HOUSE OF COMMONS

Health Committee

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

Tuesday 25 November 2014

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Written evidence from witnesses:

- British Medical Association
- Foundation Trust Network
- NHS Partners Network
- Royal College of General Practitioners
- Royal College of Nursing

Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Andrew George, Robert Jenrick, Barbara Keeley, Charlotte Leslie, Grahame M. Morris, Andrew Percy, Mr Virendra Sharma, Valerie Vaz

Questions 396 - 501

Witnesses: **David Hare**, Chief Executive, NHS Partners Network, **Chris Hopson**, Chief Executive, Foundation Trust Network, and **Professor Terence Stephenson**, Chair, Academy of Medical Royal Colleges, gave evidence.

Q396 Chair: Hello and thank you very much for coming to today's session. Could the panel set out for those following this debate whom you represent and then we will start off with some questioning, perhaps starting with you, David?

David Hare: I am David Hare, chief executive of the NHS Partners Network, for-profit and not-for-profit providers of NHS clinical services.

Professor Stephenson: I am Terence Stephenson. I am a practising doctor and chair of the Academy of Medical Royal Colleges, which is a group of about 20 charities that speaks for patient standards and the training of tomorrow's doctors.

Chris Hopson: I am Chris Hopson, the chief executive of the Foundation Trust Network. We speak for the 240 acute, community, mental health and ambulance trusts. As of 1

November, we are changing our name to NHS Providers to reflect the fact that we represent both trusts and foundation trusts.

Q397 Chair: Thank you very much for clarifying that. Perhaps I could start with you, Mr Hopson. Do you recognise the scale of the financial challenge that was set out in the Five Year Forward View or do you take a different view on the scale of the financial pressures facing the NHS?

Chris Hopson: No; I thought it was a very good document. We had a hand in helping to produce it and thought it was a good, collaborative process in terms of involving other parts of the NHS. We absolutely recognise the size of the financial challenge that we face. If you look back, our members have done a fantastic job over the last three or four years in terms of meeting most of the £20 billion challenge that we were set, but it is very clear from the figures for this year—the latest second quarter figures being released this morning by Monitor—how seriously in deficit the provider sector is. As we look forward, the situation does look, yes, really very challenging indeed.

Q398 Chair: How do you feel this compares with previous periods of financial challenge?

Chris Hopson: If you go back into the history of the NHS, demand goes up by 4%. Broadly speaking, since 1948, the NHS has always had, on average, a 4% increase. There have been a few bumpy years, but, broadly speaking, it has been a 4% increase to match that demand increase. This is the first time in the NHS's history where you have had not just five years but probably 10 years of flat cash. Our argument would be that it does not take very many years of 4% demand growth and 0% or 1% funding growth for that gap to start showing. So, in our view, it is unprecedented in the NHS's history.

Q399 Chair: Thank you. Do Professor Stephenson or Mr Hare have anything to add to that?

Professor Stephenson: The NHS clearly is under immense pressure. You do not need me to tell you that we have a population that is getting older, living longer and more obese, and we are, indeed, victims of our own success. There are more treatments and technology that we can do. The number of implantable defibrillators that save lives has gone up tenfold in 10 years. So we can do more for a population that is living longer. You can see that pressure bearing down on the NHS in the rising number of hospital admissions, the rising number of people accessing their general practitioner and more people turning up to accident and emergency. The pressure is really building.

David Hare: The Five Year Forward View set out a broad envelope over a five-year period that the NHS needed to manage within. I would say that a £22 billion efficiency challenge will be significant. For my members, the cost burden around recruitment, particularly around nursing staff, for example, is a particular challenge. It will require a fairly heroic effort over the next five years to meet that efficiency challenge. Certainly, the view of my members would be very similar to the position set out by Chris.

Q400 Rosie Cooper: Chris, you talked about changing your name so that you can take in non-FT trusts. Is that what is happening to the Confederation?

Chris Hopson: Effectively, the Foundation Trust Network used to be a network within the Confederation. Two or three years ago we became a separate organisation. We have always had trust members, but, to be honest, over the last couple of years, on a personal basis, I have got fed up with saying to people, "You do know we represent trusts as well as foundation trusts." We are merely changing the name to reflect the reality of what is our membership. Of the 240 trusts and foundation trusts, 226 of them are members of ours.

Q401 Rosie Cooper: So you are going to fish in the same pool.

Chris Hopson: No. My argument would be that there is an awful lot that needs to be done to represent both providers and commissioners. As you know, the Confederation very deliberately represents the entire system. David's network, for example, is a member of it. As you also know, the Confederation covers Wales, Scotland and Northern Ireland. We wanted to make it very clear that we represent the entire provider sector because there has been a sense across a number of different people that we just represent foundation trusts. We do not. We represent all NHS providers.

Q402 Rosie Cooper: It is very clear, with evidence from trusts right across the piece, that there are increasing financial pressures. You have alluded to that so far. Those pressures are right across the system but are being felt particularly hard in acute trusts. When we are talking about moving services out of the acute sector, I suppose my question is how serious are the financial problems that will be experienced in acute trusts now?

Chris Hopson: They are very serious. As of today, 94—in other words, 60% of—acute foundation trusts and trusts are in deficit. For the first time ever in its history, the foundation trust sector is in deficit and has been in deficit both in quarters 1 and 2 of this financial year. There is a whole range of different measures. There has been a group of traditionally financially challenged trusts that we know have always found it difficult to realise a surplus. The bit that we think is very concerning is that we are now seeing very well-run trusts slip from surplus to deficit. I will give you one simple example. I was talking to an FT chief exec last week who has been an FT chief exec for 10 years. Nothing else in her system has changed, and what has happened is, because of the increase in demand and because of the flat cash, she is now slipping into deficit for the first time ever. As she said, "However hard I work, I cannot find a way of keeping this trust in surplus." This is a trust that has never had a problem and that, for the last 10 years—one of the first-wave FTs—has always been in surplus. Our real concern is that previously good, well-performing foundation trusts and trusts are now slipping into deficit. That is a real worry.

Q403 Rosie Cooper: Your evidence around reform of the payment system would suggest that you are saying that that is exacerbating the problem. How do you think the current payment system causes that—how it almost exacerbates the problem faced by

providers? What reforms do you think would be most effective in sorting it out? I have been involved in this for years and you are talking about PBR, specialist trusts and people creaming off the less complex cases, leaving, for example, in my constituency, Wrightington to do the difficult stuff at less than cost. It is ridiculous. What is your view?

Chris Hopson: There are two things. There is one very obvious problem, which is that we believe that, as NHS providers, we are currently underfunded for the level of demand that we are now facing and it is simply that there is a gap in the amount of demand that is coming through the door. In the trust I visited last week, for example, there is a 3% increase on emergency admissions and between 25% and 50% increase in GP referrals for a whole number of different specialties.

Secondly, the way that the tariff system currently operates in a number of areas is clearly iniquitous. The example we have shared with you on a number of occasions and I know has come up in conversation before is around the emergency marginal rate, where, effectively, providers are only paid 30% of the cost of providing many of their emergency admissions. To give you a real example of the impact of this, many of you will know that Monitor say that in order to become an FT you need to have a 5% margin of revenue over cost—the EBITDA margin. The 20 smaller hospitals in Q2 have a margin of zero. What is very clear is that particularly those that have a much larger proportion of emergency admissions, as opposed to elective work, are simply being penalised because demand in emergency admissions is growing and they are only being paid 30% of the cost for doing that work. So you get what you pay for. In the end, if providers are not being reimbursed for the work that they are being asked to do, it is not surprising they are now in deficit.

Q404 Rosie Cooper: Let me put the other side of that question to you. If you are saying that you are not getting paid for the work you do, if more work is done in the community, would you be suggesting the hospitals will be better off?

Chris Hopson: We are saying that we all know there needs to be a shift from the acute sector into care closer to home, of which community is obviously one very important part. All the international evidence shows, though, that the savings from making that transfer take quite a lot of time to come through. That is what the Five Year Forward View very clearly sets out. One of the key conundrums that we have and that I assume this inquiry will be looking at is how we fund that shift when, in reality, getting the savings from it, even if they do arrive—and there is a question mark there—are probably likely to take five to 10 years, not the one to three years that most Whitehall savings initiatives take.

Q405 Rosie Cooper: What would your suggestion be? How is that going to happen?

Chris Hopson: We are very clear. We believe there needs to be investment and that, if we want to make the change we are talking about, there need to be three forms of investment: investment in order for us to maintain the current level of service, because we are currently underfunded; investment to save, of the traditional type, and we recognise there is the opportunity to realise procurement savings and shared back-office savings, but we need to invest to realise those; but we also need to recognise that, if you are going to move to the new models of care that we are talking about, there needs to be investment in that as well. That—and I am sure we will come on to this—is one of the problems we have with the Better Care Fund, which is that there has been no investment through the Better Care

Fund to drive that integration. Our answer would be that we can see the promised land that is set out in the NHS Five Year Forward View, but we need to invest in it to get there.

Q406 Rosie Cooper: How would you respond to somebody who said to you, "It has always been the case, and every time somebody has come up with a plan and said, 'Oh, we need investment; we just need money; we need to invest, and the new shape of the NHS will be better"? I have been in the health service since 1973 and I would not like to add the number of times I have heard that.

Chris Hopson: To which the answer is that I would be the first to acknowledge that investment is only a part. If you talk about what is needed to transform—and the Five Year Forward View sets this out very clearly—we need a plan and, effectively, we need local communities to plan together and the local and the national to plan together. We need time. This cannot be done overnight. We also need management capacity and capability. I visited two of the special measures trusts over the last five weeks and was intrigued to hear the message they gave me. They said, "Chris, we absolutely know that we need to transform. We know we need to integrate our local health and social care economy, but, if we are honest, we simply don't have the management capacity and capability to do that. We are spending our whole time trying to keep our very fragile trust upright and we don't have the management capacity and capability to do that complex longer-term change, particularly when it involves playing a catalytic role in pulling the whole of the local health and social care economy together. We need support from the centre, but we also need space, because at the moment all that the centre seems to be concerned about and spends its time doing is saying to us, 'Are you delivering today's operational targets?'" What I hear so much from our trust chief executives is, "We need the space, the encouragement and the right balance between delivering today's operation and tomorrow's long-term change." So, yes, money is part of it, but all of those other things are part of what is needed to drive the change too.

Chair: Do the others have something to add to that—Professor Stephenson or Mr Hare? No; thank you. We will come on to Robert.

Q407 Robert Jenrick: Following up on that, as to the £30 billion gap that has been talked about, we have heard already about the need to achieve efficiency savings, whether it is 2% or 3%. The NHS has not met that in the previous few years. From the comments you have just made—you used, Mr Hare, the term "heroic" and, Mr Hopson, there are your comments—is this a credible figure: the suggestion that we can reach that kind of efficiency within the next five years?

Chris Hopson: You have already had an interesting debate with Simon and others about how deliverable that is. It is impossible—and I think Simon said this to you—at this point to say whether that £22 billion genuinely is deliverable. What needs to happen is this, and this is a real difference. Over the last five years people have been turning the tariff screw on our members and hoping those changes would occur. They have not. The Department then moved to the next strategy, which was, on procurement, to tell us what the answer was. That has not driven the change. The point we have made to the Department and to the

arm's length bodies is that, "If you want our members to realise the scale of efficiencies that is being asked for here, we need to have a level of responsibility and input into how those savings are going to be achieved." At the moment we appear to have a system where, to be frank, the answer to that always seems to be driven from the top down. We think there is the ability to make efficiency savings if we invest properly. We are clear we cannot carry on with the salami-slicing, pay-freezing, traditional cost-improvement approach, and again I think Simon said to you very clearly that we need to invest in transformation and in doing things differently. If we do that, I think we can reach a level of savings. I think £22 billion is very optimistic, but we can get quite a long way there if we do this properly.

Q408 Robert Jenrick: What sort of level is realistic, do you think?

Chris Hopson: I am not going—

Q409 Robert Jenrick: It is a plan. We are talking about the Five Year Forward View plan. If you do not believe that figure is credible, what do you believe is a credible figure?

Chris Hopson: To be frank, it is a real mistake to pluck figures out of the air without doing the work properly. If you want to do the work properly, you need to engage our members, engage clinical commissioning groups and do a proper piece of structured work in a way that, to be frank, has not been done up to now. All of the work has been done at the centre without fully involving those people who have to realise the savings. I can point to a number of different areas. Terence's report, I thought, identified some very interesting areas where, potentially, there is waste. There are a number of different places we can go. I just think it is dangerous to put a figure on the table.

David Hare: The Five Year Forward View picked up on some of this, around investing in out-of-hospital care, and in previous sessions you have heard about some of the challenges on data and understanding precisely how we drive efficiencies in out-of-hospital care, but, fundamentally, we very much have a model at the moment that penalises hospitals for demand and taking on more demand. I know that other commentators and those who have given evidence to this Committee have spoken about whether we need some sort of transition fund, frontier shift, and so on, in order to be able to invest in that out-of-hospital care and to disinvest in hospital care. I am not seeing that plan coming through at the moment. That has to be a priority for 2015-16 and 2016-17, otherwise we are just going to keep seeing those demand pressures grow in acute systems and I do not see the efficiencies then coming through.

Professor Stephenson: There are four ways that the NHS can survive over the next five years and beyond.

One is that we need to reduce demand. That requires much stronger public health measures, and the doctors I speak for have been in the vanguard of talking, as Rosie knows, about obesity, minimum unit pricing and plain packaging for cigarettes—three things that contribute hugely to demands on the NHS. There is an estimated £10 billion spent on type 2 diabetes alone.

The second area is working smarter. I have written at some length about the fact that, compared with the kind of smartphones that you are all using around the table now and iPads that you will have used to book your train here, the technology we use in the NHS to deliver you life-saving care needs investment; we need it to be skilled-up IT for the 21st century. We also need to be working smarter in—I am sure we will come back to it—redesigning our health service for the 21st century. You have talked a little about care closer to the community, but we can talk more about what hospitals in the community should be doing.

The third area is where our report comes in. Resources can be released: one doctor's waste is another's patient's treatment. It is not just about taking money out; it is about releasing money for other people. I can give some examples of that. In addition to that is procurement. In a survey—and you will all have had one of those little cannulas put in your hand into a vein to take blood—it was found that 60 NHS hospitals ordered 1,775 different types of this cannula. One hospital ordered 177 different types of rubber gloves. I know of no other organisation in the world that would not use its £110 billion purchasing capacity to leverage better deals, essentially, for our patients.

Finally, there is investment spend. The figures are in the public domain. If you look at the OECD, the UK now spends less of its percentage GDP on health than Germany. It has fewer doctors, fewer nurses and fewer hospital beds per 1,000 people than Germany. As we look across to our neighbours in Scandinavia and northern Europe, if we aspire to and want their health service and outcomes, there is a cost to that.

Q410 Chair: The challenge presumably, though, is that that does not all come out of direct taxation in other countries. The point that has been made to us before is that it does not mean the cost goes away. It just means it is picked up by other individuals. Would you be making the case to say that that should all shift to taxpayer funding and we actually make that leap along the lines of the Barker review? Are those the kinds of things you would support?

Professor Stephenson: Doctors would be absolutely clear on this. All the professionals I know absolutely want the NHS to remain a universal service free at the point of delivery based on clinical need, not ability to pay. Behind that, if we need to get from 8.9% of GDP to 11% or 13%, it is for people like you in this House to decide how this country affords that. But it is foolish to raise expectations that we can have a health service like Sweden, Germany or France at a cut-price rate. All of the people I speak for—over 220,000 doctors practising not just in England but in four nations—would want to be clear that patients do not see that. At the point you go for help, if you have mental health problems, are an alcoholic or living under the arches, you are not deterred by some up-front cost. But behind that, doctors really want top-class care for their patients. How you engineer that requires a lot of clever people in this House to come up with the solutions.

Chris Hopson: I think we are also—

Q411 Andrew George: But there has been a lot of cost shunting, has there not, from particularly the acute sector to the community? A lot of those patients that were being treated 20 years ago in NHS hospitals are now occupying nursing home beds and are paying for

themselves, often. You cannot discount that that is going on as well. In fact, a lot of the care that used to be provided is now being hidden and, indeed, that cost is being met by the private purse.

Professor Stephenson: Yes, I would not discount that. One of the things that troubles all health professionals—and I am sure you as well—is that, if people develop dementia, it is essentially means tested and probably two thirds, 70%, of social care is provided by the private sector. If you have cancer, it is not means tested and it will all be met out of direct taxation. We all understand that. We also understand that, while some of that reduction in beds could be explained by the move of care into the community, it leaves aside those three pressures I started from that were not there 25 years ago. We had a population that was younger, it was healthier for the length of time people lived, and some people have said that care then was simple, safe and relatively ineffective and now it is complex and potentially risky, but often life saving. You have to factor those three things in that have happened at the same time as that shift over the last 25 years, in some cases quite rightly, of people going out into the community. I think we are all agreed that most doctors do not want people in hospital who do not need to be there; I can assure you it is not something we are keen on. Ideally, we would rather people were treated at home and, if they cannot be treated at home, treated as close to home as possible and only in hospital where necessary.

Q412 Robert Jenrick: I have one follow-up question going back to cost savings and efficiencies. Do you think that the quality of management, both within the wider NHS and particularly in trusts is of sufficient quality to deliver the kind of transformational changes that we are talking about?

Chris Hopson: I have worked for a FTSE 100 plc, in the civil service and in a number of different places, so, having had a very varied career, I have had an opportunity to assess—and it has always been at board level—quality of management. My personal view is that managers in the NHS are an easy target. The people that I see are capable of doing an extremely difficult job. David Bennett, the chief executive of Monitor, describes some of the NHS chief executive jobs as some of the most difficult he has ever seen. That would certainly be my experience. The gap occurs, and it is the point I made earlier, where you look at the capability and capacity that is needed, on the one hand, to keep these trusts upright in an incredibly demanding environment—where demand is going up by 4%, effectively flat cash, and it is getting a much more complex task to do and I see our chief executives running at 150 miles an hour just to keep the ship upright—and somebody saying, "Okay, we now need to do a really big transformation."

Q413 Robert Jenrick: What are you actually advocating? Are you advocating more and more managers?

Chris Hopson: No. Let me give you a very simple example. A trust I know quite well, Yeovil, basically decided that the only way it could really do this was to divide its board in two—to have one half of the trust board working on keeping the operations running day to day and the other half of the trust board effectively trying to do the long-term transformation, with clearly the chair and chief executive sitting across the top. All I am saying—and I know it is not a particularly popular message—is that I do not believe we

have the management capacity currently sitting at trust and foundation trust board level both to keep these incredibly complex difficult operations upright and at the same time to go for a really radical transformation. So, yes, we will need to invest in more management capability and capacity if we are to drive that scale of change consistently across the piece.

Q414 Robert Jenrick: I know, Professor Stephenson, that you have talked about doctors, that there needs to be a cultural change among doctors to become waste busters and to take a much more proactive view themselves. Do you share optimism about the quality of management that sits alongside health care professionals?

Professor Stephenson: That is a question that is very commonly asked. We as a profession have stepped up to the plate by saying there are resources in the NHS; my waste could be another patient's treatment. I know as a doctor that it is my signature on that prescription and my signature on that x-ray request form. There is absolutely no point in us as doctors saying, "It is the managers' fault." They do not put the signatures on those request forms. We are suggesting that we have a part to play. Where management does have a part to play—I would echo what Chris says—is that you have to create some space to make things better.

The analogy we would use is that this is a bit like fixing an aeroplane while you are still flying it. Those 1.5 million people will still be accessing the NHS over the next 24 hours. You cannot just stop the operation on a production line and fix it. To do that, you require people to be given the time and managers to be given the time—often middle managers—to take a step back and say, "Is our operating theatre working in the most efficient way? Do we need all of these prescriptions for the elderly?" That will require our clinicians to do some work and we have to give them protected time. It is a huge challenge. I have not worked in the private sector, I would be the very first to admit. I have worked in the public sector all my life, in universities and the NHS. I see some fantastic managers—passionate, incredibly hard working. I see some who are very good who are drawn away to the private sector by higher salaries in IT or HR or finance directors. I recognise that. I think we have moved on as doctors from a time of just disengaging and saying, "It is the fault of the managers." That is not constructive or helpful going forward.

Chair: Did you have any follow-up questions on that?

Robert Jenrick: No, that is fine.

Q415 Barbara Keeley: I would like to come back to the integration of health and social care. There is a consensus broadly on the need for greater integration between health and social care, and the commission chaired by Kate Barker advocated moving to a single ring-fenced budget for health and social care operated by a single commissioner. Do you agree with those proposals that she made—single budget, single commissioner?

Chris Hopson: Yes. We thought it was an incredibly valuable report that highlighted a number of issues. Clearly, the alignment and funding entitlement seems to us to be

particularly important in this arbitrary distinction between you getting access to funding depending on whether you have a particular social care-related—

Q416 Barbara Keeley: Yes, we had heard—
Chris Hopson: The reason I slightly hesitate is that I do not think we have yet got the credible path to the single commissioner. What Kate Barker's report really brought out is that we believe that health and wellbeing boards are not sufficiently capable at the moment in order to play that role. Our view would be that more thinking needs to be done about what a credible single commissioner is. But, over time, it painted for us a very compelling vision of how this needs to happen.

Q417 Barbara Keeley: So you agree with the goal.
Chris Hopson: I agree with the goal.

Q418 Barbara Keeley: But you want to see more about how to get there.
Chris Hopson: Yes. The concern we have—as I think we all know—is that there are various proposals that are floating around about what might happen on May whatever it is 2015 about how we might get there. We are sceptical about a number of those proposals that are being put forward. We do not think there is yet a credible plan out there that says how you might get to a credible single commissioner. We are clear that arguing that health and wellbeing boards on 7 May should take over responsibility for all commissioning of health and social care in their areas is not, it seems to us, a particularly sensible answer.

Q419 Barbara Keeley: Do the other panel members want to add anything?
Professor Stephenson: I think you are right about that report that came out. The Royal Colleges and doctors understand the principles. As a doctor, what is really frustrating is the frail elderly person, having had a fall, comes in, has a brain scan perhaps and some very expensive treatment, but we as doctors cannot pay for a handrail to stop them falling again. That does not make sense. That kind of working in silos clearly does not make sense. On the other hand, as I have already said, we like the principle of health care being free at the point of delivery and based on need, but Andrew George has already pointed out that a huge proportion of social care funding already comes from private means, not from direct taxation. We like the principle. Seeing how it works in practice is difficult; I do not think there is a well worked-out model. We need to make sure that there is protection in that—in other words, with an increasingly elderly population, that the social care element does not take all the resource such that we have our health service not just under pressure but absolutely on its knees. That is the difficult circle to square. We are up for examining it and like the idea but need to see how it would work in practice.

David Hare: I would share all that has been described there. One of the challenges of bringing the two of them together is currently that funding is done ever so slightly differently and we feel, and would agree with the NHS Confederation's comments on this,

that it does need to be done locally. Often, we tend to find that that is driven much more by culture and people working well together than it is by some sort of central imposition.

Going back to Chris's point earlier about leadership locally in the system, what we need to see is commissioners. Our experience of CCGs is that they are evolving into clinically-led, effective commissioners of health services. We need to see leadership at the commissioning level to determine the kind of objectives for an area, and then see whether we can bring those cultures together and, at that point, see whether we can fuse the budgets. If it is done in a top-down imposed way, we could end up with some unhelpful practice.

Q420 Barbara Keeley: How difficult do you think it would be to bring together the different eligibility and co-funding rules? You have talked about the capacity of commissioners. It seems clear that it is probably difficult, but do you have views on that? Clearly, there were suggestions in the Barker commission's report about the different ways of finding £3 billion. I do not know if you have a view on what she suggested.

Chris Hopson: That seemed to us to be one of the fundamental dilemmas that the Barker report highlighted. At the moment you have an NHS free at the point of use, but you have a social care system where, effectively, with the demand, what has happened over the last three years, as you all well know, is that it is only the top tier of highest needs that is currently being met. To equalise, in a sense, the meeting of needs, you need to extend social care into the groups that have been dropped from social care over the last two or three years. Secondly, you absolutely need to align the funding mechanisms such that people would not need to pay for the care on the basis of, "NHS free at point of use; social care free at point of use." So there is a significant financial issue about how you equalise, and again we thought the Barker report got this absolutely right. It is going to take us five to 10 years to do that kind of stuff. Her call for a proper national debate about exactly how that particular bit gets done seems to us to be really important. There are bits that can be done quickly, but that bit, it felt to us, is a really big knotty problem that does need a genuine national debate.

Q421 Barbara Keeley: Do you have any views about why this debate has not happened? The Dilnot commission called for a national debate as well, and many of us here called for a debate and a debate did not happen. There was a point when Andrew Dilnot was still around following his report that that could have happened. But it does not happen, does it?

Professor Stephenson: Isn't this where national debate happens?

Chris Hopson: You tell me if I am getting this wrong as you are much more experienced at this than I am, but I do think that our party political system occasionally finds it difficult to have the appropriate high quality of debate on really big, long-term knotty issues, of which this is an absolute classic. We seem to find it easier to revert to the "War of Jennifer's Ear". We seem to find it easier to revolve around, "You are only putting in one and a half; we are putting in two," whereas what we need is a big national debate to take our taxpayers with us to say, "Fundamentally, we need to invest more."

There is one other point I want to make. I am nervous about the language we sometimes use around health and taxation. We seem to imply that health is a burden on the tax system. All of the evidence is that every single nation, as it improves and grows its national wealth, spends more of its national wealth on improving health and well-being and improving and extending quality of life. Why wouldn't you? That effectively has got to be a key goal of any nation's life. Personally, I think we need to think carefully about spending our whole time talking about health and well-being being a burden on taxation, when actually it is the opportunity to use a growing part of our taxation to extend quality of life and to extend life itself. It is not a burden. It is something that is extremely positive, which every nation chooses to do.

David Hare: Can I come in here? One of the challenges we have by the system that Chris described is that, often, people locally are waiting for instruction from on high, whether on the health or social care side. One of the challenges that that brings is that we do not allow local attempts to try to do things differently because you end up in a bit of a blame game and then you do not really end up in a place where there are excellent models of doing things differently. The debate is a challenge, but I am quite optimistic about some of the new structures—CCGs getting into a place where they can try different things. I would like to see from the centre a bit more permission to enable people to try things and let us see what works and move that round, rather than waiting for instruction from on high, which is kind of how we have run it for quite a long period of time. We will not get innovation and change locally if that is the mindset. That is quite fundamental.

Q422 Barbara Keeley: Do you have anything to add?

Professor Stephenson: We are talking about two slightly different things here. On the one hand, you could assume there is a finite pot, and if you want fewer people to be accessing emergency services or being inpatients in hospital and you want them to be cared for in the community—the example I was giving of the handrail—you probably need to move some resource from one to the other. That is a different debate—a much wider national debate— which I hinted at with those OECD figures, but I am not entirely pessimistic. We have been through a very tough recession. As we go forward with an older population who all have votes for this House, it seems to me quite likely that, on the whole, mostly people will vote for measures that look like attending to their health and social care needs, and to the needs of their elderly parents. I am not entirely pessimistic, as we come out of this, that there will not be a greater proportion of GDP spent on social care and health. I recognise it is a huge amount and I am not putting forward that it should all come out of direct taxation, but I do not, also, accept that it needs to be completely fixed where it is right now if you take a five or 10-year look forward.

Q423 Barbara Keeley: Did Kate Barker's figure of £3 billion seem plausible to you as needed to make her model work?

Professor Stephenson: I do not know. I am only a jobbing doctor, and £3 billion sounds a very small sum of money.

Q424 Barbara Keeley: Doctors are in the driving seat now. I would just add on the national debate, Chair, that part of the difficulty, as a person who is very concerned about social care and carers, is that most of us get more e-mails about football governance and bees and things like that than we do—literally—about carers and social care. It is of great concern, and I would like to believe what you say—that people will vote and make social care an issue—but it does not happen. I have been here for nine years and it does not happen. That is a pity. We did have a witness who said he had asked a roomful of people to all go and see their MP and raise social care, and then perhaps it might change.

Finally, on the local Better Care Fund plans, the people putting together those plans are being asked to provide for a reduction in emergency admissions of around 3.5% from 2015-16 levels. Could you comment on how realistic that target is and how localities seem to be proposing to make those reductions? Are there services or mechanisms that could be put in place to help limit emergency admissions in that way?

Chris Hopson: I am happy to stick my neck out on this one and say that we are pretty confidently predicting that at least two thirds of the 151 areas will not reach the 3.5% emergency admissions target. It is a wholly unrealistic assumption. The NAO report on the Better Care Fund absolutely has that right, and you know what has been happening to emergency admissions. For example, this year they are up by 3% on average. I went to a hospital the week before last which was up 6% year on year. The idea that suddenly we can turn on a sixpence, that we can move a whole load of care out of acute hospitals into the community within the space of six or eight months after the plans have been approved—and, by the way, pulling the cost out of the hospital—is an incredibly complex task. Which chief executive is going to sign up to taking staff out if it effectively means that they are going to miss their four-hour wait target? Our view is that that assumption—and we said so at the time to the Department—seems to us to be wholly unrealistic. It is not going to happen, we believe, in at least two thirds of places. Then what will happen, as Nigel Edwards told you when he was in front of you, is that we run the risk of paying for things twice. We run the risk of making the investment in the new pattern of care but still needing to remunerate the acute hospitals where the demand still goes in.

There is, to be frank, a very unhappy track record of trying to reduce emergency admission demands. We have already talked about the marginal rate. You may remember that the withheld 70% that CCGs were holding back from—that 70%—was meant to be invested in emergency admission reduction activity, and that, we can absolutely tell you, in the vast majority of cases, has not happened. All our acute chief executives say to us that they think this is a very optimistic assumption.

David Hare: From our side—and the independent sector has only been a fairly small part of the overall whole on the Better Care Fund—one of the challenges has been provider engagement. Chris has spoken about this publicly before, but the plans, to an extent, were sort of cooked up not in quite smoke-filled rooms, but there was a sense of, "We need to deliver this. How do we"—

Q425 Barbara Keeley: So you were not involved.

David Hare: Certainly from an independent sector perspective, there was very minimal engagement over how those plans could work. While we are a small component of the overall whole, and Chris's membership is far larger than we are, we felt that it was a

process that was driven from the top, and the kind of conversation that needed to happen between different provider groups to try to find a sensible way through that did not happen. I would say, however, through this and other processes that have brought providers and commissioners together locally, that I am quite confident those conversations are now better as a consequence of having gone through some of those challenges than maybe they were at the start of the process. But provider engagement was not what it could have been, I think.

Chris Hopson: The favourite example I have of that is that the only way the provider chief executive could find out what was in the Better Care Fund plan was by going into the public gallery of the health and wellbeing board meeting that was discussing the plan.

Q426 Barbara Keeley: That is a good example.

Professor Stephenson: The principle has to be the right one. Everything we have been saying is that you want to reward people or incentivise people who can stop patients coming to accident and emergency, unless they really have an accident or an emergency. We are all agreed on that.

As to the detail of whether the Better Care Fund is doing that, time will tell, but it is up against it. I will just give you two figures. Over the last 10 years in England, the number of people going to accident and emergency has gone from 14 million to 21 million. Over the last five years, the number of people seeing their GPs has gone from 300 million to 360 million. That is about 120,000 or 150,000 extra people every day. It is about 1,000 people while we have been in this room. We are going to have to try and tackle that inexorable rise in demand, that public perception, that quick access. We are going to have to divert some of that away. We should try rewarding people who come up with schemes to do that; that is the right way to go. There was a hint earlier—I think in Rosie's question—about payment by results, which it is not; it is payment by activity, and we need to get away from those kinds of perverse consequences. We do need to reward people who keep patients out of hospital if that is the right thing for them, of course, if that is in their best interests.

Q427 Valerie Vaz: This is a forum for debate, and previously people like yourselves could never come before Parliament and say what they wanted to say. So the Select Committee is an improvement; it is a forum. Also, we ask questions of the Secretary of State. He does not always answer them, but we do try and get some sort of accountability. Actually, I do get e-mails from people telling me about the national health service and social care, and I also get people coming to my surgery in tears because they cannot get the proper care. I was struck by what you were all saying in terms of investment in transformation and innovation. I think you used the term "investment and transformation". Are you talking about extra money to come up with new models? What are you actually talking about?

Chris Hopson: When Simon was in front of you he talked about the need to—the concept that we are currently talking a lot about is a "something for something" deal, whereby the NHS is able to generate its own efficiency savings but is also able to generate some money to invest, to realise those efficiency savings, but also we need Government to help out as well. Again, I know that three economists talked to you about the transformation fund. The

transformation fund can partly be generated by funds the NHS generates but also by funding from the Treasury. So in both cases, in terms of the efficiency savings, the Five Year Forward View talked about £22 billion from us and £8 billion from the Treasury. We are then saying a similar principle—maybe a different ratio—of some money coming from us and some money coming from the Treasury. The obvious next question is where that money might come from. Clearly, one of the areas that have been talked about is that the NHS is sitting on a significant land bank that it is currently not using efficiently. It is unevenly distributed, which is potentially a problem, but there is an opportunity, in a one-off way, to use that land bank to potentially generate a fund that then enables us to invest in transformation but also the efficiency savings that we need. So it is something for something. The NHS needs to put in some money and the Treasury needs to put in some money.

Q428 Valerie Vaz: As you say, it is a one-off and owned by members of the public—the taxpayers—and we will never get it back for whatever further reason. You mentioned the Five Year Forward View. I want to take you quickly to page 18—I do not know if you have seen this—where Simon Stevens talks about new models of care.

Chris Hopson: Yes.

Q429 Valerie Vaz: I was quite concerned, or I did not quite understand, about primary and acute care systems. I did sort of put it to him that maybe this is blue-sky thinking. Initially he said it is not blue-sky thinking, but he has come forward with about five different models, so to me that is blue-sky thinking. What do you make of the system that allows a single organisation to pick out the GP lists and then take it all the way up? This is what I understand him to mean by one of them, and I do not know if you have seen them or not. I would like to ask all of you.

Chris Hopson: Let me give you a great example. Northumbria Healthcare Foundation Trust, a very good foundation trust, effectively recognises that it cannot do its job as a secondary care provider unless it gets its relationship with primary care right. So about four or five years ago it encouraged and facilitated the GPs in the area to create a federation, which is a key first step, and said to that federation, "Look, we are expert at doing HR and finances. Why don't we do all of that for you?" The next step they are then saying is, "Would you like to become salaried employees of ours, and would you, as a GP, like to join Northumbria Healthcare, in which case we can provide for you a hybrid model where you could spend three or four days of your week in a GP surgery and a day a week working in our accident and emergency department?" Effectively, over time the two organisations become merged as a single primary and secondary care organisation where these completely artificial boundaries between hospitals and GPs fall away and, as a result, you get a much better quality of service, quality of care, delivered to patients, but also you create a more interesting and rounded working life for doctors. So there is a very practical example of how that can happen.

In other places, in Newcastle next door, Newcastle Upon Tyne Foundation Trust has already bought, as I understand it, three or four GP surgeries, so it can be done in a number of different ways. The key point Simon is making, which seems to us to be fundamental, is that we have somehow got ourselves into a set of artificial boundaries

between secondary care and primary care that prevent effective care being delivered to patients.

Q430 Valerie Vaz: What evidence do you have that they will create efficiencies and they are better for the patient?

Chris Hopson: All the international evidence suggests, whether it is from New Zealand, Spain or a number of different places, that you get significantly increased patient experience and better outcomes where you create organisations that bring together primary and secondary care, which, to be frank, also integrate mental health and physical health, and also organisations that integrate health and social care. The evidence suggests that that improves outcomes and patient experience.

Q431 Valerie Vaz: Professor Stephenson?

Professor Stephenson: That is a very fair question, but, rather than get hung up on one of the five models on page 18, let me give you two examples I know of ways in which you might address some of these thorny issues. The Royal College of Paediatrics looked at 24/7 provision of care to children around the United Kingdom, not just England. There are about 220 hospitals open every minute of every day, including Christmas day, all the time. About half of those admit seven or fewer children a day, and about half of those are 30 minutes' drive from another hospital admitting seven or fewer children a day. So we put forward—it seemed quite radical at the time—that we really thought, with the resources we had in terms of people, doctors and children's nurses, the expertise a parent would want for their child, the realistic figure was 170, not 220.

The second example would be that there are about 5,000 replacement knee revisions every year. There are about 90,000 done every year and about 5,000 need re-doing. The British Orthopaedic Association looked at that. There were lots of places doing 20 a year, with the numbers so low that they had to pay to borrow the kit from companies, and, going back to procurement, they pay perhaps £5,000 for each knee revision, or £7,000. They put forward an argument for 50 centres doing 5,000—that is, 100 a year each at two a week—and they would all have the kit and would not have to borrow it. There would be better quality for patients because the people doing them would be doing them every week regularly.

Those are the kinds of things I meant when I said redesign. This is about better care for patients. It is not really about money, accounts and reorganisations of the health service; it is about saying that the health service as designed in 1948 is probably not going to be the right health service in 2015, and certainly not in 2018 and 2020, and we should be looking at all these options. If you will forgive me, probably the biggest obstacles to that are MPs. I have never seen an MP march in favour of a change in the service of the local hospital. I have seen MPs I can name you from any party march against, with the media—journalism, local media—fighting. It is not about closing people's hospitals; it is about the right treatment at the right place at the right time. That requires hospital services to be different—not lesser. In fact, I promise you that, if I thought I would get better care by going 30 miles in an ambulance to have somebody do something complex and risky, then I would go. I think most people would probably feel that.

Q432 Valerie Vaz: I have to come back to you. We march because sometimes these decisions are taken in isolation and against the evidence that is put forward. We do not march for any other reasons, and there is evidence when they close them that it affects—

Professor Stephenson: I am sure you march idealistically, but most of you march because, on average, it adds 10,000 to your majority at the next election.

Q433 Andrew Percy: We march because—

Professor Stephenson: The public know that. As much as we know—

Q434 Valerie Vaz: Can we stop the heckling? I have not finished. Do you want to comment, Mr Hare?

David Hare: I would like to. As to your point around blue-sky thinking, what Simon has set out and the leadership within the NHS is really important, but I will come back to my point around bottom-up activity, because we could get better at assessing what works, measuring it and celebrating success in the NHS rather than penalising failure. I will give one example from within my membership. One of my general practice members, working with the commissioner and care homes, examined a way to try to reduce emergency admissions, because of the number of GPs with which the residents of that care home were registered, to ensure there was proper wraparound care around the clock and that reduced emergency admissions by around 43%. There are some good models like that emerging. But I would like to see a way of getting that across, mainstreaming that, rather than saying, "There is a national blueprint for doing it," because I fear that the system is in a place where, if it comes up with three or four models, lo and behold, the only three or four models that we ever see are the three or four that the centre produces, rather than creating an environment and an ecosystem where we share and learn from the best and try and transition that.

Q435 Valerie Vaz: Professor Stephenson, could I ask you this? You made some interesting points. What would be the best way of pulling those together—the British Orthopaedic Association and the other examples that you gave? What do you see is the best way of pulling all that expertise together?

Professor Stephenson: In our report, which you probably have not read, we give 16 case examples. They are not blue-sky thinking. What is interesting about them is that they are 16 examples drawn from 16 hospitals around this country in the NHS right today. It is written by doctors for doctors in a way. It has not been imposed upon them by management, a political party or a Government. These are people—doctors and nurses—looking at how they run their service and saying that, by limiting the number of x-rays requested, by limiting the number of drugs prescribed and by looking at how we get patients through theatre, they can save money for their local people, not saving as in reducing the amount of money going into the health service but that money can then be used for someone else's cataracts or dialysis. You might be sitting there, I am sure, thinking, "Well, why not, of course?" But it is a matter of continuous quality

improvement, is it not? Over the last four years the NHS has tried very hard to deliver efficiency savings in a tight time, but the point is that when we come out the other side of that we have to continue to do so because of these other pressures—the increased demand.

Chair: Charlotte was waiting to come in next and then Andrew. Could we have short questions to follow up, if that is all right?

Q436 Charlotte Leslie: You made a very interesting point. Politicians are very good at sitting here and sitting in our House of Commons telling everyone else what they must do, but do you think there is a responsibility that perhaps our report should point back at politicians to say what we must do? I have to say that I beg to differ with Valerie. I have seen politicians of all parties marching to save a local hospital because it is the thing to do; it is in the political manual that you march to save your local hospital. There is one exception to that. My colleague Dr Phillip Lee is proposing reconfiguration which involves the closure of his local hospital, which is a very brave and optimistic vision of what politics can be. Would you agree that the debate about how we secure not only the next five years of our NHS's future but the next 50 years for the NHS being free at point of need has been held back because interesting innovations, like Norman Warner's idea about a £10 charge—I personally do not agree with it—which was creating space for a discussion, are often hampered by political imperatives? Is there a list of things that you would like politicians to do to be more responsible in order to help doctors, nurses and medical people save our NHS?

Valerie Vaz: Give them their pay rise.

Professor Stephenson: In a nutshell—to keep it short—yes, we would want you to have that debate. From all of your questions, you are obviously seized that it is an important debate and the answers are not easy, and they are going to have to come from this House. So we would ask you to have that debate, but we are not naive; you have to get re-elected.

Q437 Charlotte Leslie: I have one further thing. I think it is a matter of communication with constituents. If I know a hospital is not performing because it is not having a sufficient number of procedures to make those procedure safe, I would not want to send my gran there, and I am very happy to say to my constituents, "If I don't want to send my gran there because I know it's not safe because they are not doing enough of the procedures to make it safe, I don't want you sending them there." How and what can we do to help make it easier for MPs, who do have to get elected, to illustrate to the public that sometimes it is safer for a reconfiguration to happen—everyone cares about their loved ones—and it is safer for their loved ones after reconfiguration of services than just to keep what has always been there? What can we do to change that?

Chris Hopson: This is possible. There are now hundreds of people walking around London who are alive today, who would not be alive had we not concentrated 32 stroke units to eight hyper-acute stroke units. It was led as a clinical argument by doctors and clinicians putting the very clear safety evidence in front of local populations. The key bit is that we cannot carry on in the existing model. We have an accident of history in terms of the way the configuration of local secondary care facilities has been put in place, and I

know people are rightly and very proudly attached to their local hospital and the way it is currently configured. But if we are locked into bricks and mortar that have been there since the year dot, we are not going to be able to carry on providing the quality of care that we need. So we need Members of Parliament to help lead that process. It is about really understanding and listening carefully to what the clinical case is and then, hopefully, all of the people, all of the politicians, in a local area recognising the quality of that case and helping to argue it. To be fair, I do not think the NHS has been particularly good on occasions at drawing up and communicating that clinical case, but, if we can get it right, that is what needs to be done.

Charlotte Leslie: If any national press are listening to this, perhaps they would help us as well.

Q438 Andrew Percy: Professor Stephenson hit the nail on the head. There are election candidates right now hoping their local hospital is going to have some proposed reconfiguration—whether or not it is in people's interests—and perhaps even some MPs as well. All I would say on that point is that sometimes local clinicians do not help and often when it is their hospital they take the same view as local MPs do, which is, "It has to be bad because it is being moved away." In defence of politicians and those clinicians, it is hard to explain to Mrs Smith why going 50 miles to Grimsby is better than going two miles round the corner to Goole. What you have identified today—it is a question I have asked everyone we have had before us on this—and you talked of a reduction from 220 to 170, is that these are things which, politically, are perhaps undeliverable. We heard from the King's Fund with regard to possibly getting rid of winter fuel payments and increasing national insurance, all things that are politically very difficult. We are going to have a hell of a fight over the NHS over the next few months whatever. So the question I want to ask everybody is: is it time to try and remove all the politics from it? Do we need all-party buy-in? Do we need a royal commission on the future funding of the NHS or something similar? That would be a question for everybody, because, frankly, politicians ain't going to come up with the answer.

Professor Stephenson: Can I answer that quickly? I would agree with you that 10 or 20 years ago certainly doctors were often the obstacle. There has been a sea change in the profession; we see that is not sustainable. Secondly, it does sometimes happen. In Manchester, they went from 13 acute centres for children down to eight by mobilising the view that this was good for patients. It is quite hard for MPs to march against something if people are saying, "If you keep it the way it is, people are going to die." Thirdly, I suppose one of the good things to come out of the creation of NHS England is to some extent that arm's length detachment from the Department of Health, which you have seen with the Forward View, which is a different document than you might have seen previously in that it is less obviously political and more obviously realistic.

Q439 Andrew Percy: Do we need a royal commission then?

Chris Hopson: My answer to your question is that we need £2 billion in the autumn statement for 2015-16 in order to ensure that the NHS stays upright next year. We need a "something for something" deal in the next Parliament; for the public expenditure review that will finish this time next year, we need a "something for something" five-year deal. Neither of those will be solved by a royal commission. We do need a royal commission, or

something similar, for the five to 10-year debate about how we integrate health and social care and how we allocate the right amount of money in terms of national GDP. People often say to you—and I have heard them say in evidence given before you—"No, it won't happen quickly enough." It clearly won't happen quickly enough for 2015-16 and for the next Parliament, but we do need something similar for the longer-term health and social care integration bit.

Rosie Cooper: I want to try and encapsulate not only the stuff that you have said in the last two questions but give this an edge of reality in that I have closed a unit. I have actually closed a unit against the will, if you like, of the general view. What happened was that the Royal College said that the number of births at the Aintree centre was so low that they could not get junior doctors and the whole thing was in meltdown. So we took the decision that births would take place at the Liverpool Women's hospital only seven miles away. It is far enough, but, compared with the 20 and 30 miles I have heard people talk about, it is only seven miles. The people who caused the most hassle there were in fact the doctors. The headlines were "Babies Born at Roadside". How did I handle it? What I did was, I think it was—

Chair: Rosie, we need a question. We need to hear the evidence.

Rosie Cooper: It is a question because these guys, and politicians, try and just say, "It is down to MPs opposing it or people who don't understand." The truth is everybody has a place in this. The reality was that we provided services closer to them, so we invested early doors. For the whole of the pregnancy you got service closer to you, not any more than three miles away, but the birth took place at another distance. If I say to you, "So what am I going to do?", because there will be reorganisations—

Chair: Rosie, what is the question?

Rosie Cooper: The problem is what are we doing in the health service, for example, in Merseyside? My hospital in Lancashire has a chairman from Lymm. Aintree has a former chief exec—

Chair: Rosie, I am going to have to stop you. We need a question. We are here to hear the answers from the panel.

Q440 Rosie Cooper: But the question is how are you going to take the people with you if the doctors and the MPs you are blaming for not making the decision are not on side and you import chairmen from places not near the locality to impose decisions on local people? When that happens, the person who closed a unit will actually be on the other side saying, "This is not on because it is not a decision made by local people."

Professor Stephenson: The way you always take people with you is by rational argument. I worked in a city that had two hospitals three miles apart. Eventually they united. There was huge resistance among doctors and the public for a time, but eventually the arguments around quality of care and not duplicating services held sway. That is the way to make the argument. It is certainly not a case of blaming just the MPs or just the doctors. I

acknowledge, Andrew, they have certainly played a huge part at times in resisting change, but the landscape is different now. There is an opportunity now.

Q441 Chair: Briefly on your report, Professor Stephenson, you talk about the responsibility for all doctors to be part of saving resources. What do you think needs to happen where you have doctors who are outliers, who are clearly not taking a role in that? Now we have the resources to identify outlying practice, what is the view of the Academy of Medical Royal Colleges on what should be the approach for those doctors who take the point of view that says, "I will spend whatever I like. I only have a responsibility to the patient in front of me"? Do you have a view on that?

Professor Stephenson: Yes. Just to be clear, we do think the doctor has a responsibility to the patient in front of them and that this is not about erosion of quality of care. You have to give the person the best care you can. But there will be situations where, all other things being equal—statins are a good example of a drug millions of UK people are on to lower the fat in their blood—if I think you need a statin and that is the right thing for you, but there are two of them that cost different amounts, we should prescribe the cheaper one. How should we make that happen? With better data, I do not think doctors can be allowed that kind of degree of, "I don't care." One doctor's waste is another patient's treatment. That is something I and most of my colleagues have believed all my practising life.

Q442 Chair: Who should take responsibility for making sure? If we bring everybody up to best practice, then we can save a huge amount, but we know there are some doctors who consistently refuse to take that approach. What is the responsibility of the profession and how can we change that?

Professor Stephenson: If you go back to hand washing, there are some doctors who consistently object to hand washing. Ultimately you have to deal with it. All doctors work within an organisation—

Q443 Chair: That is a little bit shocking, isn't it?

Professor Stephenson: They all work within an organisation—yes? Whether it is a partnership, a general practitioner, or a hospital, they have peers and are within a managed system. Ultimately, people cannot just be allowed to do what they fancy. That is not sustainable.

Q444 Chair: The question I asked you was, who should take responsibility for making sure that they either change or are helped to change? What should happen if they do not?

Professor Stephenson: In my practice it would be my clinical director. I am part of a team of doctors seeing emergencies. If I was prescribing an antibiotic that none of my other nine colleagues used and it cost 10 times as much, I would expect my clinical director to say, "Can you justify this?" If I can give some reason why that was the only antibiotic in the world suitable for that patient that night, that is fine. But if I just say, "Well, it is what I

always used," or, "It is what my boss taught me," I do not think that is acceptable today. I do not think any of my colleagues think that is acceptable.

Q445 Chair: So they should be held to account.
Professor Stephenson: Absolutely.

Chair: We are going to move swiftly on to the final bit, for Andrew George's questions.

Q446 Andrew George: It is on the question of competition. It is a contentious political issue and obviously our side have views on the matter, but so do your side as well. Mr Hare, your organisation has pretty much come to the view—I hope I am not misrepresenting you to suggest—that competition certainly adds not just the opportunity for choice but has made a significant contribution to efficiency and volume. Yet, on the other hand, Mr Hopson, you are saying that the evidence is rather mixed. I would like to have your comments on how we can judge on an objective basis whether competition can make a significant contribution to the more efficient use of public resources going forward.

David Hare: What we tried to do through our submission to the Committee was to look at what really matters to patients, which is the quality of services that are being delivered and the satisfaction rates that they have. There is a danger with the debate around competition that you become divorced from what actually matters, which is the contribution that the independent sector has made over many decades now and the feedback that patients give to that. For me, looking at competition, commissioners should be free to look at alternative providers where they feel the incumbent providers are unable to deliver the kind of services that they want. There is a danger of banging your head against a wall as a commissioner if you have no alternative provision available. But where provision is good quality, then I do not think you ought to be in a position where there is compulsory tendering or similar.

In terms of judging, we are looking to try and ensure that all services are of the highest quality. Looking at the provision of the independent sector, as I say, over many decades, there is pretty good evidence that that is good quality. I would also encourage greater transparency around some of that. If I look at My NHS, that currently does not include private providers. I argue very strongly that it should because, as a patient or a commissioner, if you are not able to make meaningful comparisons between different providers, that is not a fair place to be. So I would certainly encourage the Committee to look at that. But, ultimately, for me it is a problem.

Q447 Andrew George: Before you come in, Mr Hopson, when you say a "meaningful comparison", would that include being sure that we have all the evidence on which we can base that judgment, including that private providers are subject to the same freedom of information requests as public providers?

David Hare: On transparency and freedom of information, I would take the Committee back to the Justice Committee's report of late 2012, which felt that the way in which freedom of information legislation applied to the independent sector, which was through the commissioner ensuring they get the same amount of information, was suitable. We are working with the CBI and others to look at how much more can be done within that space. Any recommendations would need to look across public services, not just within the NHS. But my sense on transparency is that I would not start there; I would start on quality and friends and family test activity, and other places, so that the public, patients and commissioners are clear on the performance of different providers.

Chris Hopson: I find it a very difficult topic on which to speak, talking about competition in its very broadest sense. There are two very clear examples. If you look at what non-NHS providers have provided in the hospice sector, it has been absolutely fantastic, and there are a number of obvious examples where having a plurality of providers has made a big difference. We would all argue, would we not, that giving patients the opportunity to choose between different providers, to choose whether they go to this hospital or that hospital to have a treatment, is important? There is an element of competition in that.

However, there are two bits that we would point to which we think are quite problematic. The first is the use of tendering in what is clearly a very immature market. The obvious example I would give you is 111, where a bunch of commissioners who did not really understand what they were commissioning asked a bunch of providers who did not really understand what they were providing to pitch for tenders. As we all know, one of those tenderers went down, and who was asked to pick up the pieces and come in behind? Answer: NHS ambulance trusts because they were the only people who were capable of solving the mess that had basically been created.

Another very obvious example we would point to where unbridled use of the concept of competition has not helped is in Bournemouth and Poole where two foundation trusts came up with a perfectly sensible idea, it seemed to us, of coming together to create a single, better, more effective service but were stopped by the competition authorities on the grounds that somehow "competition" concerns were more important than the needs of local patients.

It is a difficult debate to have in the abstract. There are areas where plurality of providers has been helpful, but I am very nervous about elevating it as an ideological principle which has to be observed in all cases.

Q448 Andrew George: One aspect of the contrast that is often made between private providers or the contract system which has been set up and that of the NHS is that, under those tendered contracts, everyone works to contract, whereas in the NHS—or at least the NHS ethos used to be, and it still exists perhaps in some acute hospitals—the providers of those services do what is necessary to do for the patient. Do you think, Professor Stephenson, that that ethos is being undermined by the stripping away of the easier contractable parts of the NHS work?

Professor Stephenson: You make a very good point. Doctors' greatest concern about competition has been the possibility of fragmented care rather than integrated care; I will

keep it brief. You hinted at that and I think that remains a concern. The second point is that now in the NHS, in England anyway, the alternative providers are paid at the same tariff as the NHS, so it is more difficult to argue that they are somehow getting the work for cheap. They are paid the same. Therefore, probably most doctors and patients are not too bothered when they are ill, ultimately, who is providing the back-office functions. What they really want is top quality care, often provided by NHS staff, whom they meet. They are probably more concerned about getting top quality care, getting it on time, accessible and free at the point of delivery based on need rather than who provides it. After all, the national health service is now made up of probably almost 300 devolved bodies. It is not the national health service as constructed in 1948 anyway.

Q449 Andrew George: Do your members not say to you—those that just work within the NHS—that they see their colleagues walking across the road, on occasions moonlighting for the private sector, arguing that they have split loyalties? How do you, as a professional body, reflect those kinds of tensions?

Professor Stephenson: I have never seen a private patient in my life. It has always been the case—part of the deal in 1948—that doctors working in the NHS were allowed to see private patients and work in the public sector. I do not really know of that happening in any other industry. I cannot see the NatWest bank letting people work for Lloyds at the weekend, but that is the way it was created in 1948 and no one has been minded to change it since. The view is that people are allowed to do what they do in their own time as long as they are not taking time out of what they are employed and paid to do for the national health service. The system at the moment is that they are entitled to spend their evenings and weekends doing what they wish.

Q450 Andrew George: Finally, Mr Hare, are you so confident of the private sector's role that you believe that, ultimately, it could take over the role of the NHS itself? In other words, the NHS will be entirely run by—I do not know—"Tesco Care" or Virgin Care, or would you prefer to see the private sector just picking and choosing the bits you think you can take on board?

David Hare: There is something quite fundamental in this almost about what defines the NHS. Chris made the point earlier that it is not about bricks and mortar. My members and their staff would say they are providing NHS services to NHS patients. While their ownership model might be private, they would not see themselves as fundamentally different.

The point about values is a fundamental one. Within my membership, there are tens of thousands of staff delivering services to NHS patients every day. Their values to ensure that the care that those individual patients receive is no less strong, inherently within them, than it is within NHS providers. In terms of the increasing role of the private sector within the health service, over the last four years we have seen round about an additional percentage point, something like that, on overall care to NHS patients coming from the private sector. If you carry that through, as a sort of broad trajectory, it will take an awfully long time before you are at anything approaching total dominance; probably the year 2400 would be pretty much where you would end up getting to. So it is evolutionary.

Going back to my earlier point around allowing local commissioning groups to make those decisions, it should be for them to make, and NHS clinical commissioners have said they want all the resources available in order to be able to secure the best quality care, and I think that should be including the private sector.

Q451 Andrew George: Finally, finally, in all of the discussion so far you have not advanced the case that, in order to address the long-term funding problem for the NHS, the answer is to go to private providers because they will provide the efficiency to make the savings necessary in the longer term.

David Hare: There is scope to use private providers to drive those efficiencies, but that should be for them to demonstrate to commissioners or work in partnership with other providers.

Q452 Andrew George: You are not making that argument today.

David Hare: I am making the argument that there are private providers out there who can generate some efficiencies, but that will be for the commissioner to determine. I would not say any sector is better than another in the health service.

Chris Hopson: It is interesting to look at the performance of Hinchingbrooke where you have a district general hospital that was absolutely on the margins of sustainability, and we would argue—it is still early days yet—that the financial performance there has really been no different or significantly different from an NHS-run hospital. There is an interesting argument about whether the private sector can provide significantly greater efficiencies, particularly given the need to run a return for shareholders in a way that clearly does not need to occur for NHS hospitals.

Q453 Chair: Can I ask a point on something that we hear a lot from the public—a question that we are asked probably more than any other—and that is, are we moving to a US-style system? Have you seen an extension of charging or top-ups? Perhaps as a jobbing doctor, as you described yourself, Professor Stephenson, you could answer? Are you aware of any new charges or top-ups? Do the public need to be concerned about that?

Professor Stephenson: Are you asking me do I think there should be or if I am aware of them?

Q454 Chair: No. I am asking you, have you seen it? It is something that the public ask us. Are we moving to a system where we are being charged for treatments? Have we moved away from that very precious principle that people hold about it being free at the point of use based on need and not an ability to pay? Have you seen any extension of charging or top-ups?

Professor Stephenson: No. Since 1948 we have had spectacles, wigs, dentistry and prescriptions. I am not aware of any great charge on that more recently, no.

Q455 Chair: Great. Mr Hopson and Mr Hare, have either of you seen any new charges or top-ups?

David Hare: I have seen no evidence of that at all.

Chris Hopson: No.

Chair: Andrew has a final point to ask.

Andrew Percy: Yes. This comes to the very point of the political debate around the NHS and how damaging it can be. I want to ask a similar question for confirmation because this nonsense that we are moving to an American system—which is obviously a private insurance-based system—is often trotted out alongside the Health and Social Care Act. We talked earlier about France and Germany with regard to their improved health systems. In France 25% of all hospital beds are provided by the private sector, and in Germany it is about 38%, or vice versa. I want to know about the ideology because I do not have any ideology one way or the other on this: I do not care as long as patients get better treatment and outcomes. Can you say a little something about what you think around this ideological debate, which seems to be occurring at the moment, and how helpful or unhelpful that is to the NHS? Also, perhaps, can we have your views on the role of independent providers, whether that is private or charitable? I noticed that when they were in Government they were "independent providers" and now they are "private providers" when we use them.

Chair: Question.

Q456 Andrew Percy: Can you confirm what the experience has so far been, which you have just touched on? Have they damaged the system? Are they damaging the system? Are they improving the system or are they pretty much turning out exactly the same as what the NHS turns out anyway?

David Hare: Can I?

Andrew Percy: I can guess your response.

David Hare: I will kick off as it is probably in my direction. The debate around the role of the private sector in the health service often gets quite conflated. The term "privatisation" gets bandied around. What we are looking at really is how commissioners can deploy the independent sector where they feel there are quality issues with incumbent providers, and if you look at some of the evidence on performance there is good evidence to suggest that the independent sector does a good job, but we need to dramatically extend that. If you look at some of the friends and family test feedback, again independent sector providers do quite well.

Chris mentioned choice and he is absolutely right to, but for certain procedures—not all—we want to be able to offer patients choice. They say they want choice and that requires, therefore, there to be alternatives, and I would argue that that will slowly but surely drive up standards. The challenge is that we need a plurality of provision. We have had a

plurality of provision, to be honest, in the health service for a long time—in mental health, since the 1980s—and we are beginning to get that more and more in other places. That is a fundamentally good thing. Unwinding that would be very difficult to do, but we need to understand much more about the quality of performance of provision, which is why I am slightly disappointed by private providers not being included in My NHS. We need to move on from that and grow and develop it significantly to enable patients and commissioners to have a much better understanding of performance. But I feel they have contributed an awful lot over many years.

Q457 Chair: We need clear, comparative data, would you say?
David Hare: I would.

Professor Stephenson: I do not think most doctors are ideologists either. I will give you an example that crystallises what you are asking. Imagine a hospital serving about 200,000 people, probably with about 400 beds—the 10 or 15 hospitals that are struggling most in England right now would be about that size—and there are three cities close by, all about 30 miles away, all with 1,000 to 1,500-bed hospitals. If you ask the people who live there and the doctors who work there, "Do you mind which of these hospitals takes you over?", or indeed, "Do you mind if a fourth body comes in that is private and runs your hospital? You get good care; you get paid and good access, and few complications and low mortality rates," I do not think those people are going to be too fussed who is running that. I will finish here as I do not want to over-repeat myself. As long as for those 200,000 people the service is free at the point of delivery based on their needs, I do not think they are too bothered, nor are the doctors delivering the care, who is providing it. There will be some exceptions to that, but, by and large, they would want the best service for their people, which might include some of the things staying there and some of the things going to those three other big cities if it is complex and difficult.

Chris Hopson: We need to look at where the private sector has most extended its reach inside the health service. The answer, as we know, is that under the Labour Government there was a real focus on creating elective factories, where effectively they were putting through significant amounts of throughput for, particularly, hips and knees. I just make the observation that bits of the NHS are now doing that, so there is a group of trusts in south-west London who have created the South West London Elective Orthopaedic Centre and they have put all their orthopaedic cases through that joint venture between—I think it is—six, seven or eight trusts and are getting the volume throughput that was the key part of the model for private providers. In mental health, there has been a bringing of some extra innovation. Hospices are an area that I was talking about earlier. There are bits of the NHS where having real specialist providers has brought a different element to things. But if you are asking me the questions, "Have they massively improved the quality of care? Have they massively improved efficiency?", the answer is no. NHS organisations have proved that they can match private providers in the quality of care and the efficiencies that they offer.

The other final point to make, of course, is that I do think—and you would expect me to say this—that the FT model, the introduction of a more fleet-of-foot autonomous organisation accountable to its local community, has enabled NHS foundation trusts to mirror some of the things that you would expect private providers to provide. They are

more fleet of foot. I would argue they are more entrepreneurial and have been able to do a number of different things that you perhaps might expect a private provider to do.

Chair: Thank you. Barbara, you had a final question, did you, because then we have to move on to our second panel?

Q458 Barbara Keeley: Yes, indeed, I did. The last range of comments that we had I do not think could just go unchallenged without any further points being made. Mr Hare made a point about evolutionary, very slow steps to the private sector. That is not the case in some parts of the country now. If Stoke and Staffordshire go ahead with prime providers being private providers, then that is all of cancer and end-of-life care services. That is £1.2 billion. It stops being evolutionary when you take a step like that, and there is concern among some members of this Committee about that.

The other point is that all of you—or at least two of you—have just made comments about efficiencies and the wonderful private sector stepping in with all its efficiencies. Who will train the people that the private sector providers rely on, if you like? The deal that was done in 1948 is fine, but those consultants who toddle off at the evenings or weekend to earn a bit more money have been trained by the NHS. We need to start thinking through, with all of these non-evolutionary, big jumps that are being made, what happens in the end? Is the private sector so efficient that you make it prepared to take on the training cost, otherwise you are just creaming off, taking the best, when you have not contributed to the training? Even employers in the construction industry have to pay a levy where they take on people trained by someone else. It is a peculiar thing that we have allowed this hybrid way of working that has come from 1948, but that changes once you get to the point of having a critical mass. In my thinking, the Staffordshire and Stoke thing pushes us to the point of who trained them and why the NHS should keep on churning out trained people.

David Hare: I am happy to pick that up. The independent sector does do training, certainly through ISTCs.

Q459 Barbara Keeley: Not full training.

David Hare: Certainly through ISTCs there is training of staff.

Q460 Barbara Keeley: Up to consultant level—of course it is not.

David Hare: My view on training is that, currently, the independent sector is not allowed to access funding for training. I agree with you that it needs a look and we need to look at how we can bring that through. I would be resistant to the idea of a levy because I do not think it reflects the training that goes on.

Q461 Barbara Keeley: But you are not then just creaming off what the NHS has done. You should not make these statements about efficiencies when you are using people that the NHS has trained.

Professor Stephenson: I was dean of the medical school in Nottingham at the time the independent treatment centre was set up, and you raise a very important issue. It created a problem for training medical students to be doctors and it created problems with training doctors to do those more straightforward high-volume procedures that were being done. It is an absolutely reasonable point to raise and it requires the commissioners to take a look in the round. It is not just about who can provide the cheapest care. It has to include sustainability— that is, training the people who do tomorrow's care. Your point is very well made.

Chris Hopson: The 111 example that I was quoting earlier gives you a classic case study of what can happen when you jump straight to a competitively tendered market in which effectively you have commissioners who do not really understand what they are commissioning, private providers who do not really understand the service they are trying to provide, and we had a bunch of ambulance trusts, who, when they put in the bids for 111, said very clearly, "It is going to cost this amount of money to run that service." Large numbers of them got undercut by commercial providers, and then what happens? The commercial providers get the contract, a year later the service falls over because it has been badly commissioned and badly contracted, and, as I said, who gets asked to pick up the pieces? The good old NHS. I have to say it is a great example for me about where you are absolutely right to highlight the dangers of jumping wholesale for these new contracting models that the NHS is not used to and where, to be frank, neither commissioners nor providers are at this point mature enough to really understand what they are commissioning and bidding for.

Chair: I know our next panel have been waiting very patiently, but, on that note, thank you very much for your time today.

Witnesses: **Dr Peter Carter**, Chief Executive and General Secretary, Royal College of Nursing, **Professor Nigel Mathers**, Honorary Secretary, Royal College of General Practitioners, and **Dr Mark Porter**, Chair, British Medical Association, gave evidence.

Q462 Chair: Thank you and apologies for keeping you waiting by overrunning on our first panel. Could you start by introducing yourselves to those who are following the debate, perhaps starting with Dr Carter?

Dr Carter: I am Peter Carter, chief executive of the Royal College of Nursing.

Professor Mathers: I am Nigel Mathers, honorary secretary of the RCGP and a GP from Sheffield.

Dr Porter: Hello. My name is Dr Mark Porter. I am a consultant anaesthetist in the NHS. I am also chair of the council of the British Medical Association, which is the largest voluntary association of doctors in the country with 153,000 members.

Q463 Chair: Thank you very much. Can I start by asking, as we did in the first panel, whether you recognise the scale of the funding challenge as set out in the Five Year Forward View, perhaps starting with Dr Carter?

Dr Carter: Yes. It is irrefutable that the NHS is under huge financial strain. You now have the majority of foundation trusts and other trusts in a deficit. That is unprecedented. We believe it is as a result of flat lining for the best part of five years. While the Government has quite rightly said that they have not cut the NHS budget, the fact is that costs have risen, activity has risen and it has not kept pace with it. If I could go on to make a point, when there were just a handful of trusts that were overspending or in deficit it was quite easy to say, "That is as a result of poor management." Now that the majority are overspent, I do not think that can be said.

If I may make one further point to demonstrate an example, if I owe the bank £1,000 and I cannot pay it back, that is my problem. If I owe the bank £100,000 and cannot pay it back, it is the bank's problem. With so many of these really good and excellent trusts in deficit, it now becomes the Government's problem and the Government have to look at it. Just pointing out or trying to say that this is a result of poor financial management does not wear.

Professor Mathers: In terms of responding to the Forward View, we very much welcome that document. There are things in there particularly for general practice that we welcome, including the areas of expanding the work force, shifting resources and also exploring and developing different models of care to ensure that more care for people takes place in the community. I would reinforce what Peter Carter is saying. It is on the background of a limitation of resources for the NHS. As I am sure you are aware, general practice is having a crisis at the moment, a work force crisis, a work-life crisis.

Q464 Chair: Would you agree with the level of the deficit—the funding gap—that is set out in the Five Year Forward View, though?

Professor Mathers: I am sorry; I did not hear that.

Q465 Chair: The question was whether you agreed with the level of the financial challenge as set out in the Five Year Forward View. Is that something you would recognise?

Professor Mathers: Yes, at least.

Dr Porter: Thank you. The Five Year Forward View is particularly important. It lays down the estimation of the funding gap. It estimates up to £30 billion in the next five years—£30 billion per year. That accords with other independent estimates—with the

Nuffield Trust—and it accords with what we are seeing and what we feel is the reality on the ground. It is also a particularly important document because it does not lay down one single method of dealing with this. It is really important to recognise that what the Five Year Forward View has done is said, "Here is the scale of the problem. There are a variety of choices and ways to address that problem, and what is appropriate for local situations and local health economies should be chosen from this, but it also requires Government to make a particular choice," and of course it is addressed to each of the parties competing for the next election. But this is all absolutely against the background of a situation where at present in the NHS demand is far outstripping supply, especially in emergency medicine and general practice.

This week, for example, we see that Devon CCG finds itself unable to cope with the expected demand and it is putting proposals to limit the national health services available in Devon, the likes of which we have seen before in response to previous funding problems but this time it is almost incomparable in scale. There are proposals to limit the care offered to some patients in order to try to prop up the care offered to others, and we are very concerned that this introduces explicit rationing at a level not seen previously under the financial pressure applied by this Government.

Chair: Thank you. You feel that has differed from financial challenges in the past.

Q466 Andrew Percy: On that, before I come to the question I was going to ask, we all understand the financial situation and we all understand the demographic shift that we have seen in this country, the cost of treatment and all the rest of it. When was the failure to plan adequately for what is happening? This has not happened overnight. We have continued with the same model of care for years, but a decade or two ago this should have been foreseeable.

Dr Porter: It is fair to look back. One of the problems here is that, when one looks back, one looks into different Governments. I try not to favour one Government rather than another, for obvious reasons, especially here, but it is possible to look back and to say that there was a deliberate decision taken about 15 years ago to increase the proportion of the national wealth spent on health. Chris Hopson, who was here before me, made the good point that that investment is something that all civilised societies choose to do as a direct benefit for their citizens. That choice was made. Perhaps there were not adjustments that went with it that went to a great enough scale, but the decision was taken in this Parliament to rack back on that, to change that, and, indeed, to stop increasing investment in the health service and to hold it to flat cash. That has produced an uncomfortable crisis. That crisis may well be exacerbated, as you say, by problems with looking at a settlement that goes over a longer period and problems with looking at necessary adjustments that go with it, but it has to be recognised, as the Five Year Forward View does, that a funding gap has opened up that finds us staring into the abyss.

Q467 Andrew Percy: That does not deal with the lack of availability of GPs at a weekend; it does not deal with a lack of available community care beds; it does not deal with the demographic shift issues. Whether or not a political decision was taken to increase spending or not—I would argue, and you could understand my position, as to why we have

had to hold that back, although at least we are not seeing what has happened in Wales where the budget has been cut—that does not change the fundamental issue. As to the amount of money going in, the fact is that how the system is designed is a major flaw at the moment. When was the failure to structure properly? Somebody should have seen this, as I have said, 10, 15 or 20 years ago. All Governments perhaps are at fault for this, but the large part of the problem we have at the moment is the failure to adequately structure the service to the demographic shift that we have, and that did not happen one year, two years or five years ago; it happened many years ago, did it not?

Dr Porter: You are absolutely right that a longer-term view needs to be taken about the settlement. One of the really frustrating things about working in health but at the representative level I work at is that we see short-term views all the time, sometimes with us, but particularly with the people who are funding the health service from year to year. Getting something like a longer-term view that goes beyond a three-year comprehensive spending review and a five-year Parliament—obviously we have only just had fixed-term Parliaments—and looks at the offer we make to the people has bedevilled health politics for decades; it is the ability to raise one's head, look beyond that and say, "What are we doing here and what do we expect to achieve in 10 or 20 years?" There was talk earlier of the Barker commission report, and that provides one seminal moment that allows us to say, "There is a choice here as to how we determine the next few decades." Our ability to respond to that shows our ability to rise above the year-to-year funding problems we are seeing at the moment.

Dr Carter: You are absolutely right that the problem is that there has not been what I would call intelligent service redesign. The RCN is not party political; we value our independence. I am going to say at the outset that the previous Labour Government did a lot of really good things—okay. What they did on waiting lists was incredibly impressive; what they did in relation to mental health was impressive. There were lots and lots of achievements, but one of the mistakes I believe they made was that, when they had that money, they should have targeted more at service redesign rather than doing the same things in the same way. An opportunity was missed. As I say, they did a lot of very good things, but an opportunity was missed. We are where we are. I would say let us look for a political consensus. Let us look at what we can all agree on.

If I can give you an example on the public health agenda—and just indulge me for a moment—what do we know? A fifth of people still smoke; a third of people are overweight; a third of people are drinking excessively. Now is the time to get upstream with that public health agenda. It will not give any MP or any of us any short-term comfort or relief, but maybe in 10, 15, or 20 years' time we will get the benefits. If you do not do it, you are going to have a population that continues to be a drain on the service because of those lifestyle-induced illnesses.

Professor Mathers: May I add a small thing? It is easy to be wise after the event. One thing that was not anticipated was the increasing numbers of older people who have more than one condition and have long-term conditions. That has been a fundamental change in the nature of the demand upon the service. The hospitals and the guidelines are all designed for the mythical average person who only has one condition that needs treatment by a specialist. But most people who are over 65, who have a long-term condition, have more than one. The most common long-term condition is to have more than one. So the GPs and the patients are at the end where you have multi-morbidity and long-term

conditions, but the service, the guidelines and the hospitals are set up for individual, single disease organisation.

Q468 Andrew Percy: We might disagree on mental health services, representing a town that lost all of its mental health services in 2008, but, anyway, I accept the point that all Governments do good and bad things.

One of the key pressures we have at the moment, we are told, is on staffing and the ability to recruit permanent staff. It is a particular problem in my trust, which is Goole and north Lincolnshire, and Hull and east Yorkshire—particularly Goole and north Lincolnshire— and especially in the area of emergency medicine. What is your interpretation or assessment of how big a problem that is and how that should be solved? Is it just a matter of pay? How do we solve this issue? We are importing nurses from Spain in my area because we cannot recruit nurses. What is going on here?

Professor Mathers: It is a cultural issue at the moment in terms of recruiting people, and I will only speak about general practice. We are not getting enough people coming forward to train as GPs. We have a large number of older GPs of my generation who are retiring early and we have a large number of non-returners who have taken time out and are not coming back. The system at the moment does not facilitate returners back into practice; it does not retain all the skills and expertise of the older GP who could be found other roles in terms of leadership and CCGs rather than just retiring. The other thing is that medical schools could do a lot better in making general practice an attractive career. For example, this year—it is a little bit late, I have to admit—we have introduced early years clinical exposure for our medical students. The first lecture the students get is from myself, and then in the next two weeks or so and then throughout the next two years they visit general practices, develop relationships with the doctors and see community practice. That is one way of addressing the problem of lack of staffing.

Dr Porter: There is a balance between three factors on this. One is the pressure that the people are under. It is general across the health service but it is concentrated, for example, in areas you have mentioned, such as emergency medicine and general practice, which are feeling a particular brunt. There are other areas that are difficult to recruit to because of the pressure of work load in that particular specialty. At the same time we have an overall health system where the efficiency savings that have been made over the last three years have come, in large part, from the pay packets of the staff. It is basically that the efficiency savings that have been made so far have been made by reducing the pay of the staff by roughly 15% over the last few years. Everybody who is involved in health economy says that is unsustainable. We are starting to see some really serious staff unrest in the national health service simply because of the way that pay is reduced year on year; costs go up; pay stays the same. It has an effect in the end. That is a general situation, but it also applies in the hard pressure areas because people feel under-rewarded.

Q469 Andrew Percy: Pay is the key issue, you believe, particularly in emergency medicine.

Dr Porter: Pay is one of the three key issues. One is pressure, another is pay and the reward that people feel, but the final one is a structural problem within the national health

service. Remember that each of these will be to different extents in different areas. We are seeing a much greater use of mechanisms that prevent permanent staff recruitment at the moment. For example, there is a lot of concern about the size of locum and agency staff bills. There are some parts of the health service—and I suppose sessional general practitioners would be a good example—where people have made a valid and good career choice to work as a sessional general practitioner, and I would say that is a brave choice in today's NHS, but nevertheless they are a valued part of the service. There are other places where the use of locums and agency staff is being used as an emergency response to the fact that one is not allowed to recruit permanent staff because permanent staff provide a long-term drain on budgets and every budget is under pressure. For example, in order to recruit staff now, it is common to have to fill out a large number of forms and get the permission of a large number of bodies that one would not have had to a little while ago. Everything should be accorded proper oversight; of course it should. But when it is impossible to recruit, let's say, consultants to a specialty where there are lots of people wanting to work in that specialty and they are required, simply because all staffing recruitment has come to a freeze because the trust is £20 million in the red this particular year, of course they turn to agency stuff.

Q470 Andrew Percy: The issue for a lot of them is not that they would not but that they cannot.

Dr Porter: As I say, it is different in different areas. There are areas, such as the one you represent, that, quite frankly, find themselves on the very underprivileged end of the national health service. When funding squeezes come, they hit the less popular and less fashionable areas first.

Q471 Andrew Percy: We do not think of ourselves as less fashionable.

Dr Carter: Mr Percy, can I say, it is not an issue to do with a lack of people wanting to do this work? There are just over 20,000 training places each year for student nurses. There are 200,000 applicants. It is quite an astonishing figure that, despite everything you have heard about nursing—and it has had a hammering in the last few years—you still have several hundred thousand people each year who want to be nurses. The problem is the lamentable work force planning. Just take here in London by way of example. Four years ago NHS London decided to cut the 2,000 commissions a year by 24% to just over 1,500. At the time we said, "This is ludicrous. London needs those 2,000 new nurses coming through each year." That has been reduced to just over 1,500. What do you now have? You have a problem with supply. So what is happening? All over London and virtually all over the United Kingdom trusts are going to Portugal and Spain, and we have depleted the Republic of Ireland—there are no spare nurses left there at all; we are going to the Philippines and Africa. Yet we have hundreds of thousands of people in this country who want to train as nurses.

It was the short-term thinking, about four years ago, to cut those places that cut the supply line. Now we are paying for that. The reality is that now, and for years to come, we are going to be reliant on overseas recruitment. As well as that, more UK nurses are going abroad now than are coming in, so we are losing both ways. We are really concerned about the possible effect if ObamaCare takes off because in the United States people are

paid more and get better terms and conditions. Recruitment companies come to the UK all the time from the US and they say, "We don't know why you are criticising what is going on in the UK. We love your nurses; they make great nurses." We are also losing them to Australia, New Zealand, Canada and the middle east. I would ask MPs to reinstate the requisite number of student nurses that are needed in order to fill that vacancy.

Q472 Andrew Percy: What was it before, sorry?

Dr Carter: We had approximately 25,000 training places. Now it is just over 20,000. Health Education England is now doing something to address that, but the damage has already been done. So there are people who still want to be nurses.

Q473 Andrew Percy: Is it going up?

Dr Carter: Now—

Q474 Andrew Percy: To what?

Dr Carter: Now they are playing catch-up and it is just over 20,000, but we are still below what we were five years ago.

Q475 Chair: To clarify, what is it now, Peter, this year? What is the number of training places this year?

Dr Carter: I cannot remember it off the top of my head, but it is something like 21,000. Can I get your Committee the exact number?

Chair: Yes, thank you.

Dr Carter: But I can absolutely assure you that we are training less now than we were five years ago.

Q476 Andrew Percy: And there is a demand for them now.

Dr Carter: As I say, you have about an 8:1 or 10:1 chance of getting in, so there are plenty of people who want to be nurses and it is absolutely tragic that they cannot do that. Also, there is something ethically wrong with going to developing countries and raiding their already stretched nursing work force in order to bail out poor work force planning in the UK.

Andrew Percy: I could not agree more.

Q477 Chair: Returning to a point that Dr Porter was making, yes, we have shortage areas in medicine, but do you think we are still doing too much to encourage doctors to go

into training programmes for which there are no consultant vacancies? Why is that continuing to happen? Why is that not being addressed?

Dr Porter: Some of the calculations of people graduating off the top of the postgraduate training schemes indicate that we have way too many coming through in total. That is not something that is new. We have a bedevilled system that has been split into different specialties for decades. It has been largely maintained by a steady increase in the number of consultants working in hospitals, many of the people coming off the postgraduate training schemes being highly qualified doctors themselves, who then take up posts as consultants. One of the big problems there is that it has been sustained by that expansion. The expansion of the number of consultants over the last 60 years has more or less matched the expansion in the general economy—the expansion of national wealth. Over the last few years that has slowed down enormously, and, with the funding squeezes in the NHS and the restrictions on recruitment that I mentioned just now, it has been much more difficult to translate people through into a growing consultant base. That is not necessarily something that we would want to do in general terms because there are specific areas that need filling, and perhaps we do not direct, allocate or encourage people enough in the right direction towards specialties that we know need more, such as general or acute medicine.

Q478 Chair: Is it not a waste of resources, though, at the moment, when we are talking about the critical strain on NHS finances, that we are still encouraging doctors to go into areas where they are not needed for the NHS? Simon Stevens has talked about the NHS having work force planning designed for the convenience of doctors rather than the needs of patients. Do you think there is some truth in that?

Dr Porter: There may be some truth in that, but not a big truth, and I was going to go on to talk about it. The reason we do not try to control this problem more carefully is because the doctors who are on the postgraduate training schemes are themselves providing an essential and completely unmissable service for the national health service, in that the national health service, in terms of acute service to the patients of this country, provides a 24/7 service, which consultants help to provide but which also absolutely relies upon the service of the junior doctors who are training for specialist roles, whether that is for a specialist role as a consultant or indeed those who are training to be general practitioners but spend part of their time working in hospitals. One of the reasons why one does not need to look too closely at that is that we derive a great deal of service from those undergoing training. If, for the sake of argument, you said, "Let's pull out all the doctors there because we are training rather a lot of them," suddenly you would find a service that was not deliverable any more. We have run that relationship hand in glove for decades, but what it has always been fundamentally based on is the steadily increasing proportion of national wealth to match the demand on the service, and it is that dislocation over the last few years that is producing bigger problems than any other factor.

Q479 Andrew George: Further to that particular point and in relation to nurse training, when you go back a decade or more, since before Project 2000, the parallel was the case in terms of a ready work force of trainee nurses on the hospital wards who are no longer there, which has left quite a black hole in the resources available to the NHS. Is there any

capacity or do you think that the nursing profession might welcome or even engage in any discussions that might bring trainee nurses back in that kind of environment?

Dr Carter: Well, 50% of the training is spent in clinical practice and we think that is right. It is also compliant with European law. Again, there is a bit of a myth that nurse training is university based. People understand that to mean that they do not see a patient until they have finished their three-year course. That simply is not the case. Half the course is spent in clinical practice and I think that is the right thing to do. We want to ensure they have good quality clinical placements. The real problem in terms of the work force is that, compared with most of western Europe and countries such as Australia and states like California, we have fewer nurses per head of population than those countries. It is a fact. We have fewer nurses per head of population than the Republic of Ireland. I do not think tinkering with the training—the education of nurses—is going to solve the problem.

Q480 Chair: Thank you. I am quite keen that we do not spend too much longer on this because we have other subjects.

Professor Mathers: I want to point out that between 2006 and 2013 there was an increase in the number of consultants of 27% and in general practice it was 4%. We are reaping the rewards of that.

Chair: Thank you. That is a helpful point. Now we will come on to Rosie.

Q481 Rosie Cooper: Not labouring the point, I have just written to Simon Stevens because my local hospital is complaining that they do not have enough junior doctors; they are worried about the balance. How realistic is it to expect the NHS to achieve the efficiencies and reorganisation to the degree that is outlined in the Forward View?

Dr Carter: First of all, can I say on record that we are hugely encouraged by Simon Stevens? We thought his plan was one of the most coherent, well written and grounded documents that we have seen in a very long time. Our wish is that he is now allowed to get on with it and, with due respect, that there is not too much political interference. If Simon Stevens is allowed to develop that plan, we think it will go a long way to ameliorating many of the problems in the NHS. Having said that, the scope for efficiency savings has been, by and large, exhausted. Yes, there will always be examples of individual hospitals or providers where you find some inefficiency. We believe that the NHS needs more money. I know people will say, and I have heard you say it, Rosie, that people always say that, but the reality is—compared with western Europe, the Republic of Ireland, most of the Scandinavian countries, and America spends over twice as much as we do on their health care system, compared with Australia and all of these other countries—that we spend less as a proportion of GDP on our health care system. So yes to efficiencies, yes to Simon Stevens's five-year vision, but also the next Parliament has to address the underlying issue that there are insufficient funds in the system.

Rosie Cooper: Absolutely.

Professor Mathers: In terms of efficiency savings, I would largely agree with Peter Carter here that there is very little scope left for more efficiency savings, and in general practice we are run ragged just trying to deliver the service as it is. What is needed is a whole different way of delivering care in the community. We need to have transformational change in the way that we look after patients in the community, and efficiency savings are not the way to go given the stretch that we are under at the moment.

Dr Porter: Let us work out what an efficiency saving is. An efficiency saving is, "Will you do the work you are currently doing for 3% less money—in other words, for about 97% of the funding you are currently getting? Will you do the same next year for less money?" In fact, in real terms, it is not even that, because by the time it gets through to the sharp end it is, "Excuse me, doctor or matron, will you do about 10% more work next year than you are currently doing but for about 10% less money?" These efficiency savings of 3% get magnified by the time you get to the front end. We are seeing money stripped out of general practice and yet demand is rising. We are seeing money stripped out of hospital departments and yet demand is rising.

The thing that strikes me about the Five Year Forward View is that it does not focus on efficiency savings, which is good. It says there are choices here to be made between efficiency savings, investment and demand management, and it also talks about reconfiguring our services to cope with the future and in particular the integration of health and social care. It does not say, as some Government Ministers might have said recently, "It just identifies the sum of efficiency savings and says 'Get on with it.'" It says, "If you think you can achieve this much in efficiency savings, you have these choices left over on investment and these choices left over on demand management. If you do not think you can make that, you have these other choices, but the choices are constrained by the efficiency savings you can make." The key thing to say about that—I would certainly agree with Dr Carter and Professor Mathers—is that the choices we have on efficiency savings are constrained by the fact that we have already made most of them; by the fact that the national health service, as judged by reputable international bodies, is the single most efficient health care service on the planet at present, and thus there is always scope to review what we are doing. Of course there is and nobody would ever say there is not, but can we strip significant billions of pounds out by efficiency savings? No, we cannot.

Q482 Rosie Cooper: I agree. So there is a £30 billion-gap. I hear what you are saying about "We have tried to do our level best"—and the Nicholson challenge was something else—"and we are at this position. We cannot go on with wage restraint; it is not fair and it is not right." But Simon Stevens told the Committee that a combination of bringing less efficient providers up to the level of the most efficient and gains that come from new technology and treatments would bring an efficiency gain of more than 2% a year. Do you agree?

Dr Porter: Long term, yes, but—do you know what?—new technology costs money and that is where you talk about investing to save. The biggest problem we have in the health service at the moment is the inability to be agile—the inability to identify investment programmes that can be made. To have to make the savings, as was said earlier, it is rather like trying to repair the engine on the aeroplane while it is still running. That is tricky, and to be able to do that with diminished resources as well is even trickier. The key point is

that the NHS is nothing like it was in 1948: its estate, staff, technology, techniques, treatment and outcomes are nothing like they were in 1948. The vision endures. What we offer to the population—our ability to provide a comprehensive and universal service free at the point of need—endures, but along the way in the last 65 years the NHS has been re-engineered from top to bottom and side to side by people who had the vision to be able to do so. We will carry on doing that, but you cannot rely on that striving for better outcomes and for changing as being the vision for delivering efficiency savings that can no longer be found.

Professor Mathers: In terms of the quality agenda, of course we want to bring everybody's standards up, and one of the best ways of doing that is through peer pressure and working closely with peers. That is why we are recommending federations of practices where best practice can be shared and some small efficiency gains can be achieved through the action of the federations. But we do not want to get into a position where our political masters are telling us that everyone must be above average.

Dr Porter: I have heard that many times: it works as a slogan.

Dr Carter: I want to make the point that Mark did that it is about investing to save. The parallel I would draw is with care in the community in relation to mental health in the 1990s. I am sure members of the Committee will remember that there was a constant stream of inquiries and scandals—homicides and suicides—and what was colloquially known as care in the community became a discredited concept, you know: care in the community fails. Actually, care in the community was a very good concept. Unfortunately, it was not properly implemented, and because it was not properly funded you had all those failures. When in 1999 the national service framework came in retrospectively and the right level of resource was put in, it did so much to stabilise things. However, the other problem with the care in the community concept was that it was overoptimistic about the reduction in beds. Just by way of example, look at the prison population now: part of the inflation of it is that you have people with mental health problems in prison who hitherto would have been in mental health facilities.

So we say yes to new ways of working, providing you get the investment and the structures in first. But do not be overoptimistic about the savings it is going to make because they may not be realised.

Chair: Thank you.

Q483 Barbara Keeley: I guess this question is in a similar vein. What part do you think changes to existing practice play in closing the gap, such as reducing hospital length of stay? You have heard a previous panel member make a robust response to targets such as reducing emergency admissions, but what part do you think the slightly different target of reducing hospital stays has to play?

Dr Carter: In 2003 there were 12,000 district nurses. What did they do? They kept a lot of people out of hospital who would develop conditions that required admission and they also facilitated appropriate discharge from hospital. We estimate that at any given time there are 26,000 people over the age of 65 who are in hospital unnecessarily; they are delayed discharges. That figure I gave was that in 2003 there were 12,000 district nurses. In the

figures published this very morning by the Government, there are now 5,595 district nurses. In a decade or more you have seen a massive reduction in the very work force that is needed as part of a team to keep people out of hospital. You can talk to GPs about their inability to access district nurses that maybe a decade or more ago was relatively easy to do. Again, that is part of the work force, part of the chain that you need to put in; if you reinsert those links, that would do so much to lessen the pressure that is currently being felt.

Professor Mathers: In terms of the work force, we strongly support Peter's comments around district nurses. We also need a lot more practice nurses as well because the secret of reducing hospital admissions is to have proactive care within the community. That is about care and support planning, putting the "house of care" model—which you are probably familiar with—in place, so that those who are at most risk of being admitted as an emergency to hospital are identified; and we have the district nurses, the practice nurses and the GPs sufficient to be able to implement those plans and reduce the number of unnecessary emergency admissions. One of the things we are seeing, and one of the reasons for the increase, is that social care has been cut so much. Adequate social care—not only co-ordinated, proactive care and support planning but also adequate social care—would reduce the number of admissions. That is my view.

Barbara Keeley: Thank you.

Professor Mathers: Let me give you an example drawn from my own practice. I work most of my clinical time in an obstetric unit, in a delivery unit. In conjunction with anaesthetists, our midwifery and obstetric colleagues, we have recently put in place an enhanced recovery after obstetric surgery programme that has reduced the length of stay after elective caesarean section by 40%. We have revamped what we offer to patients. We have changed their expectations by talking to them and changed some of the techniques we do, and we have cut the average length of stay from two and a half days to one and a half days for caesarean section. That change took place literally overnight when we introduced the new package of measures. That is fabulous. At the same time, this year our deliveries and concomitant caesarean sections have gone up by nearly 10%, following on 10% last year. The point I am making is that, yes, we continually strive, on the one hand, to make efficiencies, but the real reason we do it is because it is good for patient care and it is what the mothers want. It is to make our care better; that is what drives us. But the point is not to bank the efficiency and forget the increase in the demand because, overall, we will not make a saving. Overall, we will stand still because you have to match the efficiency against the increase in demand.

Q484 Barbara Keeley: Thank you. Can I come back to the point about district nurses and the numbers there? I am not aware of the exact reasons for the reduction, but it does seem like a very substantial reduction from 12,000 down to just over 5,500. Do you have a figure in mind that you think we should aim to get back to? Why was the cut made? The second part of that is that we hear separately about the desire to allow patients to die at home, but surely that needs more district nursing and support in the community as well.

Dr Carter: Absolutely. The reason you have seen that diminution is short-term savings—as district nurses retire, not replacing them. It is such a fragmented overarching state of affairs now that you save money by simply having a recruitment freeze because people

retire. I did not think that 12,000 was enough in 2003, and 5,500 in 2014 certainly is not enough. First, I would like to get back to the 12,000 but certainly to have more than that.

Q485 Rosie Cooper: Did not the Prime Minister say he wanted more school nurses, and as the school nurse numbers went up—health visitors, I am sorry—did not the number of district nurses go down? I remember asking parliamentary questions about that.

Dr Carter: School nurses have also gone down.

Q486 Rosie Cooper: Forget school nurses; I meant health visitors, I am sorry.

Dr Carter: As to health visitors, the Government are committed to recruiting 4,500 and we think that is a very good thing, but please do not recruit them at the expense of district nurses because again—

Q487 Rosie Cooper: Is that not what has happened?

Dr Carter: That is part of what has happened, yes; people are robbing Peter to pay Paul and that is no way to run a health service.

Q488 Barbara Keeley: Do you have any further comments about district nurses?

Professor Mathers: No, other than that we need more.

Barbara Keeley: Just a lot more.

Q489 Chair: Thank you. Can I return to the Five Year Forward View? There were several models suggested, some of which involve hospitals being able to take over general practice and some on more of a federated model. What is your view, as a panel, on the various models that have been put forward? Simon Stevens talks about, rather than having 1,000 flowers bloom, choosing from one of these models that they have looked at. Peter, could I start with you?

Dr Carter: Simon's plan came out a few weeks ago. Like many other organisations, we are digesting it and there are a lot of interesting things that he has to say. You do need a mixed economy of resources so that you do not put all of your eggs into one basket. One of the things that Simon is saying is, "Let's explore the different ways of working." If you link it to the integration, if I may go on to say, all parties in different ways are saying that they want that integrated health and social care system, which most people would see as sensible. The problem at the moment is that people are unable to articulate how that would be operationalised. At the recent round of party political conferences, at which Mark and I did a joint thing with the Nuffield on it, the Secretary of State, the shadow Secretary of State and the Liberal Democrat Minister Norman Lamb really struggled to tell us how it would work in reality. We want to see and work through with Simon Stevens how this would roll out to make it more effective. I know there is this idea that you leave it to local determination. The problem with that is that you may possibly end up with a more

fragmented level of health care provision and—the thing that politicians and most of us dread—the postcode lottery. So it is really something to explore.

Professor Mathers: It is really important that we only explore three or four models for integrated care. It would be a bad idea to let 1,000 flowers bloom.

Q490 Chair: That is what he says, so you would agree with him on that.

Professor Mathers: Yes, absolutely—three or four models of care, but not to reinvent the wheel. There are some good models of care that have been demonstrated for health and social integration. Torbay is always held up as the shining example, but there are other forms of integrated health and social care around the country. A lot has been learned, a lot of work has been done and it is so important that we do not reinvent the wheel. The "house of care", for example, has been shown to be extremely effective in managing people with long-term conditions, particularly diabetes. It has been shown to be effective in Tower Hamlets, which, I am sure you know, went from being the worst provider in the country to being the best provider in terms of their diabetes outcomes. So, yes, we absolutely agree with the proposition that there need to be three, four or even five models of care in different parts of the NHS, depending on what the local needs are and what the local expertise is, but we need to put together what we already know. Again, as you may know, at the Future of Health conference last Friday, the RCGP was one of the partners in the Coalition For Collaborative Care, which brings together all the knowledge that already exists and implements the knowledge in different parts of the country through various opportunities for practices, federations and organisations to work with.

Chair: Thank you.

Dr Porter: There are two really bad things that could happen after the next general election. One would be to carry on assuming or hoping that competitive market mechanisms will be the saviour of us all and of the health service. There is little evidence to the positive for that and quite a lot of evidence that it is wasteful and causes fragmentation. But, conversely, the other really bad thing that could happen to the health service after the next election is for somebody to come in with a new, unifying radical vision that then becomes imposed upon the entire national health service, whether in England or across the UK, as the new top-down reorganisation to end them all—so big it can be seen from space, and so on. By the way, of course, the person who commented on that was not necessarily saying that was a good thing; I would not want to imply that. The point is that, if somebody comes in with this fantastic vision again next time, the hearts of everybody currently working in the NHS will sink into our boots. It is hard not to say, "Well, there is a wonderful pragmatic medium, is there not, here?", because choosing the pragmatic medium sounds like the Goldilocks average and picking something that is between those two extremes. But if Simon Stevens and NHS England can hold to that, can hold to not assuming that the same model must apply everywhere and yet having a number of permissively chosen and sympathetically interpreted models, as they have talked about, that would be really good.

There are a couple of other considerations that need to be borne in mind there. The first is that they absolutely have to be linked with the rest of the report. It is not all about efficiency; it is about investment as well. It is not all about these models; it is about

investment and choices as well. That always needs to be remembered. There is not just a single thing that can be plucked out of the Five Year Forward View.

The second thing—and you asked particularly about the models that apply to local organisation of general practice and secondary care and the sorts of integration that can happen—is that one really big bear trap to avoid is to assume that there is some sump of general practice that can be taken in order to prop up another part of the service. There is not. General practice is under huge pressure and taking part of that resource out in order to form new integrated bodies would be a major mistake. What is really needed in general practice is an investment to match the increase in work load and the increased pressure upon general practice. If that goes with whatever local reorganisation is considered useful and valuable by the local CCGs and the other health bodies, then so much the better, but we cannot assume that there is some group of GPs out there that can be brought in to prop up the hospital services under pressure. I do not think that is true.

Chair: Thank you. Andrew.

Q491 Andrew George: I want to ask with regard to future models of care—not just those proposed under the five-year plan—if there is going to be a shift of emphasis, or rather a continuing shift, away from acute care into the community, something which is desirable, with earlier discharge and fewer avoidable admissions to hospital, what is that going to mean in terms of the future configuration, for example, of nursing care and work force planning? We have covered, to a certain extent, work force planning, but this is the configuration of nurses and the configuration across the whole of the NHS.

Dr Carter: Certainly, in the curriculum of nurse training, I would like to see more nurses having placements in general practice and more nurses being able to work with district nurses; that is currently a problem because you do not have enough of them to supervise them. The clinical practice of the nurse working in a hospital is very different from working in a GP's surgery or in the community. You need the nurses to be properly educated to do that. You do have to look at what you need in the future and you will need a different type of nurse to work in that primary care setting. But can I say—for the second time during this session—don't be too overoptimistic about the amount of bed closures that can be realised by that, because you have this growing and ageing population? If care in the community in that sense is allowed to develop and mature and is properly resourced, you might be able to do that in the very long term but I cannot see you doing it in the short term.

Q492 Andrew George: Sorry, do you mean the other way round—that you can do it in the short term but not in the long term?

Dr Carter: No. What I am saying is that I cannot see that by investing in the community it is going to give you some immediate closures of hospital beds. I cannot see that happening. But, in the longer term, if you get into what I have already said, the health promotion, and into a properly set up and funded primary care service, downstream, maybe a decade or more from now, you might realise some of those savings, but certainly not in the short term.

Q493 Andrew George: I recollect responding to the NHS Confederation back in 2006, when they came out with their report of why we need fewer acute hospital beds, that they ought first of all to advise that primary care services need to be front-loaded with resources, if that is the case. You are basically proposing a model that says that that is in effect what we need to do—to invest in primary care in order to achieve the equilibrium between acute and primary in the longer term.

Dr Carter: Absolutely, you need investment, but you need to be realistic about how long that is going to take, and it certainly will not start showing up billions of pounds' worth of savings; it certainly will not.

Q494 Andrew George: Can I ask you about something that I have been campaigning for, which is the safe staffing levels on acute hospital wards? That in itself has financial implications. There have been a number of studies looking at the health economics of this, but if we are to address the issues of safer staffing to make sure that there is a level below which nurse-to-patient ratios should never fall, you must accept that there is a financial consequence to that. What can you do, as a professional body, to persuade the commissioners of acute services that this is the right direction in which to go?

Dr Carter: Quality costs. You cannot have a quality service on the cheap. I am sorry to say that, in the first few years of the coalition, the remedy to try to address the financial pressures was predominantly faced by nursing staff, with recruitment freezes, laying people off and down-banding people. Then you had a whole raft of problems that came in, and I am not just talking about Mid Staffs, which pre-dates this. Look at the 14 trusts that Sir Bruce Keogh investigated. The Government called them failing trusts. We did not call them failing trusts; they were struggling trusts. That is not just about semantics; that is a difference. What did Sir Bruce Keogh say? The common denominator of the 14 trusts that were struggling is that they had insufficient nurses—and insufficient nurses of the right grade and the right ratio. That is a fact. If you end up having cheap care, cheap care is poor care, and poor care becomes more expensive care because you have people in hospital longer, developing more conditions, developing issues in hospital that would be avoided with good quality nursing care. Andrew, you are right, that you cannot do it on the cheap, but what price good care? I say get it up to the European average and you will do so much to address the difficulties that we are currently facing.

Q495 Andrew George: As a theme, though, of both Professor Mather and Dr Porter, one can be persuaded by the arguments that, of course, quality costs money, but you are also arguing or suggesting in the middle of that answer that it is a false economy not to invest in quality. Have there been sufficient assessments, if you like, made to show that investing in decent quality is, in the longer term, a money saver, or are there the number-crunchers back in the Department of Health, who are rather quietly saying, "It does not save money. I am afraid we have to be hard-hearted about this"?

Dr Carter: We have shared with the chief nursing officer's office and the Secretary of State's office the evidence-based research by people like Professor Anne Marie Rafferty and Professor Linda Aiken, internationally respected nurse researchers, who demonstrate

the correlation between staffing levels and good quality care. That research has been internationally respected. These two women lecture all over the world.

Q496 Andrew George: I am talking about the money side of it. I can understand staffing levels and good quality care, but does it, at the end of the day and in the round, result in money saving, because this inquiry is about public expenditure and how to manage health and social care?

Dr Carter: We believe it results in better quality care, which ultimately is not only good clinically but is good for the bank balance.

Professor Mathers: It is the argument, is it not, that you have to invest in order to save? We are 8,000 GPs short and, if we are talking about reconfiguring the service, we need to ensure that we have sufficient GPs; 8,000 GPs is only one extra GP per practice. That is one of the ways to pursue this quality agenda. With regard to whether or not it will save money, we believe it will save money by keeping more people out of hospital, and there is some evidence that the models of care that are being proposed do keep people out of hospital. But any savings are not going to be in the next year or two; they are going to be further along the line. It is this idea of proactive care planning.

Dr Porter: I want to warn against an assumption that expenditure might be able to go down in future following investment now. The reason I say that is this. There are a number of elements of increasing quality. One element is increasing safety, by reducing the complications, and particularly complications that can be due to spending too long in hospital when one should be managed elsewhere, being managed wrongly and mistakes being made, and complications occurring that are iatrogenic or hospital acquired. In those circumstances, it is undoubtedly true that investing in proper care pays dividends both in the quality of care appreciated by the person, which sometimes is of inestimable value, and sometimes can be monetised, and you can put a figure on it and show that you are saving responsibly.

The other thing we have to remember is that one of the things that characterises the NHS—and I do not think characterises it as a drain but as something to be celebrated—is the increased technology we are able to apply to improve the health and extend the lives of people. Life expectancy is going up at present by five hours every 24. It is causing us interesting problems in adjusting to it—

Q497 Chair: Every 24 hours.

Dr Porter: Yes, people live longer.

Q498 Andrew George: Do you mean every 24 hours?

Dr Porter: Yes.

Chair: That is quite staggering.

Q499 Andrew George: So for every day they live they can—

Dr Porter: You can expect to live an extra five hours. That is on average, of course. That is not for each individual person. It depends on what you enjoy doing during those five hours, but the point is that life expectancy is increasing. It is increasing partly, not wholly, as a result of what we do in the national health service. The point is that that is an expensive thing to do, but it is a good thing to do and it is something that we think the population should celebrate rather than see as a drain upon its resources. The point is that it is a more expensive thing to do. The reason I am emphasising that is what you would not want to do is to say, "If we put in brilliant care now, we will be able to reduce the NHS budget in the future." That is not true. We will have thought of other interesting and really good ways to invest money in making people's lives better. The overall budget probably will not come down, but we will know that less of it is being wasted on the complications that can be caused by poor, inadequate and—what is the word?—different standards of care in different places.

Andrew George: Thank you.

Q500 Barbara Keeley: This is a question that you heard us put to the other panel. There is a consensus that there should be greater co-ordination between health and social care services, and the commission chaired by Kate Barker advocated that move to a single, ring-fenced budget for health and social care with a single commissioner. Both the Royal College of GPs and the BMA express their doubts about merging those two systems. Can you explain first why that is?

Dr Porter: The principal doubt about that is to do with the fact that at present it is true to say that, while we have spent a lot of time talking about the inadequacy of funding in the health service, were we people who worked in adult social care or for local authorities, we would be in a far worse position, and the budgetary cuts that have been suffered in that area have been even greater. One thing that can be a matter of great concern is that it becomes systemically or organisationally possible to divert health care funding into propping up funding cuts elsewhere in local authorities and in adult social care. It is not happening on a big scale, but you see the start of that with health service money through the Better Care Fund, for example, being used in some places to enhance adult social care, to be able to take people out of hospitals when they no longer need to be there.

I am not saying that is a major problem and I am not saying that in local areas it may not be something that is worth while doing, but that explains the enormous anxiety that those of us have in the NHS in thinking that something might be brought in that could end up in removing part of the NHS budget to pay for other things, while in some way validating and authorising the cuts that have been made to a much greater extent in other areas of the care that we offer to people in our country. That is not to say that, in the long term, it would not be a good idea, that in the long term that sort of model should not be explored and in fact would be really good to implement, but it would have to be accompanied by an understanding of what it is that we offer to the population that is wider than, "Let's get ourselves out of a hole by co-commissioning and co-budgeting these things."

Professor Mathers: We would share many of those concerns, but our primary concern is that we do not want any more top-down reorganisation—massive change. We have to move towards the integration of health and social care through evolution rather than

revolution and by top-down change. Practically, for the moment, targeting support to the frail elderly—the 2% of our population who are most at risk of being admitted to hospital unexpectedly—will be a way forward.

Dr Carter: It has all been said, in a way. The basic principle, of course, we support. We bring these two elements together, but it will not be a panacea to cure the ills of either the health or the social care system. It is very complex and it will need project planning. A good start would be a single joint national eligibility assessment process so that people are quite clear about who is being offered what. But, again, the principle is fine. The optimism should be dampened down about what it can deliver. My background is mental health—psychiatry—and there is no doubt that the integration of mental health and social services in relation to mental health has done so much to iron out many of the difficulties that hitherto have been encountered.

Q501 Barbara Keeley: Clearly you do not feel that the two systems should be merged, but do you have any views about how the two systems could be made to work together effectively? That clearly is the other side of what your response is.

Dr Porter: There are a number of things that we have often talked about that are important, and none of them are revolutionary and hopefully do not need any top-down impositions. There are things like coterminosity and addressing the silo working that Chris Hopson referred to earlier with somebody only being able to find out how the Better Care Fund was used by going into the public gallery when it was being discussed at a local authority; and, fundamentally, within what we do, by things which look at a patient's journey through these systems from their point of view more often than we do at the moment. Bureaucratic systems will tend to retreat into, "My budget, your budget; my problem, your problem. Can we move this on to you, and so on?", instead of saying, "There is an individual person navigating their way through this. How can we make their journey better?"

There are parts of the country—Cornwall, for example—where pilots like that are being introduced and introduced well, and there are other parts of the country where they could be introduced and extended. All these are relatively small things, and probably the most important thing about them is to look at things from the point of view of a patient, which perhaps all of us are guilty of not having done enough of in the past.

Dr Carter: Coterminosity is key; common language; computer systems that speak to each other; and trying to get away from the situation where patients have to give the same account to many different people in the system, when you would think there would be a common template so that people would have a clear understanding. All of these little things would make life just that much better.

Mark referred to the Better Care Fund. People should pause and reflect on that. Again, it was one of these initiatives that came out of the blue. It was heralded as something that was really going to make an impact. The National Audit Office has said it is a confusing state of affairs and it is not delivering—it was overoptimistic. The Public Accounts Committee, your own peers, have called it a shambles. That is the problem when somebody thinks it up, it is implemented, there is huge overoptimism, and then within a

relatively short space of time it is seen for what it is. It is just not delivering the promises that were made.

Dr Porter: There is one key thing to say about the Better Care Fund. Remember that, as a fund, it is health funding, so it contributes to the Government's maintenance of health funding. But when you work at the sharp end in patient care, the Better Care Fund is one of the things that has been abstracted before you get your funding. That is why the cuts are bigger at the sharp end than they are in Whitehall.

Professor Mathers: I would agree very much with what my two colleagues are saying. The future has to be in primary health and social care teams. For example, on Mondays in our practice, we have community care, social care and the GPs. We have identified particular people within the practice population who are at risk and we meet and have a case discussion. Each week we might get through one or two cases, but it enables us to do this proactive care and support planning so that people know what they need to do should a crisis emerge. But, at the end of the day, it is not just about teams—it is about leadership, local relationships and training. It is about training together as well as working together. There is not one magic bullet, as everyone has been saying. It is these small, evolutionary steps—like the British cycling team—that make it happen.

Chair: On that note, on the British cycling team and incremental gains, that would be a good place to stop. Thank you very much for coming here today.