



Health Committee

Oral evidence: Public expenditure on health and social care, HC 679

Tuesday 11 November 2014

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Members present: Dr Sarah Wollaston (Chair), Andrew George, Robert Jenrick, Barbara Keeley
Grahame M. Morris, David Tredinnick, Valerie Vaz

Questions 160 - 298

Witnesses: **John Appleby**, Chief Economist, King's Fund, **Anita Charlesworth**, Chief Economist, Health Foundation, and **Nigel Edwards**, Chief Executive, Nuffield Trust, gave evidence.

Q160 Chair: Thank you very much for coming today. For those who are following this session, would you mind introducing yourselves, perhaps starting with Nigel?

Nigel Edwards: I am Nigel Edwards. I am the chief executive of the Nuffield Trust.

Anita Charlesworth: I am Anita Charlesworth, chief economist at the Health Foundation.

John Appleby: I am John Appleby, chief economist at the King's Fund.

Q161 Chair: Thank you. Perhaps I could start by asking you this, John. In your briefing you use the term "a financial crisis is inevitable" in 2015-16. Could you and then the rest of the panel set out the current state of the financial problems facing the NHS this year, how that compares with previous times of distress and what you see for the future?

John Appleby: Yes, thank you very much. You mentioned our evidence. Maybe I can set out some of the evidence as we see it now, evidence from, for example, Monitor, the TDA, who look after the non-foundation trusts, their quarterly financial reports, and also we do a survey every quarter of NHS finance directors; our latest one came out a few weeks ago. I will just draw on that sort of evidence to give a picture now.

What seems very clear is that financial problems are spreading beyond those organisations that have had a longish history of financial problems. That is the key worry at the moment. From Monitor and the TDA, we know that about a third of non-foundation trusts are forecasting a deficit at the end of this year; 60% of foundation trusts were overspent in the first quarter of this year. We do not know what their predictions are for the end of the year, by the way. In our latest survey of finance directors, we had just over a third of all trust finance directors across England respond. About one in three forecast a deficit—an overspend at the end of this year; 60% plus forecast a deficit for major acute trusts; 70% say their forecast for the end of this year is worse than their outturn for last year; and over 50% are very concerned, or concerned, about meeting their cost improvement programmes—that is, essentially making ends meet. Finally, on that, over 90% are very or fairly pessimistic about the financial state of their local health economy over the next 12 months. Not a single finance director expressed any optimism about that. I have to say that all of those numbers I have just given you are worse than any survey we have done since 2011.

So, on the health side, it does look very bad. We have to choose our words carefully. It is not a cliff edge, as such, but it is clearly very difficult and getting worse. As for next year we know, for various reasons, movement of money from the NHS budget into the Better Care Fund—as has happened over the last few years, but it is growing—has an opportunity cost. It is not new money. It has to come from somewhere. As to the outlook—and I have to say finance directors are not always the jolliest bunch in the world even when things are going well—they do express a lot of pessimism about next year financially.

Anita Charlesworth: I will not repeat those numbers. I want to say a little bit about why the fundamentals are continuing to move away from turning this situation around over the next 18 months. The planning guidance out to the NHS says that the affordability challenge on secondary care is twice as big next year as it is this year and yet we know everyone is really struggling, and NHS England in its board report last month reported a further £200 million worsening in its financial position.

The thing that worries me most about this is that, if we look at this, we are observing people's costs fundamentally running ahead of their income across the provider side. Those costs are running ahead very substantially, I would argue, from the inability of NHS providers to recruit permanent staff, and particularly nursing staff now. So we are seeing their expenditure on temporary staff rise. We saw last year a big increase in the numbers of staff employed by the NHS. That has flattened off. I think it has flattened off because people simply cannot recruit. They need more head count but are having to get that through temporary and agency staff. That is much more expensive. The work we did with the Nuffield Trust on the QualityWatch programme looked at a range of indicators on staff. It is clear as well that morale and engagement of staff in the NHS is declining, all of which makes it harder and harder to recruit, and the activity pressures on the sector are just not tailing off.

The other thing we are seeing is that people's intended savings are lower and they are more reliant on the one-offs. As you build up more and more one-offs, at the end that

crystallises into a big gap in your funding; that is starting to come home to roost. They are even struggling to deliver against their lower cost improvement plans. Those are all difficult things to turn around really quickly against a background where not only are they supposed to sustain their efficiency improvement but in fact they are supposed to double it next year.

Nigel Edwards: I am not sure there is much to add to all that; it was pretty comprehensive. I am afraid I don't add much to the joy there. Just to amplify the point about agency staff, this is not just affecting nursing but appears also to be affecting doctors as well, and, anecdotally, one hears that people are leaving training programmes or leaving employment and then basically becoming permanent agency staff. So there seems to be something that happens to the psychological contract, if you like, between some NHS organisations and staff. It is proving quite difficult to recruit people.

The other thing that is worth reflecting on is that some of the assumptions that have been made by commissioners about reducing activity certainly have not been delivered, but, even where they are, the problem is that the fixed-costs structure of most providers means that, even if you can reduce the activity, their ability to convert that into cashable savings is extremely limited. The economists are simply much more optimistic than the people in the real world, I was going to say, but that would have come out wrong. But there is a real problem there with the stickiness of the cost structure in most providers.

Q162 Chair: How much did your assumptions factor in the current wage restraint? In previous years when you have all given evidence, you have made the point that a lot of the existing savings towards the Nicholson challenge had been achieved by wage restraint. When do you anticipate that that will no longer be possible?

Anita Charlesworth: The NHS England projections in the Five Year Forward View anticipate wage restraint continuing on through most of the next Parliament.

Nigel Edwards: But not at the same level of restraint.

Anita Charlesworth: Not quite at the same level, but they do anticipate no catch-up awards and really quite a tight pay environment.

Nigel Edwards: One could argue that the agency spend that is happening now is in effect catch-up by other means.

Anita Charlesworth: Yes.

Q163 Chair: That may be part of what is driving people to agency because they are earning more, do you think?

Anita Charlesworth: Yes.

Q164 Chair: Do you think that is a significant part of it?

Anita Charlesworth: Pay is important, but when I was at the Nuffield we did a bit of work with UCL and the IFS looking at nurses who left the NHS. The majority of those left for lower pay, but they left for jobs that either offered them a better work-life balance or this soft contract, which is really important—the sense of engagement and being able to do a good job. All those things matter greatly. The collapse in morale and engagement would be as serious, I think, to the ability to recruit and retain as what might happen around pay. There is obviously a relationship between the two, but those things appear to matter very much to people who work in the service.

Chair: Thank you.

John Appleby: I know we and others have said how important the pay freeze has been in helping the NHS to keep its costs down, to contribute to the QIPP programme and to be able to do more and so on, but I am not sure it is as big as people always think. From memory, it has contributed between £800 million and £900 million a year, which is a lot of money in a sense, but we usually talk billions. It is not as big as people always assume. Having said that, clearly it is difficult to imagine how such a pay freeze can carry on indefinitely. I was looking at some figures the other day, at GPs, for example, who have also been subject to a squidge down in terms of their income; they are in the seventh year of a real pay cut now.

Q165 Chair: Is that all NHS staff or just GPs?

John Appleby: It is just GPs. I think consultants might be in the fifth or sixth year. Most other NHS staff are in the fourth or fifth year. There is a saying—Stein’s law—“If something cannot go on forever, it will stop,” and this cannot go on for ever. One of the issues is, over the next few years, to what extent will it slow down; to what extent will the impact of freezing pay feed through, as the economy grows, into problems around recruitment and retention and so on? We are seeing that with some of the agency nurse staff and so on.

Q166 Chair: It is part of it, although, as you point out, not the whole issue from your studies. You all argue that the NHS will not be able to cope with its current budget in the current year. Could you set out for the Committee what the size of the funding gap is that you have estimated from your organisations for next year?

Anita Charlesworth: For next year, if you look at the planning guidance, it is saying that there is an affordability challenge of 6.6% next year. They are saying that NHS providers might achieve 2.5%—I think that is in the category of heroic—and that there might be system efficiencies of a further 2%. That leaves a gap of 2.1%. That brings you to around £1.5 billion because that is on a secondary care budget of about £80 billion. I can see, based on where we are at the moment, no evidential basis to assume that providers will increase their productivity next year to 2.5%. So a fairly cautious assumption is £2 billion, unless something else changes to narrow the spending pressures on providers. That was anticipating a big increase in employers’ pensions, but, if you could change the phasing of

pension contributions, you might bring that down a bit. NHS England's Five Year Forward View essentially, in between the lines, asks for £1.5 billion next year over and above inflation. That would be a minimum.

Nigel Edwards: That would be on the low side.

Q167 Chair: That is on the low side. You think £2 billion is more realistic.

Anita Charlesworth: Yes, I do, because that assumes that everyone was in balance by the end of this year and I find it impossible to imagine how we are going to do that.

Nigel Edwards: We have exactly the same number.

Q168 Chair: Any advance on that?

John Appleby: There is a lot of uncertainty around these numbers. We tend to talk in billions and not 2.1-whatever billion. Clearly it depends how this year is going to end. It could well be that the system overall ends up just about in balance, when you add in all the purchasing and providing side and so on. Almost certainly the hospital provider side is going to be overspent. That might be balanced, from a Treasury viewpoint, with under-spends elsewhere in the system. There will be money found at the top. There could be a problem with individual organisations being overspent. What happens then? They dip into their reserves and carry the deficit over. They will have to pay that at some point unless they are bailed out. It is difficult to say quite where the starting point on this is.

As to the broad estimate of what the NHS needs to reasonably meet its obligations, we are looking at a 3% to 4% real increase each year for the next so many years. That translates into—whatever—a £4 billion to £5 billion real increase. The argument comes, if the money is not entirely there, as to what we shave off for productivity. What do we assume? That is what Anita was saying. How heroic is it to assume that you could generate a couple of billion or £3 billion-worth of productivity savings to direct somewhere else? It is very difficult to say. For the sake of unity, I will go with the £2 billion but there is a plus or minus there.

Nigel Edwards: It is quite a big one.

Q169 Chair: But you are all clear that it will not survive on its existing budgets without major impact on what can be delivered.

John Appleby: No, and we are seeing that now. I do not want to include my colleagues necessarily in this prediction, but when the settlement for the NHS was made in 2010 certainly there was a lot of talk such as, "Well, give it till Christmas, or give it another two years, and we will see some big ballooning in terms of waiting times and so on." It did not really happen, but now we are seeing some real pressure on elective waiting times and on some of the others—on cancer waits, for example—and so on. We are beginning to see some pressure caused by, frankly, the lack of money.

Anita Charlesworth: The other thing is this. I used to work at the Treasury and if I were at the Treasury what would make me lie awake at night is the behavioural effect here. When a small number of NHS providers are in deficit, the consequences of being in deficit are really quite serious. The issue comes when it is the norm—which it is now this year—to be in deficit as to what exactly are the consequences for you as an organisation. The other thing that worries me there is that there is a sense in which there is a choice, and the narrative is there is a choice for NHS boards among money, financial performance and quality. Whereas back in 2009-10, when Sir David Nicholson was setting out the QIPP challenge, that was framed as productivity and quality and the sense in which these two were a joint endeavour, there is a sense of a trade-off now and you have a sense that boards are saying, well, what Chris Hopkins of the FTN is saying is, “If I am going to be hung for anything, I would rather be hung for money than quality.” We just do not know what the behavioural response is here. What we do know—

Nigel Edwards: But we have case law which suggests exactly what you are saying.

Anita Charlesworth: Indeed so. Previously, the NHS could go from being in balance to a small deficit to really very substantial deficits very quickly, and that behavioural effect is a big part of this. From a financial control point of view that is what really worries me and, if I were in the Treasury, I would worry very greatly about.

Q170 Chair: So you would be lying awake at night now if you were in the Treasury.

Anita Charlesworth: I would indeed. This is a very big risk to public finances.

Nigel Edwards: On the positive side, it probably means that many of the deficits have now been declared.

Anita Charlesworth: Yes.

Nigel Edwards: It may be that we now know what the situation is because this is so widespread. The argument is sometimes made that, if you improve quality, costs go down. That is certainly true for certain types of activity and some areas of work. The big quality concern that we have not mentioned but that has been implicit in what a lot of people have been saying is the backwash from Francis, the Mid Staffs inquiry, and the degree of correction of staff ratios. This is basically plugging a deficit in quality rather than being the sort of quality improvement that might reduce costs. It is certainly likely to improve outcomes but it is important not to conflate an argument one sometimes hears that all quality improvement reduces cost. Some quality improvement reduces cost; some of it is either cost neutral or actually increases cost. What we are seeing here is a lot of correction with some of these staffing ratios that people had felt had run down.

Q171 Chair: But having agency staff does not always improve quality. In fact, it can increase costs.

Anita Charlesworth: Indeed.

Nigel Edwards: Absolutely, but that is not what is being measured.

Q172 Chair: No. Just measuring the number of staff on the ward is not the same as knowing the quality and continuity that you get from permanent staff.

Anita Charlesworth: Most senior nurses would say that, if you have very experienced people who are permanent and are used to working for a team, you might need fewer people than if you have a ward that is staffed with lots of temporary staff. That is something that people would say to you.

Q173 Chair: I know Robert wants to come in on the back of that, but I want to ask one final thing for clarification from the evidence before I stop speaking. In the evidence, I have seen different figures for the percentage of our GDP that we are spending on health, with the OBR quoting 7.7 and yet the Nuffield Trust quoting 9.3. There is a big difference between the two. Are you able to set out why those figures are so wildly different, because that is very important?

Anita Charlesworth: Yes. The 9.3, I think, is the UK health spending as a share of GDP. That is the UK, not just England; it is public and private. It is what is compared internationally. What the OBR is talking about then is UK publicly-funded health care spending. Depending on which year, that is 7.7 or 7.9. Then you have English NHS spending, which is what the Government set an envelope for as a share of GDP, which is a somewhat nonsense number because it is done as a share of UK GDP, and that is closer to the 6%. I don't know the number. You do, don't you?

John Appleby: There is no GDP for England. There is something else called GVA, but we do not usually talk about England NHS spending as a percentage of GVA.

Q174 Chair: When we are talking about international comparisons we should use the 9.3, but when we are talking about 7.7 that is the one that is most relevant to us. It is about knowing which is the most relevant to us in the context of what we are spending. In terms of tracking over time, you would recommend that we use the OBR numbers—

John Appleby: Yes.

Q175 Chair: —that are the publicly funded for the whole of the UK as a percentage of GDP. Then finally, to clarify, on that international marker, where are we in terms of the international league or should we use the OBR one, which looks at publicly funded, or because there is no international comparison presumably—

John Appleby: I would use the bigger number, public plus private, because the trouble is that in other countries defining what is public spending and what is private spending gets a bit awkward. Usually the comparison, again—but it conflates a few things—is public plus private. When we do international comparisons, it is usually the bigger number that is used.

Nigel Edwards: One might want to monitor both trends because one might predict, if you squeeze the Government contributions to health, you will probably see spill-over from out-of-pocket or private medical insurance, or people will end up paying one way or another, because in some of these cases care needs to be provided. Looking at other countries, the record is, if you hold the Government share, you will see an increase in other types of payment. So it is probably worth watching both trends from your point of view.

Q176 Chair: In terms of the international comparator for what the public purse provides for health, where are we on the international league table?

Nigel Edwards: We are very high because, as a proportion of GDP, UK spending which comes from the public source is much higher than many other OECD countries. It is not the highest, I think. I think Scandinavia may be higher.

John Appleby: The trouble is that what would be counted as private spend in Germany is not quite what we would consider to be private spend here. It is not out-of-pocket euros to pay for an operation. That is why it is difficult to separate out the public and private and then compare them separately.

Q177 Chair: Would it be possible to let the Committee have a note that reflects what we should use and why they are important? That would be very helpful to set out for the public because, otherwise, these figures become very difficult for people to interpret?

Andrew George: And break it down internationally as well in relation to it.

Anita Charlesworth: Absolutely, and the international comparisons.

John Appleby: There are OECD figures, yes.

Chair: Part of the aim of this inquiry is to be a source of reference for the public about where we are and what this means. Thank you. Anyway, enough from me. I know Robert wanted to come in and then we will go to Barbara.

Q178 Robert Jenrick: I want to ask a brief follow-up. You mentioned temporary agency workers and that is a major issue. Short of raising salaries in the NHS, which, as we know, is not currently planned, what would be your best advice as to how to reduce the reliance on temporary workers and agency staff?

Nigel Edwards: There are not very many levers at a policy level. A lot of this is to do with the way the local managers' roster staff, look after their staff and allow them to arrange their work in a way that gives them a work-life balance and plan ahead. The highest rates for agency staff are generally paid at five-to-six in the evening when the night-time junior doctor has not turned up for work. You end up paying large amounts of money. There are

things that can be done in terms of developing your own bank of staff. Some of the agency staff are employees and there are quite a lot of interesting technological and other things to create flexible pools of work from your own work force. But it does seem to become a very competitive market with agencies bidding for staff. Unfortunately, there is a very attractive sort of shadow market for nursing and other types of staff, with them outbidding each other. I hear anecdotally of junior doctors getting texts with ever-increasing amounts of money for shifts, in their own hospital even.

Anita Charlesworth: There is one thing that I would suggest. I do not think it would make the most enormous difference to the position we are in at the moment, but it is something that feels not very sensible long term. We have lots of pockets of one-off money in the NHS—winter pressures every year—which are given, in the jargon, “non-recurrently”, but they are given every year, which is an odd version of “non-recurrent”. Winter comes every year and the Department of Health and NHS England give money every year for winter, but everyone, broadly, has to spend that winter money as if it will never come again. So you end up taking people on temporarily because, in essence, you staff to your recurrent budget. In fact, your recurrent budget is never your total budget. All these little pots of money appear and they appear every year. There must be a more sensible way of dealing with the non-recurrent money that comes every year so that people can say, “Do you know what? Every year we will have winter; we will have to staff our A and E. Could we not do that in a way which recognises that?” Then there are various things that providers do around E-rostering systems and all of those sorts of things which people are looking at to try and tackle that.

Long term, that might wean the NHS off some of its temporary and agency and the shift to effective bank. But what we are seeing at the moment is a reflection of an unplanned increase in the permanent staffing requirement of the NHS, for which there are just not enough people to go around. You then also do wonder about the extent to which every hospital is going and outbidding each other on this and whether or not, again, this lack of co-ordination—

Nigel Edwards: Attempts to deal with this through organisations such as NHS Professionals do not seem to have been as successful as one might have hoped.

Q179 Robert Jenrick: We are basically competing against ourselves. Is there any way of tackling that?

Nigel Edwards: We do not seem to have been very successful at it. There ought to be a way of tackling that, but the experiments to try and do it do not appear to have got the level of traction. There is always an incentive for one hospital to defect from the pack. If they want that registrar in surgery, there is quite an incentive in the heat of the moment to leave the security of the pack and steal. The thing we have not mentioned, which may be an interesting factor, is the change in the rules about sick pay and holiday pay for agency staff, which has changed the nature of the deal now. If you are interested in work-life balance and a higher hourly rate and you are not so concerned about the pension benefits, agency working actually—

Q180 Chair: So we are making it more, not less, attractive to join an agency.
Nigel Edwards: Yes.

Q181 Chair: I am sorry. I know John wants to come in and then I think we need to—
John Appleby: I do not have a detailed response as it is out of my area of expertise. One thing I would note is that we have had trends like this in the past. It has not always been the case that we have had a very small amount of agency nurses and now suddenly we are doing it. There are big increases and decreases which tie in with what is going on in the rest of the economy in terms of what choices people make in their careers, whether they go for nursing and this sort of thing. At the moment we happen to be in a period where largely, I guess, due to the Francis inquiry—as Anita was quoting Chris Hopkins—people are saying, “I would be rather be done for too much quality than problems over my finances.” A lot of trusts are taking that sort of position. I am not saying it is just a temporary thing that will go away by itself, but there have been histories of this sort of thing.

Q182 Chair: I am trying to remember when we last did not have a winter crisis.
John Appleby: Sorry—I meant about the agency staff where trusts have found themselves suddenly looking at their finances and the times were good financially. “So we will get in the staff where we can”; then there was a bit of pressure, and one of the things you would look at is agency staff. I suppose there is a different thing now, which is the pressure that a trust does not want to be seen to be shortstaffed on their nursing.

Chair: I know David has one very small, short, follow-up point and then we will go to Barbara.

Q183 David Tredinnick: Mr Edwards, just to go back to you, you said there was a problem with junior doctors not turning up for work in the evening that creates agency demand. How big a problem is doctors not turning up for work?

Nigel Edwards: It is no more problem than it was before. It is just that they seem more reluctant to work additional shifts because there is an attractive—

Q184 David Tredinnick: Are there adequate sanctions against those doctors who do not turn up for work?

Nigel Edwards: Most hospitals, I think—

Q185 David Tredinnick: In other words, is it a management problem that people are just—

Nigel Edwards: Sickness rates in health care do tend to run ahead of the rest of the economy. There are recent staff surveys suggesting that staff are more under stress. The last time I looked at it, my impression is that sickness absence among medical staff is reasonably well managed. I would not want to give you the impression that that is what is driving the financial crisis by any means. There is more to do to improve staff welfare in the NHS. It is reflected in the NHS Forward View. That would be a cost-effective investment. It is probably more an investment in welfare and work conditions than it is performance management of unauthorised absence. In health care you are exposed to infection and heavy manual lifting labour, so you are more likely to be off sick perhaps than in an ordinary office job. But there is definitely more to do.

Q186 Barbara Keeley: We had already started, before the diversion into staffing issues, on the pessimism of finance directors and the issues facing, noticeably, acute trusts. I have certainly got a feel for how serious the financial problems are that trusts are facing. You had started on the point about what the coming financial year might bring, so I do not know if you can say more about that. Anita Charlesworth has already said that it depends what happens in behavioural terms and you had already started on that, but, given these serious and increasing financial pressures and the financial problems that trusts face, what do you anticipate the coming year is going to bring?

John Appleby: Very depressing and very difficult indeed. As I say, the feedback we get from finance directors about next year is the worst and most pessimistic view that they have expressed about a 12-month period when we have asked them over the last four years. The NHS won't collapse—of course not—but there are going to be lots more problems. I would foresee problems around waiting times. We have had hospitals—some big hospitals—which have had winter beds open from last year; they are still open and they have added more to them in the autumn. You have to take these indicators together and make some sort of prediction about next year when there will be less money for the secondary care sector. That is just how things are being planned at the moment with the Better Care Fund.

Take these things together, plus—I think we put this figure in our evidence—when you look at trends in referrals from GPs, total referrals, elective activity and emergency activity, the lines jiggle up and down a bit, but the trend is all up. It is hard to see that that will be unabating next year.

Nigel Edwards: That is at a level that is much higher than one would expect, on looking at your graph, than would be driven just by pure population change.

John Appleby: That is over and above population change as well. I take those things together. On the supply side, there is a tightening squeeze on finances; on the demand side, if people turn up at the front door, they don't get turned away. The usual measures—certainly when I first worked in the health service—where we literally locked a ward to stop patients using it for the last few months of the year, which would save a bit of money and the waiting time would go up a bit, and then the money would come in the next year

and we would open the ward again, do not happen now. Almost the opposite happens: we are opening more wards. Taking all those things together—

Q187 Barbara Keeley: But with elective waits, for instance, it is the same effect, is it not? I have had a question, which I have passed on from a constituent, about waiting lists for waiting lists: you are not on the waiting list until you have been on a waiting list. That is the sort of game you get into, I guess.

Nigel Edwards: Making people wait longer probably does not save you any money in the long term if you are going to treat that patient. You have to treat them at some point so you will at that point incur that expenditure; and you may spend quite a lot of money managing the list, expediting the patients who get worse more quickly. So it is something of a false economy. Waiting lists are quite likely to arise from another feature, which is that, as you get large numbers of people with non-elective admissions—with emergency admissions—you then have difficulty discharging them; they tend to fill up the elective beds. There is a double problem for the hospitals: they lose the bit of their work that is most profitable and their waiting lists start to grow because they cannot get the patients into the elective beds as they are filled with emergencies. The system becomes chaotic and, as a consequence, the waiting list grows. It may be more that that drives the waiting list than the direct effect of the financial impact on the surgical work.

Anita Charlesworth: That is a really important point and there are two things I would say. The NAO in its report last week said that, even last year—the position last year was better than it is this year—29 NHS hospitals had a deficit that was more than 5% of their income. These are organisations that are starting to get into really serious difficulty. That number will have grown. They also say there is no provider that has gone from deficit to surplus. Some of these numbers are getting really quite big—£50 million plus. I am very worried that that, which starts to feel like a hopeless task, starts to mean that people will not go there; you get all the churn of leadership; good staff don't go there; you start to close wards; then you have medical outliers; it is all chaotic and your productivity starts to go down as well. You get into a vicious cycle there. Then the financial performance, the productivity performance of the NHS, leaving aside quality, suffers. If you could identify now that next year the numbers just do not add up and allocate some money to go in and give people stretching but realistic financial targets, you are more likely to get engagement around that and minimise the size of the overspend, perversely, next year than if you just wait and allow this to play out in an unclear way.

Q188 Chair: It is just unrealistic, in your view, at the moment.

Anita Charlesworth: If leaders across the organisation—I mean clinical leaders as well as managerial leaders—are actually to tackle this problem, it needs to feel doable. The biggest risk to all of this is when people just give up—if the numbers that people are setting at the moment for a not insignificant minority of providers are felt to be in the “just give up” category. If you look at the organisations that have been in so-called special measures or turnaround and the NAO report on the amount of bail-out money that has come, we have ended up spending far more, for far longer, on those organisations than we

would ever have anticipated, because so often there is not that realism at the beginning. It takes time to turn these organisations around. People cannot deliver. You need to give people an achievable target.

Q189 Barbara Keeley: I understand that. John Appleby has touched on the impact of the Better Care Fund on those financial positions. Is there anything that anybody else wants to say about that? I will come on to social care itself in a moment.

Nigel Edwards: One of the anxieties is that there is a presumption that they will reduce admissions, against what is already an upward trend. There is an ageing effect, there is a population effect and there seems to be just an autonomous growth in demand; we are not quite sure what is building that. That 3% is against a moving baseline.

Looking at the evidence on reducing admissions does not give you a lot of encouragement that that is very easy to do. Even if it were easy to do, there is a presumption that it would save approximately £1,500 per admission, which is the average cost of an admission. Of course, that is not what most of the hospitals are being paid; they are being paid significantly less than that. I do not know what John and Anita think, but the Better Care Fund may make things worse for quite a few hospitals, rather than better. There is a disastrous scenario where it does not help the hospitals particularly but the money is still spent on the other schemes that were designed to reduce admissions. In a sense, we pay for something that does not work and then we pay for the activity as well.

Q190 Barbara Keeley: Can we move on to the prospects for social care and the expectation that the Better Care Fund, while it is a transfer—it is not any more funding—will distribute funds in favour of social care? Clearly, that is the effect. I suppose that, straightforwardly, that is what is being planned for—it is a transfer into social care.

John Appleby: Yes, I think so. I am sorry to quote the NAO again, but I thought that its report on the Better Care Fund was very interesting in terms of setting out the history of the Better Care Fund. It started off with the idea of identifying £3.5 billion of largely NHS money—some of which was existing money spent on various services that were provided—lumping it together, re-labelling it as the Better Care Fund and adding in a bit more NHS money. Since then it has grown to over £5 billion, apparently, in terms of the local plans for putting money into it. The time scale for doing the plans for this sort of thing is ludicrously short. It is very hard to believe that we can get some of these schemes going properly. As I said at the beginning, there is the opportunity cost of that money. It is coming from somewhere. It is not coming from the Treasury—it is coming from other parts of the NHS.

Nigel Edwards: If I might amplify that slightly, it is hard to estimate, but we think that around £900 million has gone into social care. Of course, this is only for those people who qualify for social care. Quite a lot of the problems that hospitals are experiencing are with people who end up being self-payers. There has been a slight gap in the logic. There has been a presumption that this is all about local authority-provided social care.

I agree absolutely with John. Our experience of evaluating these types of schemes is that they are quite hard to execute. The Better Care Fund plans have been sent back to clinical commissioning groups at least twice to be improved and redone. From talking to the consulting companies that have been doing the assurance process for those, I know that there is a general anxiety about their robustness and ability to deliver.

Part of the idea behind it has been to see if it will improve the way in which local government and health work together. My observation on that is that, where that is already happening, the Better Care Fund has helped it to happen better. What is less clear is whether, where the health and local authorities do not get on so well, it has by forcing them together made them work better. We have been trying that for the best part of 25 years. On its own, it may be necessary, but it does not always seem sufficient to get that sort of breakthrough in how they operate together.

Q191 Barbara Keeley: For our purposes, it is worth focusing on what the prospects for social care are in the next financial year. You have said in evidence that it is under huge pressure and has fallen by 12% in real terms. Sometimes we use a figure here of £4 billion that has been taken out of adult social care budgets. I do not know whether that sounds like a reasonable figure, but clearly a lot of support has been removed from people in need, with a marked knock-on effect in the NHS. Will that get worse in the next financial year?

Nigel Edwards: Yes.

Q192 Barbara Keeley: I know it will in my area. We estimate that something like 1,000 people in Salford are not going to get support this year.

John Appleby: In some ways, it is hard to see how it could get much worse. Something like 90% of all those receiving adult social care now are in the severe category. You have to be pretty bad and suffering pretty difficult—

Nigel Edwards: There are a few more councils with the ability to raise a few—

John Appleby: Well, a little—

Nigel Edwards: We estimate that we have taken something like 300,000 people out. Social care directors are fond of saying to the NHS, “We have managed to make very substantial savings.” They have redesigned and rethought the way in which some of their services are provided, but, effectively, much of that has been done simply by lifting people out of eligibility. From talking to adult social care directors, I know that the prospects are for that to continue.

Q193 Barbara Keeley: How significant will the Better Care Fund be in supporting social care or preventing that scope from being further diminished? Is it just too patchy to estimate?

John Appleby: I am sure that it will help. As you quoted, the numbers are really big here. This has been happening for some years and the prospect is for another, potentially, four or five years of this sort of squeeze. We commissioned Kate Barker, an economist, to take a slightly longer-term view of some of this stuff, because there is a real danger of being trapped into thinking, “Well, we are coming up to the end of April. What is going to happen? The money is running thin. How do we get from one year to another?” I am not saying that the Better Care Fund is entirely about that, but there is a longer-term picture about how we deal with social care and how we repair some of the damage done over the last few years, to be frank, instead of just passing through money via the NHS budget to local authorities. That does not seem to be a very satisfactory or sustainable way of doing things.

There is a real short-term issue about social care, the levels of funding and whether it is providing the quality of social care that we would expect in this country. Then there is thinking about the demarcation between medicine and social care. We need to try to think about both of those things at the same time. There is a danger of being trapped in the short term and never thinking in the slightly longer term.

Q194 Barbara Keeley: We talked about figures for the NHS, but are there figures that are accepted for what amount of money would be needed really to start to make that difference?

John Appleby: I cannot remember the figures off the top of my head, but Kate Barker’s final report—the commission—produced some reasonable figures, not just on the health side but also on the social care side. It is a little bit “finger in the air”.

Nigel Edwards: I cannot remember what the figure is.

John Appleby: We could send the Committee our figures.

Anita Charlesworth: Can I raise one other issue around the Better Care Fund? The work that the LGA and the NAO have done shows that one of the clear benefits is bringing commissioners together to talk. The thing that worries me is that the evidence of pooling budgets alone delivering either better integration or savings is mixed on this. We need integration on the commissioning side to be matched by a change on the provider side. With the Better Care Fund, I remain really worried about how all this work and better engagement between commissioners is translating into better engagement across the provider landscape. I thought that the NAO report was really worrying on how arm’s length providers still are in this area. That is acute providers, let alone community nursing and the myriad social care providers.

Commissioning in itself does not affect real change. There needs to be change in the way in which care is provided. The Five Year Forward View sets that out, but that is a five-year programme. There is no problem with the idea that, clearly, these systems need to be brought together, but I sense that there is an over-reliance on integration at commissioner level and how much can be achieved through commissioning, and that at the moment not enough attention is being given to providers. The Five Year Forward

View will begin to address that, but it will not deliver immediately. There is a disjuncture between that good work and the money. They are completely disconnected.

Q195 Chair: Before we move on to the next question, can I ask you how concerned you are about the additional costs from the Care Act and whether or not that will further impact on the financial picture?

Nigel Edwards: There was a set-up cost of about £135 million for the Care Act, if I remember correctly. There is another—

Anita Charlesworth: The big unknown is what the behaviour effects are.

Q196 Chair: Presumably there will be people who will become eligible because of the changes—

Nigel Edwards: They are eligible to have an assessment, but the eligibility criteria for actually receiving services are different. Interestingly, quite a few local and health authorities offer a certain amount of reablement free, before charging kicks in. There are also carer breaks and reablement funding, which I think is another £400 million or so. Part of this is bundled into the Better Care Fund, which is one of the reasons why it is quite hard to disentangle.

Q197 Chair: Yes—how much will improve. Presumably there will be many more people who will become eligible because their financial threshold will change and there will be the metering costs for councils.

Nigel Edwards: Yes.

Anita Charlesworth: Yes, but that does not impact straight away. The thing that they do not know is how many people at the moment do not come forward for an assessment because they think, “I am not going to be paid anyway,” but will now come forward for an assessment because, with the metering, it is worth their while, as there is a risk that they will reach the threshold. The people to ask are the LSE, which has been doing a lot of modelling work around this.

John Appleby: Our experience seems to be that the cloth gets cut to fit, as it were. If the budget is not there, the assessment changes. We have seen that in terms of what local authorities are having to do.

Q198 Valerie Vaz: You can carry on, if you want to say a bit more. I start by apologising to you all for the fact that I have to leave at 4 o’clock. I do not normally leave before the end, but I have to go to another meeting.

Can I pick up on what Anita said about the NAO? I think that you have all touched on it. Could you comment on what the auditors said about whether we can get the Better Care

Fund back on track or what needs to be done to improve it—to make proper savings? They said that there is “no central programme team, no programme director and limited risk management” and “no analysis of local planning capacity, capability, or where local areas would need additional support.”

John Appleby: But apart from that—

Q199 Valerie Vaz: Is that a big problem? Can it be put right?

Anita Charlesworth: There is an even bigger problem. The fundamental premise behind the Better Care Fund is, first, that integration is cost saving—

Nigel Edwards: Which it may not be.

Anita Charlesworth: It may not be. It is probably quality enhancing, but Nuffield, in particular, has evaluated lots of work and the cost saving bit is elusive. Secondly, it is that, in essence, those savings can be realised pretty much instantaneously.

Nigel Edwards: And there is cash as well—

Anita Charlesworth: Yes.

Nigel Edwards: It is just productivity improvement.

Anita Charlesworth: Thirdly, it is that you can get all of the costs out of the acute sector immediately. All three of those assumptions are highly questionable. If you were doing this based on the evidence, you would phase it in, for definite. In its report, the NAO talks about getting much more focused nationally on the actual interventions that local areas could do that could unlock some savings. It is not just programme management. I would phase it in. We need much more work on what things people should focus on that might help them. I am sure that then the project management—

Q200 Valerie Vaz: Who would do that?

John Appleby: We are back to the point I was trying to make about thinking in the slightly longer term on this. One of the crucial problems the NAO picks up on—we have as well—is how short term this is. There were plans. They were not good enough, were sent back and had to be done again. It is almost time to look at your watch and think, “Hang on a minute, next year is coming down the line now.” The money will be moved around. As Anita and Nigel said, it is almost assumed that some of this stuff will happen instantaneously—we will stop doing this work here and suddenly up will pop another service somehow to substitute for and complement it. That does not seem realistic.

There seems to be a need for some sort of central command over this. In NHS England, a new chief executive comes in and has another look at the plans. I cannot remember the numbers now, but the NAO talks about quite small amounts of potential savings. I think

that £50-something million is properly identified on the NHS side to pay for the Better Care Fund. That is not enough. We are talking billions here.

There must be a need at the right level in the system. I would guess that that right level has to be strategically, at the national level. That is where the policies come from. Everybody has to play their part at local level as well, but it is a huge thing to organise. We are talking about hundreds of organisations being involved in this. One of the issues I should pick up on is how little or how patchily the hospital sector seems to have been involved in local plans, yet it is absolutely crucial. In a sense, that is where the resource has to be squeezed out of to deal with the plans.

Nigel Edwards: This was done in parallel with the five-year plans that the CCGs were asked to do. It is not at all clear that the Better Care Fund is necessarily that well aligned with their longer-term plans. The real lesson here is that this is not a very effective way of managing large-scale change. The Better Care Fund will work in some places. It may well work in Hertfordshire, but Hertfordshire has had a very long history of productive relations between local government and the health service. Where that is not the case, it will not work as well. We are talking about professionals who are not necessarily used to working with one another and learning new ways of working, different attitudes to the managing of risk and even different definitions of what success looks like. There is a sort of elapsed time required to do that; it is very hard to accelerate. I fear that the Better Care Fund will not work terribly well in quite a lot of places.

John Appleby: It is going to be a real shame, because there is pretty broad agreement—again, thinking in the longer term—that health and social care cannot go down their twin tracks like this. There is so much overlap and interlinkage that we have to think more holistically as a system, yet we have gone off with this sort of “part the way”—and we have not even done that properly. There is a danger that we will fail on this. There will be successes, as Nigel said, because there always are, but there will be failures as well. We will look back and think, “What did we get out of that?” In a sense, it will discredit the general vision towards some more unified system around health and social care.

Q201 Valerie Vaz: I want to move on to another controversial area, which is a figure that we have been given by the Department of Health on reduction in GP spending. We have been given a figure of £400 million, but the HSCIC has said there is an increase. Would you like to comment on that?

Nigel Edwards: We were very perplexed by this, because we have two different sources apparently using the same base data. We have been in touch with the Department to try to clarify it. It appears that the Health and Social Care Information Centre kept some things in that spending that are not counted by the Department of Health, but when you remove those the figures still do not reconcile. You still have the perplexing thing that one source shows the amount of money increasing and the other shows it falling. Getting any sort of reconciliation of that is a puzzle. The response that we have had in reply to our inquiries is, “We need to investigate that.” We will need to come back to you on that when we have got to the bottom of it.

The point that John was making earlier really stands. Whatever the situation, general practice—and primary care more generally—is in a very similar situation to the rest of the NHS. It has had its spending kept very flat. In fact, in some senses there has been a harder limit on general practice than on other parts of the system, but demand, as far as we are aware, continues to increase. In addition to not having a terribly good account of what we are spending on general practice, we have no real-time work-load data at all that are reliable, other than some sample data we are still working on.

John Appleby: From 2008.

Nigel Edwards: There is some sample data; by the way, you have to pay to get access to those. There are no publicly available data.

John Appleby: There are some published for 2008.

Nigel Edwards: When I say real time, John, even by the standards of the NHS, 2008 will not do. There is a real issue here about understanding. We have had anecdotal accounts of general practice being under a great deal of pressure, for a variety of reasons. That certainly sounds very plausible—and people who tell you that feel like reliable witnesses—but we do not have a terribly good information base from which to draw conclusions.

Q202 Valerie Vaz: I will come back on the implications of that.

John Appleby: I want to come back on the GP issue. I have spent the last two months writing a 500-word piece for the *BMJ* about this. The reason that I have taken so long is simply to try to get to grips with the funding of general practice, which is one of the most complicated parts of the NHS in terms of all of the little bits of money that flow into general practice, what they relate to and the extent to which they relate to doctors' incomes rather than a service provided to a patient. It is a complicated world, as you are probably aware.

When I look at the numbers, one thing that strikes me is that quite often people are quoting different years. There was a tremendous increase—about a 27% real increase—over a couple of years around the time of the change in the GP contract. From 2010 onwards, there have been some years with a small real increase and some years with a small real decrease. Overall, it seems to me that there has been a small real decrease in what is called total investment in general practice. You can include or exclude various bits and bobs of payments from that, but it seems that that sort of figure holds up. It has gone down. The number of GPs has gone up per head of population over time, so it is a complicated picture in terms of, “Is it in crisis?” I note that Nuffield's report had a question mark at the end of the title, which is often an indication that the answer may be no. I am prepared to send the Committee this piece, which has gone to the *BMJ* and has some figures in it, if you would like.

Q203 Valerie Vaz: That is great. What are the implications of money to an important front-line service going down?

John Appleby: I am sorry to jump in, but you have to be very careful about saying that the money has gone down. Some of the reasons that the money has gone down are that some other part of the system has taken up providing a service, for example. We were paying GPs to do one thing. They have stopped doing it and the money has gone down, but the service has been provided somewhere else. For example, half of the real decrease in general practice investment is to do with a change in the discount given by the Department of Health to dispensing GPs for being dispensing GPs. That may have cut the profits they make from dispensing, but whether you think that that has had an impact on patients and their care is another matter. I would not automatically assume that, just because the total headline figure has gone down, there is an immediate direct effect on patients. In fact, what may have been affected is GP income—I mentioned that earlier—which has been reduced in real terms every year for the last seven years.

Q204 Chair: Can I follow up on the point? How much have you looked at the extent to which some GP practices prioritise profit share against service? In other words, there are some GP practices that might make a decision that they are going to take a greater profit share and not employ another salaried partner or another practice nurse. Have you looked at whether there is any link between profit share and the level of service or the list size? Are there any data on that?

John Appleby: Personally, I have not done any detailed work on that.

Q205 Chair: In the light of your point about falling incomes, how are you able to get those data? How transparent are the data on what actual profit share and take-home pay GPs are drawing?

John Appleby: It does not get into that sort of detail. The Health and Social Care Information Centre collects—I am not sure how quite sure how—data on gross earnings, expenses and then the net, which is the income before tax of the average GP, depending on the sort of contract they have with the NHS. You can see from that that gross earnings—the money we are handing over as part of this investment in general practice—went up around 2004-05 and has then more or less flattened off. Expenses have carried on rising. Consequently, income has fallen in real terms.

Q206 Chair: You are talking about net income—
Anita Charlesworth: Yes.

John Appleby: This is after expenses.

Q207 Chair: So net income of GPs has fallen for seven years.

Anita Charlesworth: Those data come from the Inland Revenue, which gives the NHS IC confidential anonymised access. As researchers, we cannot access any of that information.

Q208 Chair: You cannot access their net income.

John Appleby: Not people's tax returns.

Nigel Edwards: It is an aggregate figure for general practices. We cannot do a detailed analysis that relates the income to the list size or to the organisation of the practice. That would require a level of investigation we would be unlikely to get consent for.

Q209 Chair: Yes, but there is an interesting point, isn't there, as to what the actual take-home pay is and what is happening to the level of service to patients? Is the response to that that GPs are maintaining income at the expense of list sizes or services? You cannot answer that question, in other words.

John Appleby: At an aggregate level, it looks like GP income has reduced almost back to where it was before the "new contract" in 2004-05.

Q210 Chair: But we do not know whether that is take-home pay. We just know that it is the income to the practice.

John Appleby: No, it is income before tax.

Q211 Chair: But before expenses, in terms of—

John Appleby: No, it is the personal figure, after the expenses in the practice of paying for other staff and whatever it is.

Q212 Chair: We know that that has been falling for seven years.

Nigel Edwards: That position is to do with a change in the number of salaried GPs that we now have.

Q213 Chair: Maybe I am misunderstanding. Are you saying that you cannot comment on it because it is confidential tax information or that you—

Anita Charlesworth: We do not have access to it.

John Appleby: We do not have access to the data at a practice level that would be able to answer a question about how individual practices organise their own internal business.

Q214 Chair: So you can talk about a broad trend but you cannot talk about—

John Appleby: My general point is simply that, at a headline level, I think there has been a reduction over the last four years. If you go back further, suddenly it looks like a big increase because of the new contract and so on. As to whether that translates directly into poorer care for patients, I think that you have to be careful about making that jump.

Q215 Valerie Vaz: I was asking about the implications generally—whether you are able to say what those are, as opposed to whether or not it is poor care.

Nigel Edwards: That is why I mentioned the absence of any work-load data. In a sense, what the GP is earning may be less of an issue than how busy they feel. Anecdotally, you hear a lot of stories—one is always slightly nervous about these—that the work load is going up. I wonder whether the increase that we have seen in GP referrals to out-patients and for emergency admission reflects the fact that practices are feeling under pressure. One certainly hears a lot of people I would regard as reliable GP witnesses telling you about the way that their work life has changed over the last five or six years.

The money may be slightly secondary here. In terms of the overall impact on the system, it is about the ability of primary care to soak up what appear to be quite high levels of demand. However, in the absence of really reliable work-load data—we are hoping to have some sample data—I suspect that they are experiencing similar levels of increases in pressure to the rest of the health care system, which is what one would expect.

John Appleby: Can I reinforce what I was saying about that? We know so much now about what hospitals do. We have thousands of different codes for patients. We know not just how many hip operations but how many of a certain type of hip operation for a certain type of person a particular hospital does. We know next to nothing on the GP practice side, yet we know that there are 300 million-plus contacts with GPs every year. It outweighs any other part of the system in terms of—

Nigel Edwards: And they are more computerised than the hospitals.

John Appleby: They are probably more computerised. This is into care.data territory, but we know very little, apart from sample snapshots. We have quite a lot of information on the cost side, although that is complicated, but almost nothing on the benefit or output side. It is very hard to make judgments about what is happening on the inputs, but what is happening on the outputs? What do GPs feel? How do patients feel? What are they actually doing?

Q216 Valerie Vaz: Presumably because they are like private businesses, aren't they?

John Appleby: That is part of the history. Hospitals have been more part of the state, as it were. They get a circular from the Department of Health telling them to do this and they do it. GPs are not in that realm so much.

Q217 Valerie Vaz: Anita, did you want to comment?

Anita Charlesworth: No, it has been covered.

Q218 Valerie Vaz: This is a personal thing. I have tried to find out who has a figure for GP locums. I have asked the Department of Health and it does not know. I have asked NHS England and it does not know. I have asked the CCGs; I have asked Uncle Tom Cobleigh and all. No one can give me a figure for that. Do you know where I could find that?

Nigel Edwards: No, because many locums are contracted individually by the practices themselves.

Q219 Valerie Vaz: There is a figure floating around, isn't there? The last figure we had was for 2008.

Nigel Edwards: We are back to the same problem—that we seem to look at general practice once a decade. All of those transactions are individual private transactions by GPs as businesses. There are occasions when the clinical commissioning group may give payments. There are other people who pay for locums, for example, to backfill positions. On other uses of locums, I am not aware of any central place where that is collected.

John Appleby: I have not come across any of that.

Nigel Edwards: Not routinely.

Q220 Valerie Vaz: That goes to the heart of what GPs are about, doesn't it—continuity of care? I have a surgery that just has locums. Obviously the money is not going to patients. They do not get continuity of care and do not know the GP they are going to see.

Nigel Edwards: Yes.

Valerie Vaz: Nowhere. Thank you very much for that.

Q221 David Tredinnick: Good afternoon. I want to explore efficiency gains a little more; we have touched on that already. To close the £30 billion gap in funding that is anticipated if no change is made, the service would, among other things, be required to achieve efficiency gains of 2% to 3% net per year, against reported gains of around 1.6% in recent years. Do you think a 2% or 3% net annual efficiency gain is a credible target, given that NHS England has already acknowledged that it is not possible to rely on some existing measures such as wage restraint in the future? I know we have touched on some of this, but I want to get this on the record.

John Appleby: The 2% to 3% NHS England's Five Year Forward View refers to is for the entire NHS budget, as I understand it, more or less. When you start to think about different parts of the NHS, like the hospital sector, that number is going to get bigger. It will not be 2% or 3% for an individual hospital on average; it will probably be more like 3%, 4% or 5% a year, which is more or less what the hospitals have been trying to do over the last

four or five years. To ask for another five years of that seems to me overly optimistic—I mean really optimistic.

Anita Charlesworth: As I understand it, it is 2% for three years and then 3% for the next three years after that. I do not think that in the long run that is realistic. There is a question from the work that was done for Monitor about the scope for some catch-up efficiency gains. There is a whole raft of studies that show, if you look either geographically or at individual providers or different sectors, that productivity varies, as everything in health care and performance varies, and that there is significant potential if you could get everyone closer to the best.

Q222 David Tredinnick: That is Simon Stevens's point, isn't it? He told the Committee that a combination of bringing less efficient providers to the same level as the most efficient and the gains that come from new technology and treatments could realistically bring an efficiency gain of more than 2%. You do not really agree with him.

Anita Charlesworth: No. There is clearly catch-up potential in the NHS. If the trend rate of efficiency is closer to 1% than 2%, there is for a period scope for additional savings from catch-up. There are also things like the PPRS deal that has been negotiated that give us, for a fixed period, some relief from some cost pressures. We have all written endlessly about different aspects of the way in which, when you look across the system, the money is not spent as coherently as possible. There is clearly potential to unlock that.

I would not rule it out completely. Having a go—a really serious attempt to unlock more of those structural efficiencies and the catch-up efficiencies—is unambiguously the right thing to try to do. Putting the resourcing in and having a real plan to try to unlock that must be the right thing to do. The alternative is to say to the public, “We give up. You must not only dig deep but dig even deeper.” The consequences for other public services are potentially profound. However, if we try—I think that backing the Five Year Forward View is the only sensible thing for the health service and the public finances to do, which must mean properly funding it—we need to recognise that it is not a guarantee; it is not a slam dunk. This would be one of the most ambitious reform programmes the NHS had ever embarked on. It is a real reform programme. Those are much more difficult than the normal structural reform programmes that we do, yet we all know that even structural reforms are quite difficult.

Nigel Edwards: A very substantial amount of the NHS budget is, of course, pay—staff. As Anita said, there are things that we can do. The standard management consultant's approach to a hospital in trouble is to say that if you are in the top decile of performance you are more efficient or cheaper than everybody else. Over the years we have found that it is very difficult to get every single service very quickly to that level of performance. You need a very high level of management effort. Many of the service models that we are hoping will produce improved efficiency produce improved productivity—not necessarily reduced cost, by the way, so there is still an issue about things that require extra cash, where the prices have gone up—but require a level of managerial effort and skill that is quite hard if you are busily running to deal with the type of activity increases and requirements for short-term performance that are asked for at the moment.

One of the biggest risks here is that, while in theory this sort of productivity is possible, the question is whether in practice the system has the headroom for it. I am thinking about a little anecdote that might illustrate this. A friend of mine who is a vascular surgeon has redesigned his operating list in such a way that he can do 20% more procedures through that operating list in a day than he did previously, with fewer instruments and at reduced cost. That is one operating list for one particular set of procedures. It has taken him some considerable time and effort and it has to be replicated across his hospital and across the system, very reliably and at very high speed. That requires an investment of time and effort—and, indeed, skill. As well as being a vascular surgeon, he happens to be trained as a production engineer and computer programmer, so he may not be as typical as we might wish.

Q223 David Tredinnick: That is making better use of existing resources—a 20% increase in procedures without actually increasing resources, meaning expenses, other than know-how.

Nigel Edwards: Those sorts of improvements would—

Q224 David Tredinnick: It is a good model, really.

Nigel Edwards: Those sorts of improvements would give you the ability to absorb the very rapidly growing demand driven by ageing and population size and would allow you to treat more people for the same money. However, not all new technology saves you money in health care. There are price rises and we may have to pay our staff more, for which you will need to release cash. That is the bit that is most difficult. We can probably squeeze more work through the same plant. We need 17,000 more beds in the next five years, but we do not need to build them; we can get that figure through the ones that we have. The challenge comes where we need extra cash.

Q225 David Tredinnick: I will ask Mr Appleby and then come back on that, if I may.

John Appleby: Historically, virtually all of the efficiency gains that the NHS has obtained, such as they are, have been through reductions in length of stay of people in hospital and the movement from in-patients to day cases. There will be other examples, like a particular vascular surgeon doing whatever, but, when it comes down to it, what we have done is keep people in hospital for a far shorter time, year after year. We have been able to get rid of some beds but also use the beds much more intensively. That is how we have increased output in the secondary care sector. Whether there is much more to be squeezed out of that—and there probably is—

Nigel Edwards: It is not easy.

John Appleby: If you look historically, there is a rule—I have said this already—that, if something cannot go on for ever, it will stop. There comes a point where you cannot not

keep somebody in hospital. There is a finite time. The issue is whether we could carry on with some of this stuff. That is where the doubt creeps in. If that is not the case, where are the opportunities?

Q226 David Tredinnick: We have been dealing with the supply side issue much of the time this afternoon. We have not talked very much about cutting demand for services. I am surprised at that. In particular, there is the potential impact of the extensive use of personal budgets on the funding. We now have personal budgets that have shown that, if you give patients and their carers control of the money, they actually make more effective use of it, the costs come down and patient and carer satisfaction goes up. Secretaries of State—the current one and the last one—have said that patients have to be at the centre of the health service. It is about what patients are asking for. They may not necessarily want antibiotics; they may want to try herbal medicine, for example, or something else. Are you thinking out of the box? Have you thought through alternatives—different methods of treatment that are not necessarily available on the service—to reduce the cost? It seems to me that the whole conversation is about ratcheting up more money for the health service. I wonder whether the demand side has not been looked at enough.

John Appleby: The Five Year Forward View takes a view on how the public's lifestyle, behaviours—

Q227 David Tredinnick: Obesity, for example.

John Appleby: Exactly—public health interventions and so on. That is clearly an issue on the demand side. As an economist who spends all of his life looking at this, I have heard people talk about how we may go upstream, how we will stop people getting ill and how they will not need hospital services. Well, guess what? We have done some of that, but hospitals are still here. We keep inventing things to do to people and people keep wanting those things. Obviously I am not against trying to do something on the demand side, but I would not pin all my hopes on our being able to reduce demand and find that suddenly we can live within our budget. I do not think that is the nature of health care and health.

Nigel Edwards: There are some areas about demand that are worth mentioning where we know that there are some significant opportunities. One particular one is the care of people in nursing and residential homes. There are 400,000 people in the UK in residential and nursing homes. They have multiple conditions and are often on very large numbers of medications, not necessarily to their benefit. The adoption of a series of preventive strategies—end-of-life planning, advanced care planning, ward rounds and medicines reviews—seems to have a very significant impact on the quality of care, so that we do not get a situation where people who have expressed a wish to spend their last hours in what is their home spending it on an A and E trolley because someone got nervous. There is definitely a big group where we can do something.

We are spending a lot of money at the end of life generally. That is one of the reasons why prevention as a strategy has sometimes been disappointing, because it turns out that dying is one of the most expensive things. A lot of what we do is still quite futile, poorly planned

and inhumane. There are some things we could definitely do there that would improve the quality of patient experience and would save money. I do not recommend that we should sell it on that basis, by the way.

John Appleby: It is about the treatment as well. There is the variation bit. As I said, there is a supply-induced demand, if you like. Not all of that supply is necessarily the stuff that we should be considering.

Q228 David Tredinnick: I have a final question on this. Staying on the supply side on treatment, there are some conditions that doctors find very difficult to treat. I was at a reception yesterday evening, where we were talking about autism. This was for the Society of Homeopaths, which is now regulated by the Professional Standards Authority, and was to mark that occasion. It is producing research that shows that homeopathic medicine can treat autism and be of great benefit. Maybe we could look at that particular well-established treatment service. I know that it is controversial and that there have been attacks on it, but the doctors have been regulated since 1950 under the Faculty of Homeopathy Act.

You can link that to the massive problem of antimicrobial resistance, which the Science and Technology Committee, which I also sit on, has been talking about. There is Dame Sally Davies's book "The Drugs Don't Work". Amazingly, in the last few years there has been a 24% increase in the use of antibiotics by doctors to treat colds and flu, which can also be treated by homeopathic medicine very easily; I use it myself. I wonder whether we are weak on thinking about broadening supply; we have already addressed cutting demand. I will leave it at that. If you want to comment on that, I will hand back to the Chair.

Anita Charlesworth: I would say one thing on that. One of the things we should be very proud of in our system is NICE. One of the positive things about the NHS reforms was the remit to NICE to develop quality standards. Whatever we do in the system, if we are going to spend more on health care—history and all international comparisons that come out would suggest that, over time, we will spend more on health care—the most important thing is that we derive real value from that, really embedding the approach of ensuring that we have consistent adherence to quality standards. That quality standards of treatment are well evidenced and embedded in our system can only be to the good.

I worry a bit in all of these conversations that the potential power of NICE and those quality standards is not being followed through and that they sometimes feel a bit disconnected from some of these debates. I do not think those things will stop us spending more money—I agree with John on that—but from a macro-economic point of view and, more importantly, a moral and social point of view, it is absolutely imperative that we get value from that and strengthen that element of our system.

Q229 Chair: Do you think it would be money well spent to invest more in NICE so that it could do more of these kinds of appraisals of evidence-based and value-based approaches?

Anita Charlesworth: Yes. What worries me is not so much that NICE is not resourced to do that but that you do not see the resourcing and how that wealth of guidance, advice and expertise flows through into commissioning and providing. It comes back to some of what Nigel said about the managerial capacity and the whole improvement architecture in the NHS. That is really where you worry about the disconnect. The skills and the capacity both to understand and to implement the change that is implied by that do not seem to be there. It is more the pull-through that concerns me. There may be something about the pace of those quality standards.

John Appleby: I wonder whether there is a parallel NICE for health policy. NICE's remit is restricted to health technologies—drugs, public health measures and those sorts of interventions. Health systems—we have experienced this—are subject to other interventions that also have costs and benefits. One of the things we have not been good at in the past, perhaps, is assessing those in an independent and objective way.

Chair: I am conscious that a number of members of the Committee have to leave at a later point. Robert, would you mind if Andrew George came in next? Is that all right? Are you happy with that?

Robert Jenrick: Yes.

Q230 Andrew George: On the issue of integrated care, I was very interested to see that Kate Barker's commission report came up with the message, once again, that greater integration is clearly desirable. I am not aware of anyone producing any reports arguing that greater fragmentation is desirable, unless you are aware of that. That is not a facetious point. It seems to me that there is a unison of opinion across all parties. Unless I am missing something, it seems that everyone is saying that the more integration—

Nigel Edwards: As an approach to managing the population, and for certain populations, there is still a certain element of treatment that is episodic, where continuity is not that important and where choice, value for money and convenience may trump continuity. The NHS has a bit of a tendency to assume that we have one tool in the box, but there is quite a lot of care that we provide where—

John Appleby: The opposite of integration is not necessarily fragmentation. It could be specialisation, for example. We quite often need specialisation to be efficient. However, your main point is that there is agreement.

Q231 Andrew George: Yes, particularly on the interface between health and social care. Leaving aside the argument about whether certain services should become more sub-specialised, for good reasons of clinical governance, I am sure, or for other reasons—advancements and so on—and just dealing with the interface between health and social care, it seems that the theme is pretty well developed across the UK, certainly within the health and social care economy in England, that that is desirable. You are looking quizzical.

Nigel Edwards: There is one important thing that is worth saying. In many cases, an interface that is as important, if not more important, is that between the specialists—what one might describe as the medical “ologists”—who look after chronic diseases like diabetes and respiratory medicine and the GPs. There is a great deal of scope to improve the management of those diseases. The model we have at the moment, where the consultants are up at the hospital and have a clinic, unlike DC models where GPs and hospital specialists work very closely together on disease management, may have a bigger impact on cost and effectiveness than the health and social care interface. We have tended to avoid that because of the status of GPs as private businesses and because they are quite fragmented, but there is a growing and very rapid trend for GP practices to become bigger or more federated, which provides some very interesting opportunities to break down the traditional barrier between the hospital consultant and the GP. When you think about integration, it is very important to think about integration within the health system, because that is quite fragmented, too.

Q232 Andrew George: That is helpful.

Anita Charlesworth: More and more of the case load of the NHS concerns multiple physical and mental health needs. I would argue that the interface with mental health services is absolutely fundamental as well, although it is not talked about. Many of those people will then experience frailty and social care. They do not want to be treated as body parts; they really need to be treated as whole human beings. If you are living with conditions as opposed to experiencing an acute episode, holistic care means thinking about not just your medical functioning but your whole life functioning. All of that is a growing area of the business of health care. The imperative for quality is clear.

There are then two things that are disputed. One is, if you co-ordinate all of that better, does it save money? In the review, Kate Barker said that it probably does not in the short term, but it may do in the long term.

John Appleby: There have been some evidence reviews. I think that the answer is no-ish.

Anita Charlesworth: Yes.

John Appleby: That is not a reason not to do it.

Anita Charlesworth: That is right. There is still quite a bit of debate around the financial case for integration. It may be quality enhancing and may just be right for changing health needs, but, as a money-saving device, there is debate. The second area of debate is, if you need more co-ordinated care, do you need integrated organisations? Sometimes that is a debate that is conflated. The Five Year Forward View was quite good in saying that there may be many different ways to achieve integrated care. Often integrated care has been—

Nigel Edwards: The evidence is that organisation is a second-order issue.

Anita Charlesworth: Exactly, but sometimes in the debate they have been conflated.

Q233 Andrew George: That is extremely helpful, but can I focus in more on the interface between health and social care specifically and what appears to be—Kate Barker identified this—a lack of alignment in terms of entitlement, as it were, depending on which side of the dividing line you are on in relation to health and social care? For example, the proprietors of nursing homes tell me, “20 years ago, they all had their cars parked outside.” Now, if you talk to the nurses who work in that sector, they say, “I used to work in the acute sector or the community nursing sector. These were patients we were treating in our hospitals. Now they are in our nursing homes.” There appears to be a process of cost shunting from health to social care, where, basically, private individuals are picking up the tab. If we are going to have a single budget, how do we formulate going forward to make sure that we know when the state’s responsibilities end and the private individual’s begin and that we have consistency in the management of that?

John Appleby: Those were exactly the sorts of questions Kate Barker’s commission was trying to grapple with. The answers are not immediately obvious; they are difficult. The King’s Fund is going to do some more work around the detail of some of the things that Kate and her commissioners suggested and recommended. For example, how would it work to have a single commissioner of health and social care? Would it be efficient? How do you set it up? Haven’t we had enough reorganisation? There are lots of questions that you would want to ask about that sort of thing.

You talk about the transfer of care, in a sense, out of one setting and into another. Of course, that has happened. I mentioned length of stay in hospitals and how historically that has gone down. It is not necessarily that people are any fitter; they have just moved to a different location, which is their home. We have different ideas about how long women should stay in for maternity. You would be lucky to stay in for a day or two now, but 20 years ago it was two or three days.

Things in medicine have changed. That is not necessarily a bad thing. How we cope with that, if it is moving directly into the private sector and out of pocket, raises issues of, “Is that what we want? Is that how we want to pay for this stuff?” All that I can say is that the Barker commission tried to grapple with some of those bigger questions. Part of the solution is more money for social care, frankly. Part of the solution is to amalgamate budgets, where it seems the right thing to do, but I take Anita’s point that you must not assume that suddenly everything will be fine if you simply do that.

On amalgamating management, just look at any hospital. Nigel once memorably described them as small industrial estates with lots of small businesses. We may think of them as one integrated organisation, but often the reality of day-to-day work is nothing like that; it is something different. How you get integration to work on the ground for the benefit of patients is a very tricky thing. It is going to take some working on.

Q234 Andrew George: Do you think, for example, that continuing care is consistent across the country?

Nigel Edwards: That is a big issue. Even with a single budget, there is still the issue of who is taking responsibility for a particular person and what is a social care need. We now have a bit of a legacy issue of people feeling that they have been unfairly denied access to

NHS funding for continuing health care. Effectively, this is an uncapped budget with a long tail, because people—particularly younger people with early onset dementia—may have a very long period in a nursing home environment. You are opening up a long-term liability. There will also need to be an assessment of elements that have to be paid for by individuals. We have a single assessment process. I am not aware of its reliability and consistency between areas being investigated, but anecdotally one hears that there are significant and slightly worrying variations in the consistency with which that judgment has been made. Do you know of any research in this area? It is certainly something we would be interested in.

Q235 Andrew George: It appears to me that continuing care entitlement has been pared back to a point where you have to be virtually on the verge of death to be entitled to it, and, on the other hand, as soon as you can breathe for yourself you are discharged from hospital, so I am not sure there is much more slack.

Nigel Edwards: It is very variable. If you look at the use of nursing homes by the NHS across the country it is extremely variable, and to some extent driven by supply in fact.

Q236 Andrew George: So it is variable.

Nigel Edwards: Bournemouth has a very high rate and Newham has a very low rate. To some extent, that reflects the availability of nursing homes. There is a group of people for whom home care is an option rather than nursing home care, but it is not necessarily a cheap option. It is not immediately obvious, looking at the differential rates of utilisation across the country, that we know what the right rate is or why the rate varies as it does.

Q237 Andrew George: This is my final question, I promise. If you came to a position where you had a single budget in terms of health and social care—a single commissioner—would not that separation out, or definition, of what is continuing care and what is social care make it much more difficult for the commissioner to say, “Sorry, but you have to go and talk to our social care partners”?

John Appleby: Difficult in what sense?

Q238 Andrew George: I mean difficult in terms of entitlement to state support if the commissioner of the services is the same body.

John Appleby: There are certainly issues around means testing, and that is one of the things the Barker commission raised. If you are paying for these things in different ways, one out of taxation and it is free at the point of use, and another a means test, that gets a bit complicated. You can overcome this sort of thing; you can change the rules, I think, and deal with that.

Q239 Andrew George: If the work of community hospitals was transferred to, say, nursing homes, in a sense you are kind of cost shunting it the other way, are you not?

John Appleby: As I say, if you look at any hospital, which in a sense is an integrated organisation by definition, you will find that not all the departments necessarily work smoothly with each other, or they could work better. Simply putting things together is not the only answer.

Nigel Edwards: To support that, we do see examples where social service authorities and health manage to operate a system where there is not internecine bickering about who is taking responsibility. It is possible to do that between agencies. Likewise, creating integrated services, as in hospitals, does not necessarily remove the opportunity because there is still this question of there being a self-payment component. The short answer is that it does not solve all of the problem.

Chair: Thank you. Robert?

Q240 Robert Jenrick: We have talked at length about the Five Year Forward View and potential shortfalls that you have discussed, and how we might be able to mitigate that. I know the King's Fund have said that it may be £8 billion by 2020 that the NHS needs. Have you made any longer-term forecasts maybe at 10 years or 20 years? We all understand why a five-year forecast might make sense politically, but is that a sensible period to be looking at the future of the NHS?

Nigel Edwards: Beyond five years it gets quite difficult because there is so much uncertainty, partly because of the patterns of demand. We understand only some of the drivers of the current demand. We can explain only a certain amount of the big increase in emergency admission, for example, by factors such as population change.

John Appleby: We have to take a much longer view. We have to take, obviously, five years for a whole variety of reasons; we have to be looking at next week and the year after and so on. We have only occasionally taken—in fact only once in recent history with Derek Wanless—a 20-year view and at least tried to grapple with it. As Nigel said, beyond 10 years things look very hazy indeed. You cannot be precise, but you can start to have an idea about where there are big trends going in terms of population. It is also a way for Governments—and not just Governments, but society—to lay out their ambition about things. Where would we like to be? We may not actually get there, but where are we trying to aim? The integration of health and social care is an aim on the table which most people sign up to. There are lots of problems with how we get there and over what period. I would say, yes, at least 20, if not 50 years, to think about what sort of health and social care system we would like.

Anita Charlesworth: I will develop John's point in relation to the Wanless review. I led the team that worked with Sir Derek on the Wanless review. There are two things that are important about taking a longer time horizon. Partly, there is a strong sense that boom and bust is in itself a very inefficient way, and, almost certainly, Wanless gave too much too early and we are now cutting too much. Given the nature of lumpy fixed costs and the difficulty of making change in health care for profound underlying reasons, if you are

going to get a system which is able to sustain improvement, giving the system challenging but realistic budgets with some certainty over time is likely to deliver you a more efficient system long term than the sort of approach we have historically had. Whenever we constrain funding, we then splurge and then we constrain. It is not a sensible and coherent way of running a health care system.

The other thing, of course, which that longer-term look does—however imperfectly implemented it was in Wanless—is that it gets you to think rather more about what could really unlock some productivity improvements and value in health care. Wanless was absolutely right that the digital age and information technology would be fundamental. It was poorly executed, but we are still desperate in health care to catch up with many other industries and unlock that potential. We will not do that unless we think about that with a reasonable time proviso.

Q241 Robert Jenrick: That was one of the follow-up questions I had, because obviously every other industry that is taking even a five-year view, but certainly a longer-term view, would be looking more at IT than we seem to from the conversations we have around health care spending.

Anita Charlesworth: Absolutely.

Q242 Robert Jenrick: Is that something that any of you have given time to, to think about?

John Appleby: Unfortunately, the NHS does not have a brilliant history when it comes to IT. Maybe it is just the way it has approached it in a rather top-down way. There is fault on both sides, I suspect, in terms of the tech companies as well as the NHS. I would agree with Anita that there is a tremendous amount that could be done with technology with health care at a personal level as well as at an organisational level. It is a tricky thing to know how to provide that spur to innovate and so on. We see it in some industries. We do not see it in all private industries by any means. All industries and sectors can get bogged down and find it difficult to innovate, and then along comes some idea or a new firm, and things change.

Nigel Edwards: As to the estimates done by one of the large consulting firms of the potential impact, I have to say that some of the modelling assumptions are pretty optimistic and make the standard error of assuming that the full cost savings are achievable, but they are in the 2% to 4% bracket, which is not quite what one might hope for if you look at other industries. This partly reflects that there is a certain irreducible labour content; there is a whole set of tasks that are not that amenable to replacement with technology. We can improve the effectiveness and accuracy of diagnoses in primary care or the speed with which lab results come back, and there are some specific examples such as the reading of cervical cytology slides and the like where computerisation can give you double-digit improvements in productivity. But there is a certain irreducible content to the human contact of caring for a frail older person who needs getting out of bed and

assistance to the toilet, which at the moment is not amenable to technology in quite the same way.

The results of the digital revolution are often more around convenience, accuracy, safety and improved decision making, with some cost reduction, and perhaps some ability to make the labour force a bit more effective. But as to seeing it produce very substantial cost savings, many of those figures look like they are double counting some of the savings which also are attributed to improved co-ordination and integration because that is often what they are connected to.

John Appleby: Long-term cultural shifts are where the movement will come actually. We will suddenly find—not “suddenly find”, obviously, by definition—over 30 years that my younger kids are going to be doing things and will be happy to interact with the internet in a completely different way in terms of their health than I would be. Whereas I would like to have face-to-face contact and have that labour interaction and so on, they are happy to take some advice in a different way. It is not just the “tech” bit of the technology; it is the user bit of the technology as well.

Q243 Robert Jenrick: Do you think that the NHS is taking that seriously or do you think they are scarred by past events to such an extent that they are not interested in them?

Anita Charlesworth: Can I give a gloss on that? The work of the Commonwealth Fund and also one of the management consultancies that did some work on capital spend here both suggest that it is not that we do not invest in IT. In fact, we have quite a lot of IT compared with many other countries and other health care systems. Where we have underinvested—if you looked at other industries, they would have invested—is in the support given to people to get the value out of that investment and the changes in working practice. You drop IT in, and in and of itself it does not deliver benefit. It needs to interact with either a change in patient and user behaviour and/or a change in the service provider’s behaviour. Those changes need to be designed, and in health care they probably need to be more designed than in many other industries where they can just evolve. That bit, that linkage in with our business process redesign—to be techie about it—is the under-resourced bit, I would think, and why it is such a shame that we have invested in the kit but not realised the full benefit.

Q244 Robert Jenrick: Thank you. Can I ask you one more question, and it is a large topic and difficult to cover in the time we have remaining? The Barker commission, as you will be aware, ruled out increasing the range of charges, because they felt that the sums involved were relatively insignificant for the turmoil that might cause, or moving to an insurance-based system, because, again, that is a systemic change to the entire NHS and the way we perceive it. But, taking that long-term view, what is your opinion on that, if we were to look forward not just five but 10 or 20 years and consider where health care spending might be at that stage? Is it sensible to rule out either of those two options at this stage?

Nigel Edwards: Social insurance, if you look at the European systems, is a compulsory deduction from payroll, which sounds a lot like a tax. The evidence that the competing

insurance models in the Netherlands and Germany give you an edge in negotiating with providers that drives efficiency is not at all convincing, it has to be said. Of course, the other issue with insurance is that it narrows the contribution base so you are only taxing income on employment. What we are finding in many of the social insurance systems now is that they have very substantial contributions with direct Government subvention via tax. We do not need to rehearse the arguments on charging, but it is not a very efficient method for raising money and it is a rather blunt method for deterring demand. That is more often how we see it used in a number of other countries; it is a way of shaping, almost, patient behaviour by getting them to follow particular paths.

The administrative machinery for collecting it should not be underestimated because, generally, if the money is worth paying, you have to cap people's expenditure and/or have reimbursement and a variety of other systems to reduce people's exposure to catastrophic charging. If they become substantial enough, you get a co-insurance market which entirely wipes out your attempt to shape consumer demand because people are then insured against the charges. In other words, it is a lot of work for not that much money, with rather uncertain benefits, some of which will be unintended and probably undesirable. But I would not rule it out. What one might think about—

Q245 Robert Jenrick: But is it your recommendation then that we stay in the current system?

Nigel Edwards: If you look at what WHO say on this, that is their general advice: if you are not doing it, probably don't do it. There might be some things around prescription charges. I thought the Barker commission had some interesting things to say and John might talk about that. Also, there might be some ideas, in the longer term, for things like continuing health care, which are definable risks, that you could move to a defined benefits system with co-insurance. Effectively, you are just deciding to collect the money you are spending in society through different routes. The bigger choice is, "How much do we want to spend?"

Anita Charlesworth: There are two things from me. From a macro-economic point of view, people get terribly exercised that health spending is going up and we cannot afford it. If you take the OBR or the OECD projections out to 2060, we end up with shares of GDP which are similar to countries across Europe that are already spending that level and their economies function perfectly acceptably. The macro-economic issue is not, "Are we spending 10% or 12%?" It is, "Are we extracting every pound of value from that?" The drag from a macro-economic point of view is if you have sectors that are not productive. The OECD also did some work back at the end of the last decade that suggests that, if you are worried about the productivity of your system, there are more productive social insurance systems and less productive ones; there are more productive tax-based systems and less productive ones. There is no sense particularly that, if you are focused on improving productivity and value in your system, you would look to how you pay for it as a first port of call, and when you add in the degree of upheaval you definitely would not go there first. It would not be driven by economics. There may be political debates to be had about it, but it would not be driven by economics.

Q246 Chair: I have a follow-up point on that because it is a question the public feel quite concerned about. Are any of the panel aware of any new top-ups or charges that have been introduced since the Health and Social Care Act? It is something that there is a lot of heat about, so it would be nice to answer that question. Are any of you aware of any new charges or top-ups?

Nigel Edwards: The introduction of charges is reserved to the Secretary of State. There have been a few cases over the years where individual people have tried on a charge for an evening antenatal class or for surgical appliances that are not in the schedule, and I believe that is ultra vires.

Q247 Chair: But in terms of any evidence that that is happening, because there is a lot of heat that suddenly we are moving to a US-style system where everyone is having to pay for treatment, you are not aware of any charges or top-ups.

Nigel Edwards: There is, I suppose, one area. It is not really a top-up, but there are quite a lot of areas of the country where, if you present yourself to a GP with something that needs physiotherapy, you may well be advised to go privately.

Q248 Chair: Yes; so being advised informally, but again that has happened for a long time.

Anita Charlesworth: Similarly with orthodontics. “The waiting list is two years, by the way, so you might want to consider...”

John Appleby: Just on where we get the money from, how we take money out of people’s pockets to pay for this is what we are talking about here. We have a general taxation system which is mildly progressive—only mildly; the rich pay proportionally more than poorer people on the basis that a pound to a rich person is worth less than a pound to a poorer person, so that seems to fit morally and ethically with what we think about how we should fund these things. I agree with Nigel that all the advice is to stick with the system we have for a whole range of efficiency and equity reasons. The one thing I would raise, apart from the prescription charges, is that Barker has made some suggestions around looking at that and we have not yet formed a view as the King’s Fund about it, but we will have a look at that as well and there may be something in that.

One of the things that other people have talked about is what about a specific NHS tax, for example? Over time, could we tap into people’s love of the NHS, perhaps their willingness to pay for health but their unwillingness to pay taxes for other things, by more readily identifying what they pay with what they get in terms of the NHS? It has some appeal, but the big issue it still leaves on the table is the decision about how much to spend on health care. Of course, somebody somewhere in the system is going to have to set the level of the tax which provides a certain pot of money for health care. It does not get round that difficult problem we have been discussing of whether we are spending enough. If we are not, how much more should we spend, not just next year but over the next 50 years or

whatever? I can see the appeal of that sort of specific hypothecated tax, but it does not address a really difficult problem, which is in the end a political problem about how much budget we should devote to the NHS.

Q249 Chair: One of the proposals from the Barker commission was to have 1% national insurance on wealthy pensioners. Is that something that—

John Appleby: We set up the commission as an independent commission on purpose, so we will be looking at their recommendations in more detail and doing a bit more work around some of the more tricky areas such as a single commissioner for health and social care and producing something in due course—not very long.

Q250 Chair: Is it possible to know approximately when that will be produced? Would your appraisal of it be produced in time for the end of this inquiry? Kate Barker is coming to give evidence here, but we wondered whether the King's Fund's work—

John Appleby: Your inquiry, no, I do not think so.

Chair: Thank you. We probably need to move on and we are coming next to Barbara's questions.

Q251 Barbara Keeley: You may have touched on this in part, and you have certainly all given evidence about it. It is about how organisations in the current pessimistic financial position and dire situation they are in will be able to make innovations and test new models. The current financial situation predicates against that. They are in that precarious position and it is pretty dire, but what is the best way to fund innovation to make sure that it happens and not just that you get transfers in to shore up the direness of the finances?

John Appleby: Thanks for looking at me. That is a very good question but really difficult. I do not know what the answer is on that one; it is a very tricky one. We have said in some ways that, clearly, trying to do things in a very short-term way is not going to work. The effort involved in making some of these changes—we are talking about some big hospitals in London which are billion-pound businesses, with thousands of people employed—changing the way they work with primary care, local authorities, their patients and their communities, is no mean undertaking. We talk almost blithely sometimes about transformational change—and I almost did the inverted commas there. It is really big change. So time is one issue. Quite often up-front money is what is needed, and NHS England is now talking about a transformational fund, as yet unidentified in terms of its scope and size. I will identify those two things.

Nigel Edwards: The first issue with this being run by an arm of Government bureaucracy is that this is inherently a risky business. If you are running these sorts of change programmes in a commercial setting, you would expect a significant number of them to fail: people would try things out and you would almost have permission to fail; in fact, if

you were not failing, you probably were not being ambitious enough. But I guess we suffer slightly here from a culture of risk aversion, and the sort of portfolio effect that you would have in investing in a wide-scale set of changes across a system is not available to you if every single item of your portfolio has to succeed.

The second issue related to this is the headroom of the clinicians and the managers. The improvement skills required to do this, and the space and time needed to be able to take a step back and do the type of redesign of the operating session I was describing earlier, are quite difficult when people feel that they are on something of a hamster wheel. Buying people some headroom and time, giving them skills and the capability to do it, allowing them to try things out and to move to a model that is more about rapid experiments rather than big projects, is probably where quite a lot of the answer lies.

Anita Charlesworth: The Health Foundation and the King's Fund jointly are doing a piece of work between now and next summer to try and develop some more concrete proposals around a transformation programme. If we look back to where we have not delivered before, we need to bring all these things together. We need to bring financial support, which enables people to double run; we need to bring time; we need to bring some kind of framework that gives people permission but has due safeguards, as this is public money and public service, and health care is serious stuff; and, also, the skills and support that they need. Those things are not going to come together if we just wish it. It is going to be a very different way of working. Whatever happens after the election, if the Five Year Forward View is to have any chance of success, it will need a different approach to change and implementation from the traditional one that we have had in the NHS—and we are going to look at some case studies of other countries, other changes. We have delivered wholesale change in the NHS before, and the movement of people out of long-stay mental health institutions into the community shows that we can deliver.

Nigel Edwards: Although Enoch Powell made the speech in 1961 and the first institution shut in 1984, so don't hold your breath.

Anita Charlesworth: Indeed.

Q252 Barbara Keeley: If I could just add, I was in local government and involved in social care years ago, and that happened at a time when social care budgets were much more substantial. We covered fair, moderate or even lesser needs than that. People used to have all kinds of services that they do not have now.

As a final comment, do you think there is a problem with capacity in local government where this integration work involves bringing social care in together? Not only has my local authority had to cut services to pay off £100 million but it has had to lose staff, particularly senior staff, who are the sort of staff that might do strategic work of this sort. Clearly that is not going to be even, though, is it, because not all local authorities have lost as much percentage-wise?

John Appleby: I do not know the details in local government but I can well accept that the pressure to work within shrinking budgets has meant that all areas of staffing have

suffered. Certainly, these things have to be managed; they do not happen by themselves and you need people with experience, and often local experience as well, to see some of these projects through successfully.

Q253 Barbara Keeley: It might be worth looking, as you look at it, at what the capacity is.

Anita Charlesworth: The skills and capacity. It is both managerial skills and then also clinical leadership. All these things need to be aligned, and they are not areas that we have invested in and supported systematically through the system. It is very patchy. Often what we observe at the Health Foundation is that you can now point to some acute hospitals that do have some critical mass here, but how well connected in are they in primary care? If it is hard in a hospital, which has scale, to think about doing this in primary care and in social care, which is so fragmented into small organisations, and bringing all that together and aligning it, will be a very significant undertaking. But then you have to say, what is the alternative to trying? We have to have a jolly good go at this, don't we?

Q254 Chair: Continuing the theme of transformation, one of the issues that was identified in the Forward View was property assets and whether they could be used as part of that transformation fund. Have you, as a panel, formed a view of how much would be available from that source, how long it would take to access it and how realistic this is?

Nigel Edwards: There are wildly different figures—everything from £1.5 billion to £7.5 billion. The £7.5 billion, which you quote in your evidence, actually includes underuse. One of the problems at the moment is that this is probably not a good time to be selling property. One more imaginative solution that I have seen is whether the NHS should set up an endowment fund and issue social investment bonds backed by property, and use that property more strategically—for example, to deal with housing and community development. So, rather than selling the family silver always, an idea would be to use it in a more imaginative way that would then allow you to fund an investment fund that was run more like an investment bank with a portfolio than a bureaucracy worried about Margaret Hodge and the Public Accounts Committee. So there is a bit of a risk.

As to the state of property management in the NHS, we ran a round table for people engaged in property management across the NHS. It is very clear that there is a real issue about skill and capability to get good deals on property, to think strategically about how it is used. There is a significant risk of thinking in the short term “We have to balance the books,” and selling property, and without leverage and the full advantage of it. We may not even be getting the best value from it and not thinking strategically about the whole public sector property rather than just the NHS property. Increasingly, we should be thinking about putting quite a lot of health services into local government property or into schools, and vice versa indeed.

Q255 Chair: So this is across the public sector.

Nigel Edwards: It is across the public sector.

Q256 Chair: Do you think it is realistic to be able to guarantee that that money goes into transformation rather than just being sucked into filling an end-of-year deficit?

Nigel Edwards: At the moment one of the problems is that it goes back to the Treasury, though not for foundation trusts, of course.

John Appleby: It depends on whether they are foundation trusts. The other issue about asset sales is that when you look at who has the assets it is very variable across the country. If you are—let us pick a hospital at random—the Royal Free in north London, you own property, in an area of London, which is of extremely high value. If you are somewhere else, it is different. I am sorry to be expanding on Nigel's point, but, if we are going to look at it, of course the NHS should use the minimum amount of land and buildings that it needs to deliver whatever care we want. That is an aim, and if we have too much land and buildings then we should be using them in some other way. But simply to think of it on an organisation-by-organisation level is wrong, it seems to me, and inequitable, but also maybe even as a sort of NHS versus local authorities, versus education, and so on. There is a bigger picture here about land and buildings.

Nigel Edwards: It is lack of skills. One of the things that very much struck me about this round table with people from the private sector was that imaginative ideas about how one could use the property in different ways have been largely lacking in the way that we have thought about it in the NHS.

John Appleby: Rather than simply selling it off.

Nigel Edwards: Yes, rather than just selling it off now quickly to make money to balance an in-year financial problem. There is a significant unexplored opportunity here. Exactly what it is I cannot yet tell you because we are thinking about it, but we have under-exploited this and the NHS is not well placed at the minute to deal with it. There is this thing called NHS PropCo, but there is a general anxiety that it is overwhelmed by the complexity of its task and, again, it does not yet quite have articulated a strategic approach to how it might deal with this property; and, of course, all it has is redundant property from primary care trusts that was declared redundant. It does not quite give you the full leverage it could do if you were to rationalise health care and local government property across the geography.

John Appleby: There are some interesting examples, though, in London, in terms of the academic health science centres and so on, where you have big hospitals coming together with elements of private industry, universities and so on. Some of the chief executives on the NHS side just think of themselves as property developers—one in particular that Nigel and I both know. They are dealing with these big, very expensive buildings, with lots of very expensive equipment in high-cost areas of cities. So there are some interesting examples of where the NHS is not simply selling off. It may even be buying some land to do some things.

Q257 Chair: There are some interesting examples, but I am not sensing that there is a great deal of optimism about the possibility of this closing the gap.

John Appleby: It is a one-off, isn't it?

Anita Charlesworth: It won't close the gap.

Q258 Chair: In terms of investing in system change that would close the gap.

Anita Charlesworth: But it is important—and we are going to have a think about this in our work programme—how we think more strategically about the asset base and whether or not we can realise more of that value to support change. Of course one of the problems in doing that is that that will be a one-off capital receipt. When you look at successful change they may need some capital, but, probably, of the spending that would be needed to move forward with the Five Year Forward View, a bit would be capital but more of it will be revenue. It will be periods of double running, investment in people's change skills and in giving people time and headspace to develop new models, and retraining the work force to work in different ways. To unlock these assets and use that one-off asset in a way that helps the NHS to get on to deliver the sort of vision in the Five Year Forward View will be very difficult, but it definitely will not be done unless there is a systematic and strategic look at it.

Nigel Edwards: You are thinking too narrowly. It is not just about a way of funding transformation: it is the opportunity to use it to change care models in quite different ways as well—for example, under-exploited use of extra care housing to facilitate early discharge from hospital, the creation of a sort of village model of mixed use, as in Henley, with private residential, extra care housing, nursing home and residential home, community hospital and general practice on the same campus, with the ability to flex the capacity between them. There are much more imaginative ways of—

Chair: That is more of an imaginative way of using that released asset. Thank you very much. I am going to come on now to Grahame.

Q259 Grahame M. Morris: Last but not least. I want to ask you some questions relating to the terms of reference of the Committee looking at public expenditure but looking at the extent to which patient care and support services are provided by, first, NHS bodies and, then, non-NHS bodies. The reason that the Committee would like some clarification is that we had Simon Stevens at the Committee last month, and he and the Department of Health said that around 94p in every pound the NHS spends goes to NHS providers, the assumption being that 6p in the pound goes to non-NHS providers. However, both the King's Fund and the Health Foundation suggest in written evidence that the spend was over £10 billion, which is a rather higher figure. What are your thoughts on that and why the discrepancy?

Nigel Edwards: That is the figure in NHS England's accounts.

Anita Charlesworth: Yes. The £10 billion is spending by NHS bodies on non-NHS providers. That is independent sector, voluntary sector and local authorities. I do not know if what Simon Stevens was referring to was the independent sector bit exclusively within that, but for non-NHS providers as a whole, which is those different categories, the NHS accounts and the Department of Health accounts—it is in both—are absolutely clear that it was £10.2 billion last year and it has been increasing towards that steadily for at least five years.

Q260 Grahame M. Morris: I do not think Simon Stevens made that differential about the independent sector. He was simply saying 94p in every pound is spent with NHS providers directly. Presumably, the rest is everything.

Anita Charlesworth: I do not know.

Q261 Grahame M. Morris: You cannot answer; I understand that. You have touched on my next point then. I have just been reading that there is an announcement that Sir Richard Branson's Virgin Care group have finalised a £500 million five-year contract to provide a variety of community health services in Surrey. According to the figures that you have presented in written evidence to the Committee, as you have mentioned there, you have said it was £10 billion—these are to non-NHS providers—in 2013-14. Is the trend that that is actually increasing?

Anita Charlesworth: Yes. It is worth saying that from 2008 to about 2011-12, following on from the choice policy and any qualified provider in 2008, there was a big increase in—

Nigel Edwards: The big one is transforming community services.

Anita Charlesworth: Yes, I was going to come to that. There was a big increase in NHS patients choosing independent sector providers for elective care. What we are seeing from 2010 onwards is that that is kind of stabilising. The big growth area now is community health services. Now, £1 in every £5 of NHS community health services is spent on non-NHS providers. Some of that, though, is this transforming community health services, where community health services that were previously provided by PCTs have become social enterprises or other services and then, obviously, there is some tendering. I cannot disaggregate from the data what the contributions of those different factors are.

Nigel Edwards: Where we are in the cycle now, a number of those are due for re-procurement. As to the rules on procurement, there is a general feeling that the clinical commissioning groups are somewhat nervous about the decision as to whether they should market test or whether they can roll contracts on or just continue with an existing contract. The tendency is for risk aversion that infests the system. The advice they are getting is tending to suggest very often that they should re-procure, even though the contract lengths have been quite short. So we will see more of these types of deals. Alongside that, there

has been a little growth in interest in innovative contracting models for long-term contracts, which is why we get £500 million. That is £100 million over five years on average.

Q262 Grahame M. Morris: £100 million a year.

Nigel Edwards: Yes.

Q263 Grahame M. Morris: And the key hospital in Cambridgeshire as well.

Nigel Edwards: Yes. We will see the elderly services model in Cambridge, musculoskeletal services in a number of places, and very big experimental procurement for logistics and what is effectively supply chain management of cancer services in Staffordshire, alongside lots of very small procurements as well. This is a very mixed picture, but the general trend is that it is likely that this market testing will continue. On the whole, the independent sector—the private sector as opposed to the charitable sector—is better placed to respond to these very clunky, labour-intensive, very high bid costs procurements that are being done. You expect the graph that is shown in the evidence to continue in a gentle upward trend at the moment.

John Appleby: It will be gentle, I think. One other area is mental health—I do not know whether we mentioned that—which has grown, and I am not sure of the time period, over 10 or 15 years.

Nigel Edwards: It has been a much longer period because in mental health the private sector largely moved into areas that the NHS did not seem terribly interested in doing—in particular, various types of medium and high secure addiction services, eating disorders and various more specialist ends of mental health. There has been a long-standing use of the private sector in mental health. Again, it may be likely to increase and there may be some things that will reverse out with people trying to do more of that work locally.

Q264 Grahame M. Morris: If I might just make a brief comment there, one of the problems in terms of the NHS competing is about the lack of a level playing field. I am introducing a private Member's Bill for freedom of information, so, with issues like that, mental health and Winterbourne, it should be possible to isolate the cost centres. It is a one-way street at the moment.

Nigel Edwards: Research on this is rather mixed. KPMG were commissioned two or three years ago, and I think there was then another consulting company that did a study. The playing field is tilted depending on which bit of it you tend to be standing on. It is a much less straightforward equation and your point of view definitely influences it. There are differences in access to capital, the treatment of VAT and the use of NHS pay scales, for example, which makes it quite hard to determine who is getting the short end of the stick. There was a degree of swings and roundabouts and I have not seen anything that has convinced me that we know the answer to who is doing better, but the NHS may not do as

badly as they sometimes think. The issue may be more about their ability to respond in an agile way to these procurement processes.

Anita Charlesworth: On a different issue, when there was the shift of hospital care, particularly elective health care, that was done under the national tariff and we have public reporting there of quality standards. It was not perfect at the beginning, but it has got better. There is literature which is very clear and which would certainly suggest that, while there are continued debates about whether competition under fixed tariffs has delivered quality improvement or not, competition on price imposes very significant risks. What worries me now with the move with community health services is the lack of transparent data on unit costs—on the amount of activity and the quality of service, and how we can judge systemically whether or not we are securing real value here and whether or not quality of care is being maintained or improved. If individual commissioners are confident, that is fine, but system-wide we do not know.

Nigel Edwards: I think the commissioners seem to be more worried than that.

Anita Charlesworth: We don't know; I was being—

Nigel Edwards: I have come across a number of instances, say, dermatology services, where commissioners are saying they want to commission it via a community tariff, which means it is cheaper, but the service model that is being offered is distinctly inferior and effectively you have price competition based on a reduction in quality, which was not the intention of the Act at all.

Q265 Chair: The Act specifically bans that competition.

Nigel Edwards: Yes, but this is happening, and it is certainly not very good for the patients involved in these particular cases.

Q266 Chair: Is it possible for you to write to us specifically with where you see examples of that happening, because that is quite important?

Nigel Edwards: I will send you an example.

Q267 Chair: Do you mind if I ask a couple of points? One thing about the data that was given by the Secretary of State, and the various figures for this, which interests me is that it does not include general practice, which of course has been an independent contractor model. Patients do not visit their GP and think they are seeing an evil private contractor to the NHS—of course—but I am wondering, in your view, should we include general practice within that and view it as an independent, or is it just that traditionally we have always viewed—

Nigel Edwards: From a pure theory of the firm economics basis, it is a private sector entity.

Q268 Chair: It is, and if we included general practice in that figure—
Nigel Edwards: It is another £8 billion.

Q269 Chair: —it would greatly change the numbers, would it not? Is it possible for you to drop us a note about how that would have affected it if we had included it right from the start?

John Appleby: We could add about 7% on to that, whatever the figure we had before, which is—

Nigel Edwards: We were not sure what we were supposed to do on general practice.

Q270 Chair: Indeed, but I just find it interesting that people never consider that as being—

Nigel Edwards: Yes. I have had a very interesting response when you have a conversation with the public—for example, on the radio and with other policy commentators. People are very shocked by that suggestion, but of course it is the case that they are private sector businesses, yes.

Q271 Chair: Do you feel there is a case, as we talked earlier, about the public not really knowing how much companies are taking as a profit share from the NHS? Is what the level of profit is one of the things we should be more transparent about, or should we purely focus on quality and make sure there is transparency around quality and sticking with the contract?

Anita Charlesworth: And the prices that we pay.

John Appleby: There is this issue about the quality. I want to go back quickly to something that Anita said—that we find it difficult to measure quality—and what is the value of these contracts? That may well be, but we have the same problem, in a sense, with whether it is a public or a private provider here. That is an issue in its own right that we should solve. We need to have much more information, whoever owns the means of production, if you see what I mean, about the quality of the service they provide.

Q272 Grahame M. Morris: With all due respect, John, the problem is that private sector providers are exempt from FOIs, so in terms of identifying cost centres, my concern is particularly, for example, in social care where Care UK are involved in a major dispute. They are engaged as a provider with NHS public money, and whether they are passing on the terms and conditions to the people who deliver that service is a real concern. If they are squeezing profit from the system, money that would otherwise go to pay staff and to deliver a quality service, it should be a matter of concern and a matter of public knowledge.

John Appleby: I sort of agree. There is obviously a difference between a public entity and a private organisation, and there is going to be less information, I guess, from the private side for a whole variety of commercial reasons.

Q273 Grahame M. Morris: They are excluded from FOIs; that is the specific reason.

John Appleby: No, but it seems to me if you are a commissioner of care from a private organisation, and your concern is not just with the measurable outcomes for the people who use that service but for the employees as well, which is what you are saying, presumably that could be made a condition of the contract you enter into; if they want to enter into that contract they do, and if they don't they don't. There are other ways, it seems to me, of tackling that rather than it necessarily becoming public information, in terms of addressing that concern about employees.

Nigel Edwards: There is an interesting example in the Valencia region in Spain, which has a number of its health systems operated by private sector providers, one of which is BUPA Spain. That has an explicit profit cap and an open-book accounting principle, and, I suspect—I do not know—if they are sensible, controls on contracting to subsidiaries so that you do not just farm your profit out through the—

John Appleby: It is an interesting example of where, over time, over the decades since 1948, the contract has evolved. As I say, I struggle to get my head round some of the payments, but it has evolved in a whole variety of ways to try and link payment to activity. We encourage GPs to do certain activities by paying them certain amounts of money and we measure things. Essentially, it is a complicated but private contract. There are ways of solving this. It is not easy, though.

Anita Charlesworth: But Monitor, in its review called Level Playing Field, recommended that FOI be extended, applied, and I do not know whether that has been implemented.

Q274 Chair: Is that something that you would recommend to the Committee should be done?

Anita Charlesworth: I was involved with the Level Playing Field review. I think a level playing field is the right way to go—information. There are types of information that it seems to me to be quite appropriate to have. For example, I do not understand why GPs do not publish audited accounts given that they take public money. That would seem to me to be a completely appropriate thing.

Q275 Chair: Because then you could judge whether your GP, for example, was prioritising profit share over service to their patients.

Anita Charlesworth: Yes.

Nigel Edwards: We would be able to answer your questions.

Anita Charlesworth: If you take public money, there are certain levels of reporting.

Q276 Chair: You would recommend we go down the Spanish route of having open book and FOI, and would you also recommend that we go down the explicit profit-limiting public share or not?

Nigel Edwards: That is a little trickier, but this may be a matter for the commissioners rather than a matter of public policy. The commissioners should be deciding what level of profit they feel comfortable with.

Q277 Chair: But open book and FOI you think would be a reasonable route for us to go down.

Nigel Edwards: Yes.

Q278 Barbara Keeley: But if I could just add this, if you start lumping GPs into it, GPs have not, in my experience, behaved like, say, Care UK, as my colleague Grahame Morris just mentioned, in slashing the terms and conditions of staff, to be—

Nigel Edwards: I am not so sure about that. You may find some.

Q279 Barbara Keeley: I don't know.

Nigel Edwards: General practices are very variable and contain both the excellent and the worrying.

John Appleby: Yes, the not-so-quite excellent.

Q280 Barbara Keeley: But that is gradually, over time. I do not think you very often find a situation where people who perhaps have worked a lifetime in delivering services to the NHS—in this case learning difficulties, people that they were working with—and are very experienced, suddenly find themselves on minimum wage or less with no pension any more. If you can quote us examples I would be interested, but I very much doubt that happens.

Anita Charlesworth: There are two separate but interrelated issues. One is, if a service is being provided from public funding, are there levels of transparency and accountability that are fundamental to good government? I would argue there are and that means that we need to have consistent, good quality, activity cost reporting. Having published accounts is essential to that.

The second thing is, is there poor commissioning practice going on, which means that for services, when they are re-tendered, the contracts are very poorly specified and the new provider is not improving the value for money and the delivery of the service? What they

are doing is cutting corners and slashing costs. That is poor and ineffective commissioning, which is Nigel's point, and you need to tackle that through commissioning.

John Appleby: Sometimes we do demand these things of private suppliers. For example, any private or independent sector hospital providing NHS secondary care has to provide patient-reported outcome measures, where appropriate for the particular surgery they are doing, so it is just part of the contract and they supply the data. There are ways around this.

Q281 Robert Jenrick: I want to ask a quick follow-up question. You mentioned poor commissioning and procurement. What, in your opinions, can we do to improve that, because that is something we have heard on a number of different inquiries in the past? Do you have any views, briefly, on what we might be able to do to improve that?

Anita Charlesworth: Nigel?

Nigel Edwards: This is really crucial because the empirical evidence across the world is that ownership is less important than how you regulate and pay. There are some very good for-profit providers and there are some terrible not-for-profit ones. It is probably easier to regulate the not-for-profit sector because it has more of a social mission, but you should not entirely rely on that. That is such a big question.

I have two or three things to say. If you look internationally at what is happening, commissioners are moving away from trying to describe the detail of how providers should operate, of which we have had a bit of a tradition in this country. It is as though the commissioners have continued to try and manage the detail of how hospitals and other people work. They have moved more towards specifying outcomes and putting more risk, as it were, on to the providers to ask them to solve the problem and then to be held to account for how they do it rather than to describe the detail. You get into describing the detail where the providers are clearly failing. One interesting implication of that is that the commissioners can do that on quite large populations because there are economies of scale in doing so. Because you are not down in the detail of how the providers are working, you can take a step back and perhaps be more rigorous, but, if you look internationally, very few people have really cracked this question of how to commission something as complex and difficult to measure as health care. People are feeling their way towards it, but the direction of travel certainly seems to be towards more outcome-based contracts, which means more bundling of what you are doing into bigger groups—more about what and less about how.

John Appleby: There are things to be learned from how the GP contract has developed over time in this country. It is a complicated contract. It has to be one step ahead of the GPs, in one sense. We have to trade off various things in terms of what we want: what do we want GPs to do? We are giving them public money by and large. How do we change their behaviour without destroying their professional integrity? All these things are balances. Anyway, there are some things we could learn from how the GP contract has developed over time.

Chair: Grahame, did you have another question?

Q282 Grahame M. Morris: I know we are short of time, but could we touch on PFIs? I know that in particular the King's Fund did point out that, to put it in context, the PFI spend is a relatively small proportion of the total budget, but it does present significant problems for a certain number of, particularly, hospital-based trusts. Might you say a few words on that, and, again, just to conclude things a little, I can give an example in my own locality? One of the NHS trusts—the foundation trusts—has managed to reduce its financial commitment long term through the local authority buying out the debt.

John Appleby: That is very interesting.

Q283 Grahame M. Morris: Have you looked at that?

Nigel Edwards: You also have to have someone to buy the debt from, and one of the difficulties is that some of the debt has been securitised and is not necessarily available to be bought back very easily.

Q284 Grahame M. Morris: Thinking about it in two parts, should we as a Committee and you as expert economists be advocating this? If I can just pose another question, the new hospital that was proposed to serve my constituents was cancelled as part of the emergency budget in 2010, and that was to be a Treasury-funded acute hospital—£464 million-worth. The trust has been directed down the PFI route. Is that sensible given the problems that have arisen, and what is your advice to Government when Government can borrow at a fraction of the price that the PFI companies can?

John Appleby: First of all, I have not yet seen a definitive cost-benefit analysis of PFI policy.

Q285 Grahame M. Morris: Is that not your job?

John Appleby: We have a lot of things on our plate, I suppose.

Q286 Grahame M. Morris: It is a big issue.

John Appleby: It is a biggish issue.

Q287 Grahame M. Morris: UNISON have done it.

John Appleby: There is not a straightforward answer. It is not an easy bit of analysis to do. First of all, to simply say that, of course, the repayments are more than the Government would make, yes, that is one aspect of it. There were other benefits—at least advocated by

proponents of PFI—that the schemes would be delivered on time and be better designed and all this sort of thing. I am not going to argue about whether they were or not, but it is not simply about the repayment of the money. It is also about the marginal cost, because if you want these new shiny hospitals, the money has to come from somewhere. It is either going to come out of Government borrowing or extra taxation. Looking simply at the total repayments on PFI is not the figure to focus on. The figure to focus on is whatever the difference would be, taking into account all the other potential benefits and costs of that scheme. All I am saying is that I have not seen a definitive pin-down of all those costs and benefits. We put in our evidence that PFI repayments are relatively small. They are relatively small given the total spend on the NHS. They clearly vary from hospital to hospital. One of the crucial things, of course, is that quite often they are fixed in the short to medium term. They are problematic from that point of view in that, if you are a hospital looking to make productivity gains, there is a chunk of money which in a sense you cannot do anything about. You cannot shave a little bit off that by being a bit more efficient. That is just the cost that is sitting there. So it is a problem there.

I have a couple more things. NAO found a weakish link between those hospitals with high capital charges and those hospitals with significant deficits. It was not a sophisticated analysis, I have to say. Monitor have found the opposite. They have found, for small hospitals—I think, from memory—using a multivariate analysis, a positive impact of PFI on small hospitals' finances. So, to me, it is not a clear-cut picture.

Nigel Edwards: But that conflates, of course, the financing method with all of the other things that were bundled with PFI around design, build and soft facilities management operation. It is very complex.

John Appleby: But when people have looked at it, it becomes a much more complicated effort to try and disentangle what is cause and effect and what is going on there in terms of what is better value for money.

One last thing is that one of the NAO's general conclusions in their series of reports—and they have looked at some 70 or 80 individual PFI schemes—is that the NHS has got much better at negotiating better deals for itself and that there were early PFIs which were simply not good deals for the NHS.

Anita Charlesworth: Across the NHS, if you are looking at the system issues, it would not be high on your list of things to address, but what is clear is that there are good PFI deals and there are poorer PFI deals. The particular issue which is most worrying is not, overall, the amount of repayments but the problem of the minority of hospitals, which have long-term structural issues, which are really struggling under big deficits, and the NAO said that about two thirds of those also had a PFI. It is the inflexibility of that. If you were going to recommend anything, the most important area to focus on is how Monitor and the TDA get a regime to deal with providers in extreme distress that they end up having to put into special measures or turnaround that enables them to make long-term sensible decisions for the health economy as a whole, rather than decisions that are driven by the imperative of that particular PFI. I would focus on that rather than PFI generically.

Nigel Edwards: Though, if you are considering a PFI for your constituency, you may want to bear in mind some of the lessons that we have learned about the extent to which they do not give you the flexibility that was promised, and the risks of inflexibility do not appear to have been transferred to the PFI operator; they stay with the NHS. So there is—

Q288 Grahame M. Morris: It is not limited to financial risk. I mean, if you want to reconfigure—

Nigel Edwards: Yes, there is the service configuration risk, exactly.

Q289 Grahame M. Morris: There are huge penalty charges to do that so it works against service transformation.

Nigel Edwards: Yes, that is precisely the point I was making.

Chair: We are nearly there, but I know Robert wanted to ask another question.

Q290 Robert Jenrick: You have almost answered my question. I am very interested in this as well because my locality has a trust that is in the category you refer to. It is a trust in special measures with a very high and poorly-negotiated PFI contract. You mentioned what sort of regime could be put around those trusts. If you were giving advice, what measures could you take specifically for that small number of trusts in a very difficult situation? My own trust spends 16% of its budget on PFI payments.

Nigel Edwards: They need a long-term subsidy. It is something that other systems do, largely more around rural and remote areas, but there are some places with unavoidable cost differences, and there is therefore no point having a pricing regime that is designed on the premise that the cost differences are amenable to management action. If you have a legacy problem and you want to have that hospital continuing to operate, it does not look very equitable from the point of view of the rest of the system, but there is virtually no other option than to say, “This will require some form of long-term subsidy,” and maybe a longer term strategy to extricate themselves from some of the more avoidable costs, because there are elements around the contracts where there is sometimes some flexibility.

John Appleby: Ultimately, we do not want patients to suffer. That has to be the bottom line, so it is whatever it takes, in terms of dealing with a hospital in financial distress from whatever sort of cost area it comes from. By the way, if it is 16% of your trust’s costs, there is 70%, which is pay. In terms of identifying a particular cost area which is the problem, it seems to me that is not taking a view across the piece, as it were.

The other issue with PFI hospitals is that there was, in some areas, rather too much optimism on the part of the NHS about what they would need in the future and what income would support what seemed at the time a good deal but in the end did not turn out that way. We can look back and say that the contracts should have been more flexible, and

in the end, as I say, there will be flexibility because—there is a moral hazard here—we cannot let a hospital go out of business where it is going to harm patients. In the end there will be a rescue of some sort arranged.

Nigel Edwards: The Secretary of State stands behind all of the PFI contracts, so, even if your hospital totally disappears, the Secretary of State will still be liable for the 16% that is currently being paid.

Q291 Chair: Can I very briefly touch on an answer you gave earlier simply because part of the purpose of this inquiry is to answer questions that the public have? Did I hear you correctly in saying that you cannot disaggregate, within community services at least, how much of the increase of private provision is due to transforming community services and how much is due to the Health and Social Care Act?

Anita Charlesworth: Correct.

Q292 Chair: It is not possible to unpick that. They are both significant.

Anita Charlesworth: Indeed. What we have is, and this year for the first time I cannot tell you how much of that £10.2 billion has been spent on community health services because NHS England has not collected that data—

Q293 Chair: So we cannot also disaggregate how much of it is voluntary sector, community interest companies and how much is private providers. These are questions that the public ask us. We are trying, if we can, to set it out for them in a time line, but you are saying to us that it is not possible to set that information out.

Anita Charlesworth: Absolutely. What happened was that PCTs—when they existed—in their accounts listed how much they had spent of their commissioning budget with non-NHS providers, and they categorised those into four categories: independent sector, voluntary sector, local authorities and others, or some version of that. That is where the data comes from. There was no data then on who were the actual providers. So they do not distinguish between the transforming community services; we do not know whether they have chosen to put those in voluntary sector or independent sector and we cannot separate them out from existing charities and private providers. In the last accounts—2013-14—NHS England did not collect data on how much of the commissioning spend went on community, mental health, acute and primary care any more.

Nigel Edwards: With the added complication that, from this year, there is also spending by local government on some of those services, particularly in areas like sexual health, for instance.

Anita Charlesworth: There are big issues about data going backwards this year. Equally, you can no longer tell how much NHS funding has gone on a population because all of the central, already-commissioned services are done on where the patient was treated. NHS

England will no longer be able to tell you how much they spent on the people in Liverpool.

Chair: Right, okay.

Anita Charlesworth: That is my understanding.

John Appleby: We are sure to work that one out.

Q294 Chair: So the data is getting less rich at answering those kinds of questions. But up to now the other issue has been around the income that hospitals get, foundation trusts and other trusts, from private patients, because obviously the thresholds were increased. But my understanding—could you please just clarify this?—is that, while in a few teaching centres that proportion has gone up, for hospitals as a whole it has been pretty static. Is that right?

John Appleby: Do you mean gone up in reality—that their income has gone up?

Q295 Chair: I mean as a proportion of their total income.

John Appleby: It almost literally is a handful of hospitals. Across the NHS in England there has been almost nil change in the proportion of income derived from private patients.

Q296 Chair: The fear that was widely expressed at the time was that there would be this explosion in the proportion of private income for hospitals. You are saying that has not happened.

Anita Charlesworth: No. In our evidence on figure 10, in 2009-10, in real terms it was £450 million. In 2013-14 it was £500 million, and the NHS budget is £110 billion.

Nigel Edwards: The acute sector is about 50.

Anita Charlesworth: It has crept up, but it is still tiny.

Q297 Chair: It is tiny. It is really limited to a few major teaching centres. Is there any evidence that that has been ploughed back into patient care? Has it been a good or a bad thing where it has happened within those centres? Do we know whether it has impacted?

John Appleby: You could name the hospitals, hospitals like the Royal Marsden—I cannot remember the proportion of its income, but it is 25% or 30% maybe—and Moorfields. The Royal Marsden, for example, on its CQC ratings has been the top rated hospital for years. It is financially secure and so on. They would argue that they are a very particular specialised hospital for cancer, they have had a particular market and they get income, and, as far as I understand it, it is spent for the benefit of the hospital and they demarcate clearly between their private and public activities.

Q298 Chair: So, as a panel, you would not feel that the public should be alarmed. In fact, if anything, you think the evidence is that, where it has happened, it has been of benefit.

Nigel Edwards: At the level it is at, it is more likely that the benefit is positive rather than crowding out NHS activity.

Chair: Thank you for clarifying that. It has been a marathon session. I am really grateful to you for staying so long. Thank you.