many of these changes are going to require much longer-term investment, are they not? We need to explore all ways that we do it.

Q69 Gregory Stafford: I am always pleased to hear about "getting it right



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first time”.

Dr Fuller: I know.

Gregory Stafford: I know you do that deliberately. That was a successful pilot because of the force of personality of Professor Tim Briggs and—I would say—the forward looking of the then Health Secretary, Jeremy Hunt, to get that. My point is not to make a political point. It is to simply say that, in many cases, if not all cases, it is a lot down to force of personality and local innovation, but the IEP report found that there was a lack of protected time and incentives for NHS staff to engage in innovation activities. Dr McLean, how do you build capacity at a local level to undertake innovation activity?

Dr McLean: It is a good question. Often, people are very stretched and doing their day jobs, but there are ways of supporting people within trusts, within primary care and across the system so that there is a focus on those. One thing is aligning it to the local strategy, whether that is within an organisation or elsewhere. Then it becomes part of the delivery arm. Very often, we find that these things do well, as you have indicated, where you have clinical champions and people who really want to take this forward. The honest truth is that they find the time and then bring other people into the mix. A lot of these things require a huge culture change, so that is an important part of that.

Q70 **Gregory Stafford:** To push you on that, you said that people find the time. Would you not think it would be better for you to somehow practically give them the time to do this?

Dr McLean: Yes. In good organisations, where leaders spot what needs to happen—and I have been to visit many where this is happening—people are aligned to these programmes. The problem can be that they are funded short term for the programmes, and then it is what happens after that. They need to be embedded. This comes back a little bit to whether you have made a return on your investment, so that measurement of that early on. It is sometimes quite tricky, particularly if it involves multiple partners. The benefits may be seen outside of the NHS and I do not think that we are great at acknowledging that.

Q71 **Gregory Stafford:** Are you in essence saying that the IEP report is wrong, or that you are not as concerned as it is about the ability, at a local level, for innovation?

Dr McLean: Innovation requires a certain amount of risk taking. You have to get partners agreed that they are happy to take risks. If you are going to go innovate, you have to assume that some of them might not work. That is an important part of that. There is much more for us to do. As been mentioned, for example, strategic commissioning will help us make some of these changes, but it is happening across providers at all levels as well.

Q72 **Gregory Stafford:** Dr Fuller, as Dr McLean has just said, clinical



leadership appears to be crucial as to whether the pilots scale successfully. From an NHSE perspective, how have you been supporting leaders to give them those skills and, I suppose, the knowledge to drive innovation?

Dr Fuller: One reason I took this job, rather than staying and being a chief exec of an ICB, was realising the power and the need for clinical change. There is so much you can do with policy and from executive land, but, if clinicians do not start working in a different way, nothing actually happens.

One thing that I have done in this job has been building a much stronger network of primary care colleagues around the country and better connecting primary and secondary care colleagues. We have produced the red tape challenge document, again working with the very fabulous Professor Tim Briggs. As a result, we have both been around the country, visiting some of the PCN test site pilots.

The thing that they highlighted was the difficulty of communication between primary care and secondary care and that the things that could have been done within a hospital setting were being passed on to primary care, increasing the workload. We created a checklist for organisations to undertake, which they now do on a six-monthly basis, looking at things such as whether consultants are making the onward referral, whether we are doing the fit notes in hospital as appropriate and whether we are making sure that, if tests are asked for in secondary care, they are followed up in secondary care.

That was something that was a bit of a side product that came out from the visits to the PCN test pilots. We have now spotted what the things that will work are and are then spreading. There is a bit that we do not often do. We often put the guidance out, but the bit that makes sure it happens is putting it into the national oversight and the national assurance process.

Q73 Gregory Stafford: That is an interesting example. On the wider point, I suppose I am trying to get the idea of whether you believe that innovation in the NHS, certainly from an NHS England point of view, will only come, and of necessity comes, from individuals, whether they be managers, clinicians or both, driving this forward. Is there a failure in the system that needs to be addressed? Are you comfortable—maybe I am putting words into Dr McLean's mouth—that people will find the time? The innovators who want to innovate will do it. Is there something more fundamental that the NHS, at either a local or a national level, needs to change in order to promote innovation?

Dr Fuller: Innovation is the classic bell curve, is it not? You are always going to get your 20% that are out and leading the pack. You also want to make sure that you never stop them, because otherwise you do not ever drive the change. The bit that we have to do—and it is the thing we are doing through the national neighbourhood health implementation



programme—is identifying those themes and trends that those trailblazers set and then codifying them to make it easier for others to follow.

We have the 41 test site pilots. We have baselined now to look at what they are all doing and a number of themes have come through that we will now baseline the rest of the country to, to look at what they are doing. We can then look to assist them.

You will never stop our absolutely brilliant leaders, who will always innovate. You have to then, for those who are working under more difficult circumstances or have different skillsets, codify that and put it into national planning and national oversight and assurance to make it much easier to drive up and bring the change across the country.

Dr McLean: I agree with that. You will always have people who are very keen to innovate. They come up with ideas. They send them to me even, at times. Some of the things that make small things become successful are aligning the incentives as well, so that financial and other kinds of incentives get aligned, you link it to either national policy or local strategy and you can sustain that in that way. Developing leaders so that they know how to create the culture for it is also something that is really important.

Q74 **Gregory Stafford:** My takeaway from this conversation is that the key things are incentives and the freedom to take the risk within the framework of the strategy. Is that a precis of what you are both saying? We are not necessarily going to make recommendations, but, if we make recommendations off this report, those would be the things that you think would be the key things to drive innovation, so freedom to take risk and the incentive to be able to do it.

Dr McLean: Yes, freedom to take risks, incentives, the alignment to policy and a good approach to evaluation, so that it starts early on if it is not something that is already known to be effective.

Dr Fuller: You have to look at the data and you cannot necessarily predict what it is going to show you. I would put a relentless focus on data as your third one.

Chair: That brings us very neatly on to Dr Beccy Cooper's questions, I believe.

Q75 **Dr Cooper:** Yes, thank you. I would like to discuss evaluation with you. I heard you tell my colleague earlier that, understandably, you do not know how many pilots are running at any one time. That makes sense. I wonder, Kath, perhaps with your NIHR hat on, whether you know how many NHS pilots, as defined by Claire, are currently being evaluated by the NIHR.

Professor Checkland: I do not. I am sure that that is something that could be found out. HSDR—the health and social care delivery research



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programme—does a lot of these evaluations. I am sure that it has the figures. I do not.

Q76 **Dr Cooper:** If you could let us know, that would be great. Similarly, Kathy, do you know across your three ICBs, which is ambitious, roughly how many pilots are running at any one time?

Dr McLean: No, I do not know all the small ones, obviously. I am aware of some of the larger things.

Q77 **Dr Cooper:** Okay. In terms of the larger ones, how many do you have running across the three ICBs?

Dr McLean: We probably have, at the moment, about four or five larger ones that I am aware of, but I am only a chair.

Q78 **Dr Cooper:** That is helpful, thank you. When we are thinking about evaluation, as you rightly said, Kathy, the key is to plan your evaluation rigorously before you even start your pilot. Before we come to the nuts and bolts of it—I do not know whether this is a question for Claire—I am quite interested in the idea that evaluation leads to either a scale-up or a close-down of an innovation or a pilot. I wonder, Claire, whether you have any evidence of how many larger pilots have been either scaled up or closed due to effective evaluation. Take a three-year or five-year time period, whatever works for you.

Dr Fuller: I am not going to be able to give you exact numbers. Martha's rule is a brilliant example of something that we piloted. We saw the impact from it and then we scaled up.

The one that is harder to give examples of are the things that we have stopped, but I have one. The evidence for hypertension case finding is irrefutable. As we come through the modern service framework, looking at particularly the cardiovascular outcomes, I think that that is the thing that we will find. One thing that we believed, which I personally believed as well, was that investing in more people looking for hypertension cases—we looked at dentists—in different settings within primary care was good, cost-effective way to find new cases of hypertension. Actually, when you look at the return on investment, there are better ways to invest your money to find more cases. We are in the process of publishing that as a, "We tried this. It did not work". We find it much harder to stop things, partly because so many things are driven by such brilliant clinical passion.

Q79 **Dr Cooper:** Before I move on, would you say that it is reasonable, therefore, to presume that, within excellent clinical practice at any one time, there will be ongoing pilots that perhaps are not proving effective or are not producing sufficient ROI, but continue nevertheless because stopping things is quite difficult? Would you say that that is reasonable, Kathy?

Dr McLean: It is a bit difficult to comment on that, to be honest.



Q80 **Dr Cooper:** What about in your experience as a chair of ICBs or a clinician?

Dr McLean: If things are not going anywhere, they tend to fizzle out, to be honest, because they do not have the support.

Q81 **Dr Cooper:** Your phrasing is interesting. It is “fizzle out” rather than a proactive “We are going to stop this” decision.

Dr McLean: We do a lot of work that is looking at health inequalities, so the gaps in survival for people in poverty-stricken areas compared with others, for example. The time taken to see whether it is effective is long, so when do you stop? When do you actively stop?

Q82 **Dr Cooper:** As a public health consultant, Kathy, I would say that you never stop.

Dr McLean: No, I was going to say that. Exactly, yes.

Q83 **Dr Cooper:** If I look at your pilot planning, Kath, perhaps I could come to you because of your NIHR skills. How well do you think evaluation skills are understood when pilots are planned, in your experience? How available is skill training for evaluation, because it is a specific skill, for sure?

Professor Checkland: “Understood by whom?” would be the question. We have a brilliant community of evaluation experts across the country. We are very lucky that we have NIHR. Many other countries do not have anything similar. NIHR has invested very significantly in building an infrastructure of rapid evaluation. We have a number of rapid evaluation teams across the country.

Q84 **Dr Cooper:** Do you have enough?

Professor Checkland: We would always like more money in NIHR. That is fair to say. The capacity for rapid evaluation has been extended quite significantly, particularly in the HSDR programme.

Q85 **Dr Cooper:** When you say “rapid evaluation,” are we talking real-time evaluation? Are we literally saying that we are evaluating as we go and therefore we do not have to start evaluation once we have undertaken 12 months of a project?

Professor Checkland: That is very difficult. As Kathy said, sometimes the outcomes are not obvious for quite a long time. Sometimes you might start doing something now and you cannot expect to see any change for three or four years. That is very difficult in NHS funding terms anyway. We have the infrastructure to get evaluation up and running quickly. We have the skills, and those skills can be transmitted as well. We have the health innovation network across the country, which is what used to be the academic health science centres, and the ARCs—the applied research collaborations. We have done evaluation training locally. In Manchester we have trained the local clinicians in evaluation.



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Q86 **Dr Cooper:** That is wonderful in Manchester. I am delighted to hear it. My follow-on question to that, Claire, is whether this is standardised. That is excellent practice. Is this standardised across the country? Could I go to all three of Kathy's ICBs, my ICB, your former ICB, ICBs around the place and see evidence of this evaluation training and skillset at work?

Dr Fuller: There will be variation.

Q87 **Dr Cooper:** Right, so that is problematic for us. How do you propose to address that variation?

Dr Fuller: The best way to address variation is the way that you always do it. You identify best practice, benchmark and then shine a light. People never like being a poor performer.

Q88 **Dr Cooper:** Do you have plans to do that, or is that something that you already do?

Dr Fuller: I will come back to you on that.

Q89 **Dr Cooper:** Back to you, Kath, are rapid evaluations the best type of evaluations to do in the national health service as it stands today? Is that the best way to understand the pilots as they are working? I appreciate that there are longer-term issues. I absolutely appreciate that, but, in general, are they the best way to do it?

Professor Checkland: It depends what it is you are doing. For some of the very small pilots, local test and learn, good data analytics support and quality improvement methods are the best. When you are looking at something quite large or that might involve a significant change in practice, you have to have robust evaluation. You know as well as I do that regression to the mean means that something may look as if it is working, but, when you evaluate it properly, you find that it is not. There are many examples of those, and that is why evaluation is vital.

Q90 **Dr Cooper:** My final question is longer-term evaluation. We have established that you have your rapid evaluation teams. You have increased it. Claire is going to go away and look at that sort of standardisation across the piece. How are we in terms of resourcing longer-term evaluations and allowing skills to be manifest across the country?

Professor Checkland: Again, we are quite good at that. Sometimes, for some programmes, NIHR will go out to tender and procure a really all-singing, all-dancing, long-term evaluation. What we are not necessarily very good at, it is fair to say, is waiting for the outcomes of those evaluations.

Q91 **Dr Cooper:** That is what I am trying to get to. You can do an evaluation, but what does it show? Do you have examples of evaluations where the results were inconclusive or you needed more time and simply did not get it?



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Professor Checkland: I would not say that the results are inconclusive. We have a tendency to go ahead and roll things out before we have the full results. There was a really good example with social care personal budgets. There was an evaluation, and the decision to roll out was made before the evaluation was finished. We are much more likely to do that than for the evaluation to run out of money.

Dr Cooper: That is really helpful. Thanks so much.

Q92 **Ben Coleman:** Do you have examples—perhaps you could write to us with them—of pilots that stopped, were then evaluated, and were then rolled out and started again?

Dr Fuller: I will find out. I do not know, given that we have so few pilots that have been stopped. Do you mean where the pilot bit has finished?

Q93 **Ben Coleman:** You are about to stop the sickle cell pilot. Is there an example of where pilots have been stopped because the money has not been made available, but then the evaluation comes in and you start it again, which could be helpful in the sickle cell case, or is it just that, once it stops, even if the evaluation comes later, that is the end of it?

Dr Fuller: We continue to look long term at outcomes. Many of the cases that we are describing as pilots are quality improvement programmes to improve outcomes, so that piece of work will be continuously ongoing, and the intervention that will bring about the improvement may change with time.

Q94 **Ben Coleman:** If the evaluation shows that the pilot was effective and the pilot has stopped, might you then still roll it out?

Dr Fuller: It depends on how you are judging the effectiveness of the pilots. The sickle cell one is a brilliant example, because you are receiving analgesia within 30 minutes, and we will continue to look at that and see what happens. We have to finish the evaluation, and there is more work going on around, again, GIRFT looking at sickle cell services. The world moves on. The pilot is conducted in a context, which is why looking at the outcomes for the population is as important as looking at the intervention that is going on.

Q95 **Chair:** Can I just ask whether I have understood this? We were given the example of a clinician who is now worried for her job, which is not great for productivity or their mental health, and all the rest of it. In its current form, it may shut down, but there will be elements from within it that will then get carried over into the rest of the system. That is the bit that you are interested in. Have I understood that correctly?

Dr Fuller: I am not going to comment on it, because we are awaiting the evaluation and no decisions have been made.

Q96 **Chair:** Not that one, but as an example.



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Dr Fuller: The way that we deliver services changes all the time. That is quality improvement. That is continuous improvement. You would want that to happen.

Q97 **Chair:** We are interested in that team and what they are doing now with that population in that locality. It could be any, not just sickle cell. We have seen it in community mental health hubs, for example. This is a common story. A team comes together around a passionate clinician. They then offer something to a community that says, "Hallelujah, we have an answer," and then it just fizzles out. It disappears. It is never seen again. It often then does not get rolled out. This is one example of so many.

Am I to understand that the fizzling out is part of the process? Do you see that as okay, so long as elements from within that learning get rolled out, or, as my colleague was suggesting, if that does fizzle out, and then the evaluation comes back and says, "That was great," is there any chance that it could be restarted?

Dr Fuller: It is the difference between implementing a specific project and the concept of quality improvement. At the basis of delivering clinical care, we constantly change how we deliver them because new things come through. When I started in general practice—ramipril, an ACE inhibitor—we had to admit people to hospital overnight because that was what we did at that time. Now I would start multiple drugs in the setting in general practice because that is the right thing to do. Medicine and technology continue to evolve.

Q98 **Chair:** I am talking here about something very specific. There are several pilots with teams across the country, some in this room and some not. If those teams' funding is not continued, specifically to answer my colleague's question, it is unlikely that they will restart in that exact form. Is that correct?

Dr Fuller: I could not guarantee that that pilot would remain in that form. I would expect that all clinical care would continue to evolve and improve.

Chair: That is as much of an answer as I am probably going to get.

Q99 **Josh Fenton-Glynn:** I am going to carry on with this theme. We regularly have the Secretary of State here. He loves the phrase, "In the NHS, we learn from the best and roll it out to the rest," because he likes a rhyming couplet. I am not sure that it is true, though. Do we get the right balance between funding pilots and funding adoption?

Dr Fuller: The right answer to that one is, "I don't know," because it is very hard to view them as two separate things. If you look at how the civil service defines pilots, it looks at testing of policy, testing with the market, and test and learn. Pilots is the definition that we then use just for the roll-out bit. I know that I keep coming back to it, but it comes back to the NHS definition of pilots not being the most helpful thing, because we are covering quality improvement, implementation of new



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technology, and pathway change, whether that be local or national. I am hesitating to answer because, if you want the broader definition of pilots, implementation would be part of that.

Q100 Josh Fenton-Glynn: So you think implementation is part of a pilot. A pilot scheme has an implementation plan attached. I mean broader roll-out.

Dr Fuller: When we talk about a pilot, we are sometimes talking about testing a policy, and that is not the same thing as implementation.

Q101 Josh Fenton-Glynn: Just thinking of an example that we have seen, Layla referred to community mental health. It was a three-year pilot. As far as I can tell, it probably took them most of the first year to get up to speed. They have maybe a year of operating. They are then winding down and evaluating for the third year. It does not feel like an effective way, particularly when something is working, for the NHS to roll something out. It does not feel like that is the best way to get the results, to get the understanding and, hopefully, to push it out.

Dr Fuller: Our most effective way to drive continuous change is through quality improvement.

Q102 Josh Fenton-Glynn: The problem then is that you are not doing anything radically different, because you are just improving processes in places. If the model is not working, mental health being a good example, then you are not changing things.

Dr Fuller: Look at some of the things that we have changed radically. If you think about the roll-out of the covid vaccine and covid testing, FIT testing is a brilliant example of that. Radical change will come with new technology and innovation. When it is improving how services look after the people we need to look after and we have agreed outcomes, which is the importance of the modern service frameworks and setting those, that is about quality improvement. It is helpful to test the policy in isolation to make sure that it works and then spread that.

Q103 Josh Fenton-Glynn: It is interesting that you mentioned the covid vaccine, because that was not done as a pilot. One of the reasons that worked really well there was that there was a clear need and then they rolled it out. I was a council cabinet member for social care at the time, so I saw that roll-out at first hand. It seemed to me very clear that one of the things that they did very well was to remove some of the normal bureaucracy, and perhaps that is something that we do need to learn from. You are nodding, so I am taking that as assent that we are going to do it. What tools are available to successful pilot projects that we are looking to scale?

Dr Fuller: There is a national offer and there will be local offers as well. Nationally, the improvement team put together learning and innovation networks that are led from local leaders who are doing well. The frailty collaborative is a really good example of that. It is about bringing



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together really high-performing places, which spread their learning and then share it. We are doing similar with the national neighbourhood implementation programme. It is about communities of practice, the sharing of the evidence, and then the opportunity for frontline leaders to make sure that they have access to the right resources to help them unblock the problems that they come up against.

Q104 Josh Fenton-Glynn: What is your reaction to the experience of people such as Dr Kilcoyne in the first panel, who said that they do not have the tools and support to better scale up their project?

Dr Fuller: I am very happy to have a conversation about what we do, but that is about local variation and understanding how we can better support people locally.

Q105 Josh Fenton-Glynn: Moving to local variation, Kathy McLean, one of the stated aims of the Government is to use the NHS as an engine for growth. Part of that is about successful pilots and so forth. What efforts are ICBs making to be better recipients of that innovation?

Dr McLean: As has already been said, ICBs are moving to becoming strategic commissioners. In essence, that means that we will be more effective in terms of the commissioning cycle. We will better understand, using data, what the local population needs, and then tailor that much more, based on communities, to what is commissioned and the outcomes. We keep saying outcomes, but it is something that we have not focused on in the past. We will be seeking those outcomes, and that will quite often require innovation.

Q106 Josh Fenton-Glynn: Can you define the key outcomes? There are patient outcomes such as a healthy or comfortable life. What are the other outcomes that you are looking at?

Dr McLean: They are myriad. We have an outcomes framework. There are some high-level things but also some very detailed things in there for each of the programmes. Just going back to what makes it successful and why things do not work, an example that I would give that is working pretty well is of targeted lung health checks. It is a national programme. We piloted it. I was so interested in it. I went to visit it. I kept a track of what was happening. I can see that it is rolling out across the country, but not equally everywhere. One of the reasons that that is doing that well is that it clearly met a need, and one of our jobs is to ensure that we meet the need, particularly in deprived areas. Therefore, we arrange buses to go to those with the kits, so that you really get into that. We will be driving innovation because I do not think we have an alternative, really.

Q107 Josh Fenton-Glynn: One of my previous roles was at the GMC, looking at medical education. There is often a vast difference between trusts. Trusts in urban areas that were better funded and often in better-heeled areas would be more likely to be centres of innovation. Is it the case that we spend a lot of time innovating on the already healthiest patients?



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Dr McLean: That is an interesting one. There is a difference between a trust and our job in ICBs to understand the population's whole health and to break that down. We can do that to varying degrees, but we are able to do that really well. It is fair to say that, if you look at, for example, elective care, more people who are better off at the higher levels of that tend to get more of the elective care, whereas those from deprived areas tend to use our emergency services far more, and are probably not accessing as much as they should in terms of early cancer diagnosis, elective operations, and so on. There is a distinct variation and one of our jobs will be to think about how we use and apply our resources.

Professor Checkland: We know that treatments tend to get tested in better-off populations. This is one of the things that NIHR is trying to address. All projects that come through to the funding committees are asked to ensure that they are looking at how they are going to recruit from the more deprived populations. Something that the NHS is putting a huge amount of focus on is how we make sure that we are not just going to the usual populations where it is easy, but that we are asking, "Why are we not recruiting to trials from, for example, rural and coastal communities with deprivation?" That is a big focus for NIHR.

Q108 **Josh Fenton-Glynn:** In some ways, the advantage that the NHS has over so many health systems is access to a wide variety of patients. We see that with some of the stuff that is in the cancer plan today. At the moment, as things stand, I am not sure that people feel fully confident that pilots will always have access to those patients. How are we going to make sure that that happens, Dr Fuller?

Dr Fuller: You bring in another really interesting angle of the importance of research, and whether we are describing research as being pilots, which is the importance of why we evaluate it properly. Teaching hospitals and the importance of research to the clinicians within them is the thing that we underestimate in terms of what keeps clinicians engaged and involved in their jobs. We need to do more research in other settings, particularly in primary care. There are some brilliant examples of larger-scale primary care organisations. In Birmingham, Vish Ratnasuriya looks after a population of several hundred thousand and runs research across those, including some really quite deprived areas. It is getting better, but it needs to get even better.

Josh Fenton-Glynn: I have taken the mickey with my time, so I will hand back to the Chair.

Q109 **Chair:** Kath, you have had a long career in this. We have a 10-year plan. We are looking to do things differently. There is a huge reorganisation of the NHS, with big changes and, arguably, a return to the more strategic commissioning of the past. You were a key evaluator of the vanguard programme, and there are key lessons that we all need to learn from this. Lay it to us straight. What are the areas where, if we do not do better, we are going to fail, from your experience of particularly the vanguard programme, but, indeed, your entire career?



Professor Checkland: I have spent a lot of my career evaluating these really complex pilot programmes, such as the vanguards, which are very different from, say, a service evaluation, such as for sickle cell, which is really focused.

Vanguards were huge, and there were multiple objectives. What I would say about the neighbourhood health implementation programme, which my team are looking at in part at the moment, is that we need to be really clear about what we are trying to achieve. We are not quite there yet, and there is more guidance to come. The vanguards started off with a very broad remit, in that it was all about integration and people could set their own objectives. In year two of the programme, they were suddenly told, "If you are not reducing emergency admissions, we are going to cut your funding." A lot of them had not started off trying to, so we need to be really clear from the beginning about what we want people to achieve, what our theory of change is, what our logic is, and why we think that this thing is going to deliver what we want.

For something very large-scale such as neighbourhood health, we did some longer-term evaluation of the vanguards. We looked at outcomes three, four and five years after the programme had ended, and found that, in some areas, outcomes continued to improve. My big plea would be, "Let's not make any changes again soon. Let's do this. Let's put money and energy in it, but then let's stick at it." Something as complex as neighbourhood health has lots of moving parts. We are moving things out into the community. There are lots of ways in which we are going to be doing things. We are probably not going to see any benefits in the short term. The benefits are going to come in the longer term, and so we need to stick with it, but we need to evaluate it properly.

Q110 **Chair:** Over what timeframe would you say to politicians, "Hold fire"? Forget about the spending review for now. Of course, the Department will not, but, from an evaluation, roll-out and implementation perspective, what is the right timeframe?

Professor Checkland: It is going to be five or more years before you really see benefits. We have to move more quickly than that, but we need to really spend our time now with those 40 sites. We do not quite yet know what it is we are trying to do, so we need to define that now and then build evaluation around that.

Q111 **Chair:** When you said that we are not quite there yet with what it is that we want to do, what is coming that we should be expecting?

Professor Checkland: There is more guidance.

Dr Fuller: We are clearer. We know that one of the things that neighbourhood health needs to fix is GP access. We need to reduce non-elective admissions. We need to have an impact on waiting lists. At the moment we are baselining to see where people currently are. We have done the 41 test sites, and we will do the rest of the country, which will



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then start to give us a bit more of a road map about when you might be able to expect to see some progress around the country from this.

Professor Checkland: What we are not quite clear of yet is exactly what neighbourhood health is going to involve. We know what the problems are, but we are not quite sure what the steps are going to be.

Q112 **Chair:** Have we set out interim evaluations along the way? How are we going to be able to hold the Department to account for the direction of travel? All the detail of that is to come.

Dr Fuller: That is all to come.

Q113 **Chair:** When can we expect some of this detail?

Dr Fuller: We are hoping that the model neighbourhood guidance will be out in February, and there will be more information about the model neighbourhood health centres. Then, of course, we will have the workforce plan, which will include a chapter around neighbourhood workforce as well.

Q114 **Chair:** What about interim evaluations?

Dr Fuller: We will continue to monitor. In terms of the things that we will be looking at, we just need to agree the metrics around GP access and non-electives, as well as around patient and staff experience, and the PROMs and PREMs as well.

Professor Checkland: There is formal evaluation going on. The strategy unit from the midlands is doing some work with the pioneers. I cannot think what we are calling them, but the implementation pilots. The strategy unit is working with them particularly around data and monitoring. One of the NIHR rapid evaluation units in Northumbria has been commissioned to do a more formal evaluation of neighbourhood health, which it is working on and getting up and running at the moment. That is going to be a longer-term evaluation to look particularly at implementation and the factors affecting it.

As with all of these things, when you are talking about complex service change in a complex environment, there are lots of issues around implementation and local contextual factors that we need to understand, and an evaluation is going to be very important in making sure that we understand what supports things working and what gets in the way.

Q115 **Chair:** From an ICB perspective, does this sound good to you? Is it what you need?

Dr McLean: Yes. I have one of those pilots in my patch, but that is not stopping us going ahead with developing neighbourhood health. We just cannot wait for the five years, so we are getting on with that, looking for the guidance, and so on. Again, the implementation will be very different in different places. You mentioned coastal areas. I have a bit of coast. It is going to be really different out on the coast of Lincolnshire compared



with the Peak district or the centre of Derby. We are doing that, we will learn as we go along, and we will look to the outcomes as set out in the guidance when it comes.

Q116 Chair: I have one final question or thought. Pilots are inextricably linked to innovation and improvement. Claire, you have taken pains to make us understand that and its context. We also heard quite vividly from the last panel—and particularly from my Deputy Chair, Paulette Hamilton, who really drove this point—that, so often, they are set up when there is intense media scrutiny, or when a prominent MP or an effective APPG takes this on, and it has political heft behind it. It happens, and that community is really delighted that it has happened in the places where the pilot runs, but then they go away. My reflection—and I would love your comments—is whether there are just too many pilots.

Dr Fuller: The joy of the NHS is that we are the seventh biggest employer in the world. We have an ever-changing landscape of brilliant innovation that is coming through. There will always be people who want to do new things, and we should celebrate that people want to continue making care better. Again, I will come back to it. It depends on what we mean by pilots.

Q117 Chair: I understand, but let us just take the three examples. A specialism or an interest area sets up in a particular community. The bit that I am trying to get to here, really, is whether we are not just leading people up to the top of the mountain, showing them what is possible and providing, very often, a level of hope, especially to families and patients, that this could be better not just for them but for so many others like them. Are we actually just helping politicians say that they had a win? For a little while, someone was looking at it, and then, for evermore, someone can say, “We looked at it. We did a pilot,” but it is not really addressed.

The better thing to do would be not to do a pilot but something that is a longer-lasting improvement in that area. I am not suggesting that we stop improvement in that particular area. I am just perhaps suggesting that those specific two or three-year pilots in specific areas such as that might just be a bit cruel.

Dr Fuller: Our role nationally is to set what the really important outcomes are and to hold people to account for them. Where people are achieving that, that is absolutely fine. You will get local variation because of different demography and geography, which means that you need to deliver care in different ways in different places.

Sickle cell is a brilliant example of that, in that there will be different concerns and issues around the country. The political insight and shining the light on the fact that people were not receiving analgesia within 30 minutes has been incredibly helpful. That is not going to go away. We just need to keep on improving how we deliver care and striving to deliver better outcomes. Sometimes, that will include enabling people to



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have a small amount of money to test different ways of working, but, ultimately, that then needs to become how we deliver the care. We need to stop relying on pots of money.

Q118 **Chair:** Even if it is a bit cruel, is it still worth doing?

Dr Fuller: I do not think that it is cruel, because it shows you how you can do things. The bit that we need to get better at is making that how we deliver the care rather than making it additionality.

Q119 **Chair:** Kathy, from an ICB perspective, it is going to be ICBs that are often asked at the end of these evaluations. Every single one of them shows, "You have saved money". It could be £200,000 or it could be millions, but what is the one thing—and I am going to press you for just one—that needs to change so that ICBs, in their new roles, will feel properly empowered to roll out these great ideas in their communities rather than just thinking, "Well, lucky them. They have a pilot, but what about us"?

Dr McLean: If you want one thing, some of this is certainty of resource so that we can assign it to things and know that it is going to go on. That is quite an important one.

Q120 **Chair:** I am going to press you on "know that it is going to go on". What does that mean? Is it two, three, five or 10 years? Give me a horizon here. What does that mean?

Dr McLean: If something is going to work well, it could and should go on for years and years. You want it embedded in the business as usual and the doing things as normal. The tricky thing, because you have asked me for one thing, is that you need to know that it is going to work, first of all. You need to know that it is going to be effective.

Once you have done that—and this comes back to measuring from the start, knowing what your outcomes, objectives and alignment are, et cetera—you can then employ people and give them longevity. It is then easier to spread, because you have people who can share that. If you have pockets of money coming in, which we have had—and Patricia Hewitt's review referred to this as well—it is okay for a bit, but you cannot get that longevity. You cannot get that ongoing improvement. That is really what we need.

Q121 **Chair:** So it is better to pool the money for improvement over a longer period, rather than have pockets of money that then just suddenly disappear.

Dr McLean: Yes, which is what we did at Nottingham. We did this health innovation fund, and people could bid against it to do small things, some of which will go on because they are successful, but some not. Not everybody has been able to do that. It sounds like a small amount of money, and it is, relatively, in the context of our large commissioning amount, but it is really valuable just to get things going.



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Chair: We are about to lose quorum, and I am going to give the last thought to Kath.

Professor Checkland: It is very different for different types of pilots. If you think about the diabetes example, it is clearly working very well in Sheffield. I was a GP in the Derbyshire dales, and it would not have worked for us, because people do not want to travel to a hub. It is very different. It depends on the thing that you are dealing with. The context is really important. There are some things that you could clearly say are really important, for example the standard around analgesia for people, but you might deliver it in different ways in different places. We need to be aware of the contextual differences.

Chair: Thank you very much. We really appreciate your time.