



Health Committee

Oral evidence: [Impact of Comprehensive Spending Review on health and social care](#), HC 678

Tuesday 23 February 2016

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Written evidence from witnesses:

- [The King's Fund](#)
- [Nuffield Trust](#)
- [Health Foundation](#)
- [Joint submission: Nuffield Trust, The Health Foundation, The King's Fund - written evidence](#)

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Members present: Dr Sarah Wollaston (Chair); Ben Bradshaw; Julie Cooper; Andrew Percy; Emma Reynolds; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford.

Questions [1-85]

Witnesses: **Professor Matt Sutton**, Professor of Health Economics, University of Manchester, **Dr José-Luis Fernández**, Deputy Director and Associate Professorial Research Fellow, London School of Economics, and **Professor Nick Mays**, Professor of Health Policy, London School of Hygiene and Tropical Medicine, gave evidence.

Q1 Chair: Good afternoon and thank you for coming to this session on the impact of the spending review. Could you introduce yourselves to those following this Committee from the outside, perhaps starting with you, Professor Mays?

Professor Mays: I am Nick Mays. I work at the London School of Hygiene and Tropical Medicine, which, despite its strange name, is the national school of public health. I am a health service researcher and I direct a Department of Health-funded research unit that evaluates policy innovations.

Professor Sutton: I am Matt Sutton. I am the professor of health economics at the University of Manchester.

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Dr Fernández: I am José-Luis Fernández. I am a deputy director of ESHCRU, which is the Economics of Social and Health Care Research Unit, and I am based at the London School of Economics.

Q2 Mr Bradshaw: Could Professors Mays and Sutton help the Committee unpick the reasons for the large and growing deficits in the NHS provider sector, or give your views as to the reasons?

Professor Mays: I think Matt should go first as it is not really my area of expertise.

Mr Bradshaw: I am very happy for you to bow out if you do not think it is your area of expertise.

Professor Sutton: We certainly know there are many reasons for it. We know that, basically, productivity in the hospital sector is lagging behind the efficiency savings that have been planned. We know that part of that is new requirements on increasing staffing to increase quality, with the sort of concerns about quality that there have been. I am sure José-Luis will talk more about the effects of social care and the problems in discharging patients early enough. One other problem has been controlling the utilisation of hospitals. That is both on the emergency side—we have had 4% growth in emergency admissions last year—but also in planned care and elective admissions. Elective admissions rose 5% and outpatients rose 5%. Although we talk about the important things being prevention, quality, keeping people out of hospitals and treating them closer to home, essentially none of the existing initiatives has been working and there is more activity going through hospitals. If you look, for example, at accident and emergency departments, the increase in attendances there is 2%, but then the people waiting over four hours has risen by 11%. It is clear that there is activity rising, but it is control or coping with that level of activity that has been the problem. We have a real problem of quality declining at the same time as all this extra activity going through.

Q3 Mr Bradshaw: Can we try to separate out the two issues? I will come on to the big range in productivity and efficiency in a minute, but, as to the big picture, the macro-picture, of how much we spend on the system as a proportion of our GDP and the amount of demand that is put on the health service, there are those who would argue that one reason the hospitals are running these deficits is in order to ensure patient safety, and they do not think they can do so without running deficits given that the level of investment as a proportion of GDP is going down. Do they have a point?

Professor Sutton: The figures that have been produced that show where the UK will be as a proportion of spending of GDP by 2020-2021, in terms of an international league table, are pretty horrific. We would be very low down that table in the percentage of the GDP we spend on health.

Q4 Mr Bradshaw: Can you give a bit more detail on that—how low, what percentage and how does that compare with the OECD average?

Professor Sutton: Your witnesses later on will tell you more, but I think 6.7% is where we would be by 2020-21. That means we will be lagging a long way behind other countries.

Q5 Mr Bradshaw: What is the OECD average? Can any of the other witnesses help?
Dr Fernández: I cannot, no.

Professor Sutton: I think it is 8.5%.

Professor Mays: The EU average is more like 10%, I think.

Q6 Mr Bradshaw: What is that down from, at its peak, as a proportion of GDP? Do not worry. Perhaps you could write to us with that figure.

Professor Mays: We have ranged up to about 9.5%, have we not?

Q7 Mr Bradshaw: It is down from 9%-9.5% to 6.7%.

Professor Mays: It is something like that.

Q8 Mr Bradshaw: On the productivity and the efficiency, how do you explain the huge gap in productivity between different providers? In our evidence, we have been given some quite dramatic figures as to the gap between the best and the worst performers. Professor Mays, do you want to have a go at that one?

Professor Mays: It is really not my area.

Professor Sutton: Essentially, we see a lot of variation there. We understand relatively little about what drives that variation. You will always see variation, obviously, but it does seem an incredibly wide distribution and we understand relatively little about it.

Q9 Mr Bradshaw: Given that we have a certain amount of money, it would be quite helpful if we had a better understanding of that in order to encourage and help those poor performers to perform to the level of the higher performers, would it not? What do we need to do? Is it a data issue? What is the challenge?

Professor Sutton: Essentially, the Carter review has identified potentially up to £5 billion-worth of savings there, but for me it is a slightly strange notion that we might have a model hospital—the best possible productive hospital in all possible ways. I am not sure we learn a great deal from variation. There will always be people who will be in the lower half of the distribution. We were talking about this before we came in. There are very few examples where people have taken an extent of variation and said we need to lift the bottom half up to, let us say, the 90th percentile or something like that. Essentially, we have never seen that philosophy—of saying there is variation and we need to reduce the variation by making everybody as good as some of the top performers—working.

Q10 Mr Bradshaw: Can you address this puzzle of productivity? I think you said that productivity has not increased to the same level as in the wider economy. We have been provided with evidence that productivity growth in the NHS in the last few years had been relatively good. How easy is it to measure productivity in the NHS? What does productivity in the NHS mean? I remember that when we were in Government and pouring money into the NHS productivity dived because we were employing a lot more people. Now we have a

period of spending restraint and the same amount of activity, so naturally productivity—the headline figure—improves. Is that a kind of crude but accurate analysis?

Professor Sutton: Yes; it is certainly a comparison of the growth in your inputs and the growth in your outputs. As you say, back in the mid-2000s, there was substantial additional investment and there were substantial additional inputs, and it took a while for the output growth to catch up. What we are seeing now is both input and output growth at very low levels. As to the difference between them, in the hospital sector in some years we are seeing negative productivity growth. While we are getting positive productivity growth in the NHS as a whole, that tends to be in all the services outside of hospital, so in the community and primary care.

Q11 Mr Bradshaw: Why are we getting negative productivity growth in the hospital sector?

Professor Sutton: I wish we knew that.

Professor Mays: In some ways, you could interpret it positively because we have a number of policies that are trying to disincentivise increasing output in hospitals' measured output. My area of interest in this discussion is about integrated care, and one complaint of people trying to integrate health and social care to improve the care of people with long-term complex conditions is about the remaining incentive structure in the reimbursement system, which, from their perspective, tends to suck patients into hospital, or at least encourage hospital trusts to think about income maximisation. Your special adviser, in another analysis, was commenting on how trusts' financial strategies seem to be encouraging them into deficit because they focus on the income rather than the cost side. Again, trying to maximise activity in order to maximise revenue could be an inappropriate thing. It may be that we should abandon or be very careful about looking at input/output productivity, particularly if we take the hospital sector in isolation, which is where we have all the best data, because from a systemic point of view we would not want to be encouraging all kinds of hospital output against inputs. We would be wanting to look not just at the value of that but at the nature of it: in what circumstances are people using the hospital? Unfortunately, that does not lend itself to aggregate long-term trend analysis and arguments about productivity versus the rest of the economy, for example.

Q12 Mr Bradshaw: We are going to come on to that in more detail in a moment, but the point I am trying to get at is this question of productivity in the health service. Productivity growth in the wider economy is assumed to be a good thing and is relatively easily measurable, but in the NHS, if you freeze pay and work the staff harder for the same outputs, you are improving and increasing productivity, but is that necessarily a desirable outcome?

Professor Sutton: In the short term it might achieve that, but you have to worry about the sustainability of running such a system. We should not forget—although again this makes it even harder to measure—that what we are interested in is improving health. We do not just want to have more patients going through hospital. We are trying to improve patients' health and we are trying to keep them out of hospital. I agree that only focusing on the output of hospitals is the wrong thing to focus on, but, as Nick said, that tends to be where the data are better, so that tends to be where our attention seems to be drawn. In fact, the whole discussion about deficits is clearly where our attention is being drawn.

Just quickly, one thing that was interesting was looking at the Department of Health's delivery plan where they talk about how output growth has been running at 3% and their intention is to reduce that growth in output. That is around this philosophy of wanting to care for people outside of hospitals. Unless you remove the inputs, you will see a catastrophic fall in productivity. If you want to reduce the output of hospitals, you have to cut back on the amount of inputs—the amount of staff and the amount of equipment you have in hospitals—and that has proved very difficult to do.

Q13 Mr Bradshaw: Can I finally and briefly return to the issue of the difference in performance between hospitals? You seem to suggest that this was a given—that we did not understand it, for a start, and, second, even if we did, you did not think very much could be done about it. Do the other witnesses have a view? Are we talking about different populations, sizes of hospitals and geographical differences, or are we just supposed to accept that there is no explanation or there are no theories about why this might be the case?

Professor Mays: There are lots of factors and I do not know, on the particular analysis, what was taken into account, but the one a lot of people talk about is the PFI arrangements and the level of debt that different hospitals bear because of their history of investment and infrastructure. That varies very widely, does it not, as does the price of some of those contracts? That would be one thing—a contextual thing—that you would need to take into account in order to understand whether it was being well managed financially.

Q14 Dr Whitford: Professor Mays, could I pick up on your comment about the disincentive for looking after people in the community around the way things are funded? Do you think that the current payment system using the tariff, therefore, should be changed?

Professor Mays: I think everybody, from the Department of Health outwards or downwards, thinks the same thing. Certainly in the research I have been doing, looking at various integrated care initiatives across the country, perhaps slightly to my surprise, local managers and those directing and leading those kinds of initiatives say the same things that they were saying a number of years ago, despite the fact that we know that there has been a lot of effort led by organisations like Monitor to provide ways of flexing the existing payment system to mitigate it and there have been experiments with different forms of funding, bundling together care along a care pathway, including the hospital and the community services, perhaps for “a year of care” and so on. We have had quite a lot of innovation, but the respondents to our study of the so-called integrated care pioneers were saying the same things in late summer or autumn last year that they were saying to us a year earlier about the difficulty of reducing or moderating the incentive in the tariff system to pay for activity in the hospitals, which of course is yesterday's problem in a way. Everyone agrees on the problem and at the moment, at least if you talk to people at local level, they have made some progress, but they still generally seem to feel this is a big issue that somebody else ought to fix.

Q15 Dr Whitford: Do you not think it is basically an underlying issue? I saw in Monitor's report that they have talked about moving more to capitation and back to geographic. Does that not take us right back to the Health and Social Care Act 2012 in that what we used to have—what we still have in Scotland—was a geographical health board that got their amount of money to look after their population in as joined-up a way as possible,

and that this breaking down and handing money from A to B to C is wasting a lot of money and energy and therefore we need to reform it fundamentally rather than flexing it locally?

Professor Mays: Clearly it made sense at the time because, in a sense, the tariff was a major reform in the past to solve perhaps a different set of problems.

Q16 Dr Whitford: The problem of waiting lists.

Professor Mays: Yes. Any time you change the way that you reimburse providers, either as institutions, teams or individuals, you have to remember that they are all least-worst forms of payment, are they not—fee for service, capitation and salary? All these things come with upsides and downsides and all address different problems to different extents, so if you move towards a system of capitated funding from your local providers, one thing you are effectively doing is certainly drawing an end to that era of market-type reform. You are saying you are essentially funding an organisation to meet the needs of a population, or the big challenge is funding a group of organisations to meet the needs of a defined population using a capitated needs-weighted budget. That is the sort of accountable-care organisation idea, which I think the English NHS, in its own way, is moving gradually towards. I was about to say groping towards, but I think it is moving gradually towards that, which in a sense is the way the NHS has historically functioned. Certainly, since the 1970s, you carved the resources into blocks, related them to a population and told the organisations within that area to make the best of the budget you had given them. We are gradually reverting to that approach.

Q17 Dr Whitford: Do you think we are feeling our way back to where we were before dividing things up into competing groups to get back to co-operating groups?

Professor Mays: That too, yes. At the moment, we have a bit of a disjuncture between the regulatory and legislative arrangements we have in place and what most of the agencies involved in the system are trying to achieve. In a sense, the Five Year Forward View, in code, is saying we want to move back to place-based, area-based, population-based planning, although you cannot use the word “planning”; it is not polite any more. That is effectively what it is talking about. Related to that, you want to provide services in a very different way, so it is planning a different kind of health and care system.

Q18 Dr Whitford: Professor Sutton, talking about the variation implies that we have people who are doing really well and people who are doing really badly, but, as was picked up in the first question, the deficits are now so ubiquitous that it cannot be that 80% of our trust management teams are plain hopeless. There obviously is this underlying systematic problem.

Professor Sutton: Yes. Could I come back on the idea about using the tariff? We should not forget—and one thing I would emphasise is—how effective the tariff can be in achieving the goals that you want to achieve. We have seen some nice examples where the payment mechanism has been adjusted in a way that lines up with what everybody agrees is the right thing to do and then it is a real facilitator. The shame in the last few years has been all that work done by people at places like Monitor to design much better tariffs, but then, when it has come to discussions with providers about implementing it, they have got stuck on the overall price level rather than the structure of the prices, so because the overall price level has to have some productivity gains in it, it has to have some estimate

of how much there are cost pressures. That is where there has been huge debate between the providers and the price setters, and then because they have not been able to reach agreement we have gone back to sticking with the tariff as it always has been. In some sense, we need a much more mature way of agreeing what the payment system should look like independent of the level at which the prices are set. There does need to be a debate about what the price levels need to be, but there seems to me to be much more agreement about the way in which prices should be set and we need to decouple those things so that you can improve the pricing system even though you might still have this conflict about what the price levels will be.

Q19 Dr Whitford: Certainly I have met someone involved in doing outreach into the community of complex paediatric cases to stop them landing in hospital, and, having achieved a reduction in admission of 40%, it was pulled because the hospital was not getting the income. To me, that seems a major disincentive to achieving the joined-up primary and secondary care.

Professor Sutton: Paediatrics is a good example of what I was talking about. There has been some very good work done at York University on the specialist care top-ups—paediatrics is one of the areas where most of those top-ups are paid—and the evidence is not there to support the existing specialist care top-ups or paediatrics, but because we have not been able to reach agreement on the overall tariffs, there has not then been agreement on those tariffs. So we continue to pay in a way that we know is wrong because we cannot reach agreement on the overall package.

Q20 Dr Whitford: Some of the extra money that has been put in has been described as being for transformation and sustainability, when obviously a lot of it is just going to be sucked into deficit. How can we use the system, whether it is the tariff or the funding system, to get the transformation, the change in shape that we need to see in the next five years?

Professor Sutton: The thing that is potentially very exciting, but also very high risk, is that we are entering a period where we have more of the “spend to save” programmes. The philosophy seems to be that we need to have this transformation fund so we can introduce new services on the promise that they will save money later on. I am sure my colleagues will agree that we have seen this so many times, but are we to believe yet again that it will work? The real challenge is going to be how you hold those schemes that promise savings in the future to account for making those savings. There are lots of good ideas about ways to change services to try to prevent things happening in the future, but I am not sure in my head how you make sure that those schemes deliver, otherwise all you have done is introduce a new way of spending more money.

Q21 Dr Whitford: Is it not, though, that sometimes you may prevent other things, in that you prevent harm and side-effects and you improve quality and something else? It is not as if the actual spend ever goes back down, because the demand is always going up. If this lady is not in a bed, someone else is in the bed. It is not just that the project has failed—because often it has not and has improved something—but it does not usually result in saved money. That is not the measure that would show you that a project had worked.

Professor Sutton: There we completely agree, but the problem is those schemes are introduced to save money. The rationale for why they are introduced in the first place

seems to me a false premise, because, exactly as you say, we have seen so many examples where the scheme might in itself have worked but it did not achieve the overall objective, which was to allow us to reduce activity going through hospitals.

Q22 Dr Whitford: Talking about the pressure that all elements of the NHS are under, what do you feel about the proposal of the seven-day working, particularly from the point of view that it keeps smearing across on to seven-day routine working? Strengthening the emergency services is important, but there has been a lot of discussion, both in primary and secondary care, of having routine access seven days a week.

Professor Sutton: I will take this if that is okay. What we do know about seven-day services is that those patients who are admitted at the weekend have a higher death rate than the ones who are admitted during the week. We need to remember that what we are seeing at the weekend are much fewer admissions and fewer deaths. The things that we need to understand about the weekend are that there is much less activity going through hospitals, it is harder for patients to get admitted, and so there is a strong reason to believe that the patients who are admitted at the weekend are a different kind of patient—a more severe patient. Then, of course, people try to estimate statistical models to try to understand to what extent this is just about a sicker patient; but none of that is perfect, so we are left with something that might be a problem. We might have patients dying at the weekend who do not need to die, but we are not sure that that is a problem and we certainly do not know what is causing it.

In work I have done with colleagues, we looked at the amount that the NHS was planning to spend on seven-day services—just the hospital sector—and if we took the most optimistic scenario, where we assumed we could save all of those excess deaths, because the NHS, we think, is planning to spend £1.1 billion to £1.4 billion, it cannot be cost-effective. I think that, because of a concern about what might be a genuine problem, we have a very large response, but that response is only going to divert money away from better things that the NHS could be doing with that money. From my point of view, we still need to see the evidence that the places that have extended services to be seven days have actually cut deaths. There are places that claim to have done seven-day services, but we are not seeing evidence that it is improving any patient outcomes at all, and there is a danger that we divert very scarce NHS resources into seven-day services when those resources could have been spent better elsewhere.

Q23 Dr Whitford: I found it strange that in the paper elective cases were just lumped in. As a surgeon myself, I know that to admit an elective patient on a Sunday they need to have had a heart attack, renal failure and type 2 diabetes, and probably one leg missing, so you are talking about an utterly different cohort from those who will come in on the morning of surgery, which is normal. In the Freemantle paper, they showed them 25% more in the highest risk category; 15% more died, within 30 days, not on the weekend, as you say. You could be saying, “We did really well; we saved 10% of people who, if they had just gone through in the risk category might not have done so well.” I think people would agree there are weaknesses in the emergency service, but the response seems to be opening up everything to seven-day working. Is there evidence on the actual cost-benefit analysis, just this amount versus the 11,000—£1.4 billion over 11,000—to get a QALY kind of thing?

Professor Sutton: Again, this is a totally optimistic scenario, where all those lives could be saved by the plans that are in place now, but even then, if you were to subject it to the traditional test we have of cost-effectiveness, it would not be cost-effective.

Q24 Dr Whitford: Do you think there are any particular things that could be focused on? As these are deaths within 30 days, one of the obvious ones is diagnostics, getting a scan, getting your diagnosis made and getting the first step taken. Has there been work done to identify what would be the most cost-effective way?

Professor Sutton: That is where I think the priority should be. Instead of having this extremely large-scale plan for a major overhaul, we need to identify the individual things that will make a difference to patient outcomes and that can be afforded within the existing budget.

Q25 Chair: We do not yet have evidence on that. That is the area that is missing, in your view.

Professor Sutton: That is correct, yes.

Q26 Helen Whately: I want to pick up on the question of the tariff and particularly to ask Professor Mays about it. I heard from you—if I heard right—that the tariff is something that is unhelpful to the pioneers, from your analysis, and is a barrier to their success. Have you come to a view as to what would be the more helpful payment mechanism—is it the capitated payment system?—to enable integration, given that that is such an important part of the NHS transformation plans in the coming years?

Professor Mays: Not directly. The tariff in a way is not so much an instrument of integration as one of the key bits of supporting infrastructure. Local healthcare providers and social care providers need to be clear what it is that they want to do together in terms of producing a service and then put in place a payment system that supports it. Also, critically as well, another area where, to our surprise, they consistently still report problems is around linking information systems, information governance at the individual level, which would enable them to put in place a robust system of care that would co-ordinate across different organisations. It is a support to integration—it is not an instrument of integration—but they certainly see it as a barrier. In our work, we have not looked in detail: we are looking at the world as it is rather than mounting experiments with new payment systems.

The evidence that was reviewed by the Centre for Health Economics in York is looking directly at a payment system that had been designed to improve integration. Again, it was rather disappointing; it did not identify any payment arrangements that seemed to be in their own right sufficient to break through if organisations were struggling to collaborate well. It may be an important support, but it is not sufficient in itself to enable better integrated and co-ordinated care. The problem with integration is that it is about re-envisaging a different sort of health and care system, which is a huge undertaking when you still have also at local level a whole range of discrete, autonomous and accountable organisations with different mandates, different legal structures and different professional cadres at work, so it is not surprising that we have been working at this for about 30 years. The problem at the moment is that it has become rather urgent that we try to do it because,

in a way, these new forms of care delivery at local level are seen as part of the solution to a big financial problem, whereas before many of them were seen as a solution to an improvement-of-care problem. That in itself is hard enough, but if they are also going to solve a financial problem at the same time, that puts a huge demand on them. So far, the evidence from the sites that we have been studying is that they are making progress, but it is at a pace that seems disconnected from the urgency of the national policy discourse and concerns around deficits, funding, access to social care and other such things.

Q27 Chair: Today we have seen recommendations from the maternity care review that we go for personal budgets. Do you feel that is going to complicate the picture further? Is that helpful or unhelpful?

Professor Mays: We are also studying a variety of personal budget pilots, admittedly not in any area related to maternity. In some of the more ambitious pilots that are trying to link different sectors of care, health, social care and housing together at the individual level, the technical difficulties of doing that are huge, so the maternity care version will be a lot easier to implement. It also stands a much better chance because it is in an area where, in a sense, there is a degree of predictability about what it is that you are taking a personal budget for. There is a range of options. There is a lot of evidence about choice and how it can be facilitated, so, in a way, if you are going to pick an area for personal budget piloting, assuming you wanted to go down that route, it might well be reasonably feasible. There is still a prior question about why you would do it because it obviously provides quite a big challenge, none the less, in deciding what you are going to put into the budget, how you are going to price it and how you are going to allocate it to individuals who might have different characteristics and requirements. It is quite a big technical problem, but compared with our other personal budget pilot efforts and offers—things like direct payments to frail older people—it is probably a more tractable implementation task.

Q28 Emma Reynolds: Philippa alluded to this problem a little earlier. What is your opinion of, particularly, the extra front-loaded money in the comprehensive spending review? To what extent will that solve, or otherwise, the financial problems and the needs of the NHS? There is a concern that it will just be sucked into deficits of providers and could just plug a gap in increasing demand. To what extent will any of that money really go towards solving the problems? Professor Sutton, you were pretty critical of some of these so-called “spend to save” schemes. A lot of those projects are doing some interesting work, but to what extent will this money transform the service?

Professor Sutton: I will not repeat myself and I am sorry for going on. It is a real issue. Certainly, people can already see that most of this front-loading of the funding will be taken up by things like additional pension contributions and the deficits that are already there, but then there is this model where you have a higher increase initially so that you can sustain the service with lower increases later on. Personally, I think it means you need to have a mature way of dealing with these pilots and initiatives that are going on. Rather than getting very excited about a single example of something that appears to have done something wonderful—it is too good to be true—it probably is too good to be true, will not be sustainable and will not be generalisable, so you have to get to the point where people can say, “This seemed like a very good idea and we designed it very well, but it did not work.” We have this culture of people finding an idea, looking for some evidence that it appears to work in the very early stages and then we very quickly get all excited about it,

that this is the brand new solution to the problem. Things like the Five Year Forward View are going to take a lot of very measured evaluations of what is being done and all the ideas in the vanguards so that you can see a sort of sustainable, generalisable solution rather than small ideas that appear to work.

Q29 Emma Reynolds: Professor Mays?

Professor Mays: It is not really my area of expertise, I am afraid.

Q30 Emma Reynolds: I know also the vanguards are integrating in different ways. I visited the Dudley vanguard and they seem to be doing very good work, but in my own area, Wolverhampton, they are doing vertical integration, so they are taking GPs into the acute sector and working more closely with them. Is there any attempt to think that this is going to be generalised and rolled out, or is the programme really to get different areas to do things in different ways anyway?

Professor Mays: As you say, there are different strands of vanguards and some are trying to fix quite specific problems. Others are more ambitious, moving towards the world that I am studying in our work on the pioneers. My personal view is that I cannot see how a system transformation that does not absolutely directly focus on the interrelationship between the NHS and the social care worlds can possibly be a long-term strategic asset to the system. By all means fix the relationship between GPs and hospitals, and hospital specialists and GPs, as individuals and as team players, but when you look across the system it seems to me that the interface with local authorities, social services and social care, and indeed supported housing and the benefits system, is pretty critical in the longer term for a well-functioning system.

We have made some choices in England, for example, to focus on and to protect in the short-term NHS spending in a defined and quite narrow sense, and we have made some big changes to the local authority funding of social services. By contrast, we can see in Wales a different approach was taken and they perhaps sacrificed some NHS spending in order to protect their local government spending. They saw, for example, a much lower increase in delayed discharges and difficulties in getting people out of hospital, which is entirely consistent with that policy, and, in the short term, they did see waiting times for elective care that were not as good as England's. In a sense, you can see that the priorities and choices you make—both in terms of what you pilot or, in this case, what you put in your vanguard and then the bigger spending choices you make—show through at the national level, but I do not see how a programme that does not eventually focus on the relationship between health and social care could be long-term sustainable given the changing demographics and demand factors in the system currently in play. I do not know whether my colleague wants to comment on that.

Dr Fernández: I absolutely agree that working on the integration and the co-ordination is key—integration means so many things, but I think improving the co-ordination between health and social care is vital—but I sometimes worry that we look to social care as some sort of magical system. It is quite small when you compare it against the NHS, yet by getting that interface right we seem to think that we are going to be able to solve all the deficits and so on. We have to be realistic about the contribution that even significant improvements in the co-ordination between health and social care will have on, for

example, the NHS's financial position. I agree in principle that it is a very important question that we need to tackle, but we need to be careful, in looking into this integration issue, of ending up thinking of social care as an instrument for solving the NHS's problems, when actually social care has a core activity, which is looking after people with social care needs and improving the quality of life, which we could be losing sight of.

Q31 Julie Cooper: Given the conversation that we have had about looking at hospital outputs, that it would be desirable perhaps to see fewer people in hospital and more maybe benefiting from better social care, and given the funding constraints on social care budgets at the moment, what impact would you say that is having on the NHS at the moment? Is it causing a backlog, with issues not picked up in social care? How is that impacting on the NHS?

Dr Fernández: There is now growing evidence that there is a clear interrelationship between health and social care. For example, by providing more social care you reduce demand, to some extent, on the healthcare system, or there is complementarity between the two systems so that by providing social care you make the activity on the healthcare side more effective. Yet over the last five to seven years we have seen unprecedented contractions in the social care system. Over the last seven years there has been around a 40% reduction in the proportion of all the people, for example, reaching social care. So it is slightly surprising that we have not seen a bigger impact on some of those indicators of acute care performance—for example, delayed discharges, emergency readmissions and so on—because the contraction has been so brutal. It is interesting then to see what has happened. Given that local authority supported care has contracted so much, what is happening to those people?

Although the data are particularly poor in social care, there are, for example, good hints to suggest that privately funded activity has gone up. For example, the numbers of jobs in the social care sector has been growing steadily despite that reduction in state-funded activity. There is also good evidence that informal care has been going down.

The question is this. If we carry on like this over the next CSR period, with further cuts, given that, generally speaking, the first couple of years of budget cuts are the easiest—in the sense that you can cut those things you might be able to do away with—and given that we are five years into what are very significant cuts in social care, one would perhaps expect those cuts to have a bigger impact on the acute care and in particular performance.

Q32 Julie Cooper: Thank you. The point was raised a few minutes ago that there is now a financial urgency to look at the NHS and social care together. There has been an urgency around patient wellbeing identified for a long time, but now the urgency has switched to financial concerns, which always seems to speed things up. I know that work is going on out there in the community to look at better ways of delivering these together. Is there any evidence there at the moment of good schemes? Are you in a position, Professor Mays—I know it is a particular interest of yours—to update the Committee on any successful projects that give us cause for optimism?

Professor Mays: There are some. In our evidence, they tend to be quite small scale, so if I come back to the programme I am most familiar with, embedded within these pioneer pilot sites, some of which are extremely large, there are schemes and initiatives, many of which

have been quite long in gestation, so they cannot be attributed to the selection of some areas, as it were, for being seen as pioneering or particularly expert. For example, in Cornwall there are schemes for augmenting care of frail older people using the voluntary sector and more intensive forms of multidisciplinary team support that have been evaluated in various ways and that suggest quite dramatic improvements in quality of life and reductions in hospital use to such an extent that I find them implausible. The interesting question will be to what extent these can be scaled up even within that large county. Cornwall is advancing across the county with a similar set of schemes, but they took quite a lot of time to be put in place and are apparently producing very positive impacts.

The scale of the impacts, though, is so large that I find it strange, because reports from other parts of the country and the more rigorous research evidence consistently suggest, as Matt was saying, that the impacts of good forms of care co-ordination are relatively modest, at least as measured in things like reduced unplanned use of hospitals. If anything, in fact, the most consistent finding of better co-ordinated care is that it uncovers unmet need and raises costs. That may be a very good thing for the people whose needs are uncovered, but again, given the systemic imperatives or pressures on the system at the moment, that would not necessarily be your top investment. There are good pockets and there are individual schemes, but the issue that many local health and care economies face is the scaling up and generalising of these things, doing them consistently across a patch rather than just in a small number of places.

Q33 Julie Cooper: To clarify, you are saying that the evidence from the schemes you have seen is that, far from saving funding, they identify currently unmet need and the outcomes are better for the patient and for the individual in the community, but they are ultimately not a means of saving NHS funding.

Professor Mays: That is the research evidence. The practice-based evidence from the schemes in places like Cornwall with a local evaluation, not an independent evaluation, seems to be extremely positive. That raised the question that was raised before about whether that is because of who is running them—the context: “Is it true?” and “Is it sustainable?” Certainly, the more rigorous research evidence tends to suggest that better co-ordinated care can be of higher quality, with better user and carer experience and covering unmet need, and is unlikely to reduce costs. There is very little evidence that these schemes are more cost-effective, but that may just be because of the absence of evidence. There is not very much economic evaluation of co-ordination schemes. There is some across the world, but it is very context-specific as well, which is a problem. Unfortunately, we need evidence in this country, in this setting and at this point.

Q34 Maggie Throup: I want to continue on the theme of social care and explore the likely impact of the comprehensive spending review on social care. Can you comment on what would be the likely effect of the new powers that councils have to raise the precept for social care?

Dr Fernández: The precept can be seen as a very flexible way of allowing local councils to raise resources to meet increasing demands for social care. From that point of view, it is very welcome. The challenge of the precept is its impact on perhaps spatial or geographical equity and the fact that a 2% increase in council tax will not translate into the

same increased revenue for local councils across the country. This is important because those councils that have the greatest opportunity to raise resources—the wealthier councils and, therefore, those with the highest tax base—are also those that are likely to be faced with the least demand for social care, because there is a very strong correlation between deprivation and demand for local authority supported care. This is partly because needs are higher—there is a positive correlation between needs and deprivation—but also because people living in those council areas are most likely to meet the means test, so are also more likely to qualify for local authority funded care. Those councils are also more likely to be affected by the introduction of the new living wage because wealthier councils are likely already, or to a greater extent, to be paying the living wage in terms of the services. There is a cumulative effect there that means there is likely to be an imbalance in the funding of social care in England as a result of the introduction of the precept if every single council were to go for the 2%, let us say. It is already noted in the CSR statement that there would need to be some sort of mechanism put in place in order to rebalance that funding, which to some extent might go against the phasing out of the revenue support grant.

Q35 Maggie Throup: With regard to the Better Care Fund—a transformational fund, one of the “spend to save” funds—it looks as if it may now be used to top up the councils that are not able to raise as much money through the precept. What impact do you think the CSR has on the Better Care Fund?

Dr Fernández: The Better Care Fund could have two sorts of impacts: one is on the amounts of resources in the system, in the sense that at the end of the CSR period over the last two years there is going to be a meaningful increase in the resources coming into the system; the other is whether it is going to lead to improvements in the efficiency of the system.

We have to be realistic about what the Better Care Fund is. The Better Care Fund is not a model of care; it identifies a budget and sets some rules for how that budget is going to be spent, which requires the co-operation and agreement between health and social care managers on the ground. That is likely to be beneficial, is going to increase the flow of information and is going to set some clear objectives with, hopefully, measurable outcomes associated with them. The extent to which it is going to lead to savings or to improvements in efficiency will depend on the schemes that are commissioned on the ground, and those are highly variable.

Different local authorities will be going for very different things. Going back to what we were saying a second ago, we need to learn from the wealth of experimentation that is going on now in order to try to improve our understanding of the technology of integration, which we do not yet know much about. We do not know exactly what forms of integration—whether it is joint commissioning, joint funding, joint assessment or rapid response teams—work for whom and where. That is a very big question in terms of the impact that the BCF will have on the system as a whole.

Q36 Maggie Throup: If some of the Better Care Fund is used to top up the councils, do you think there will be enough money left to continue that integration between health and social care?

Dr Fernández: I am not sure whether I agree with the question in the sense that sometimes propping up social care might be the best thing you can do in order to reduce hospitalisation, for example. In some instances, providing resources for core social care services to be there might be quite a cost-effective way of going about it. Then there is the more general question that the BCF is meant to be doing other things, and if we are going to use all the money for just reducing social care deficits how much are we going to change the system? I think that is a fair question. I do not have the answer.

Q37 Andrew Percy: On the issue of the social care precept, can you explain what you meant when you used the phrase “wealthy councils”?

Dr Fernández: By that I mean simply that the tax base is higher. Therefore, the relationship between a percentile increase in council tax and the amount of money raised per inhabitant will be affected by it.

Q38 Andrew Percy: I follow the argument, but that is quite simplistic then because underpinning all of that there will be the per-person council funding, there will be the rurality factors and the deprivation factors, which you mentioned, of course, are already factored into the revenue support grant that comes from central Government in a way that rurality is not. The areas with the highest and fastest-growing ageing populations are the most rural so they may have a lower customer base, but they have the highest costs of providing social care. I understand what you are saying, but it is quite a simplistic way of describing the impact of the social care precept, is it not, because of the other factors that underpin it?

Dr Fernández: There are other factors that you need to bear in mind for sure.

Q39 Andrew Percy: Those are the more important factors because that is where most of the funding will come from—determined by the other factors.

Dr Fernández: The plan is to phase out the revenue support grant, so some of the compensatory mechanisms that you were mentioning are likely to disappear little by little as the RSG disappears. The fact that the precept will not generate the same amount of money across all councils is something to bear in mind. Indeed, I think the—

Q40 Andrew Percy: But they are not all starting from the same base.

Dr Fernández: Indeed not. There is likely to be a correlation between your capacity to raise revenue from the precept and the unit cost of the services that you are paying, because wages are likely to be correlated with tax base, so there is going to be some negative doubling of effects, if you see what I mean, between what is the capacity for councils to raise their additional income through the precept and all the commitments that they will have to phase in in line with the CSR settlement and in particular the national living wage.

Q41 Mr Bradshaw: Are the Government currently proposing any mechanism to help address that?

Dr Fernández: I believe the CSR settlement talks about a consultation process that will discuss this.

Q42 Emma Reynolds: If there is not a mechanism to rebalance and redistribute between what are well-recognised criteria that determine the table between the least deprived and the most deprived and you are an elderly person who is in a most deprived area—Wolverhampton being one of them, and we are really quite high up the deprivation table, unfortunately—and if your council is being hit by the double whammy of a living wage, which I support as a Labour MP, which is going to be more costly, and an inability to raise that much in the precept, are you not going to be given poorer care than somebody in the least deprived area where they are able to raise more tax through the precept and do not have the same needs?

Dr Fernández: I would not want to say that it follows directly that you are going to get worse care, but the resources available for councils to use will be different.

Q43 Chair: Before we finish today, Professor Sutton, you have not left us with a very optimistic picture of the prospects of addressing variation in the NHS, and the impression given is that we might improve quality but we are not going to tackle costs. Could all the members of the panel say a little more about what recommendations you would like us to put in place around how we evaluate these projects and move forward from here?

Professor Mays: My research team is involved in a number of evaluations. My recommendation would be that the commitment to evaluation is sustained. One problem with doing good evaluations of complex initiatives, particularly when the local actors, if you like, are under a lot of pressure, is maintaining the ability to engage with researchers who are trying to understand what is happening on the ground and what its consequences are. Anything that involves whole-system change, which is what the new care models, the pioneers and others are trying to do, is extremely difficult to evaluate because you are talking not about a discrete intervention; you are talking about a changed health system and whether it is heading in the right direction or not and whether one of those different kinds of vanguards schemes is the one that you would want to ultimately put most of your effort behind. As a researcher, I would say we should try to encourage, support and make sure that there is a long-term commitment to learning from the way we are trying to change the system. There is always a risk that there is enthusiasm for the idea of being involved in a pilot scheme, a programme or a vanguard, and then the question is, yes, but what does that mean in terms of being able to collect data, for example, and actually be open with researchers and try to assist that process?

Q44 Chair: In the last Parliament, this Committee heard repeatedly that sometimes the benefits are not delivered in the short term; they come further down the track. So, definitely, your plea would be for longer term. Is there also an issue that sometimes the methods of evaluation are not comparable so it is very difficult to make direct comparisons? Is that your experience as an academic in the field?

Professor Mays: Yes. Evaluating the sorts of schemes we have been discussing today is on the limits of what is technically feasible to expect, particularly in the health field where we have very high standards of what we think is a robust study, hence the debate about seven-day working, which has led to a lot of quite arcane discussions, quite appropriately. We have a very high standard of what we take to be evidence, and yet what we have is a lot of complex, locally determined attempts to improve the system, which are not

standardised, which are very difficult to compare; they are all explicable in their own terms as to why they are different, so the job of the evaluator is very tough.

One I suppose related hope or plea is that, having done some of our learning and put in place and tested out informally and formally some of our ideas about improving the system, if we can then perhaps try to identify and describe more clearly what it is we are asking people to do at local level, that would greatly assist the ability to learn from the vanguard schemes. The attempt to codify, at least in broad terms, what it is we are asking people on the ground to do would then make it possible to say, “This is what we are actually looking at and here is type 1, type 2 and type 3,” and we are going to be able to do some kind of comparison. The problem at the moment is that it is immensely difficult to be clear and understand, when people say, “We have this scheme,” whether it is a scheme they have always had, a scheme that is a really detailed plan, a twinkle in their eye or whether it is happening on the ground and, if so, for how many people. Those questions are often very difficult to pin down because we have been through a phase of very much bottom-up learning and innovation, which is entirely appropriate, but at some point we need to bottle that learning and turn it into some prototypes or different approaches that are more discrete and more comparable, if you like.

Q45 Chair: Who should lead that? Who would you say would be the most effective person in the system to say, “This is what evaluation should look like and these are the models we should use”?

Professor Mays: It is more about what the schemes should look like rather than the evaluation. We have quite a lot of focus on evaluation. The problem is that what we are trying to evaluate can be extremely diffuse. I would liken the evaluation of the pioneer programme to eating porridge with a knife and fork because it slips off the fork just as you are about to get it to your intellectual mouth, as it were.

Chair: On that “Goldilocks” moment, we will end today. Thank you all very much for coming.

Examination of Witnesses

Witnesses: **John Appleby**, Chief Economist, The King’s Fund, **Nigel Edwards**, Chief Executive, Nuffield Trust, and **Anita Charlesworth**, Director of Research and Economics, The Health Foundation, gave evidence.

Q46 Chair: Thank you very much for coming this afternoon to be our second panel for today on the comprehensive spending review and spending in health more generally. Could you start by introducing yourselves to those following this from outside the room, perhaps starting with you, Nigel?

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

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

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

Q47 Mr Bradshaw: Without being rude, I am hoping you might be able to help us a little more with this problem of the deficits. What is causing them? Is it just about the overall lack of enough money in the system? Is it about the gap in productivity and efficiency between providers? What explains the gap and what can we do about it? You can all have a go at that.

John Appleby: At some sort of basic accounting identity, the deficit is just that costs are greater than income. That is the problem. Why are costs higher? Costs are higher than anticipated. Income has been under tremendous pressure. Over the last five or, I think, six years the tariff has been reduced in real terms each year to encourage hospitals to be more productive. Crucially, it is about the ability of trusts to close that income expenditure gap, so their cost-improvement programmes are yielding less and generating more savings over time has become tougher. This is the sixth year now of reduced overall funding, so there is less money in the system than perhaps it needs. Bring those things together and we have seen a growing pattern since two years ago when there was a small overall net deficit among providers in the NHS; last year it grew to about £820 million or so, and halfway through this year it reached £1.6 billion. That was the target for the end of this year, by the way. The target was revised to £1.8 billion. We now know it is somewhere between £2.3 billion and £2.8 billion possibly by the end of the year. You can see the downward trend. I think somebody else on the Committee pointed out that this is not just a few isolated mismanaged trusts. This is 95% of all acute trusts—essentially everybody—now looking at a deficit by the end of the year.

Nigel Edwards: To summarise quickly, if you do not give the trusts the money that they need to deliver what they need and you set them efficiency targets that have never been achieved anywhere in the NHS's history, do not be surprised if the income separates from the expenditure over time, particularly against a background of growing demand. For probably as long as I can remember, the NHS has been asserting that it will manage demand in some way; it will make a downward pressure on admissions. It has consistently not done that. Again, no one else in the world, barring natural disaster or war—and those are not policy suggestions, by the way—has managed to bend the curve on admissions, it appears, so there is an ineluctable pressure. There is an awful lot of costs baked into providers that just do not fall out in the way that economists have tended to assume. As John was saying, they were set 4% tariff reductions against growing demand and that has finally caught up with us to the point where the deficit will now take some years to clear.

Anita Charlesworth: To paraphrase Bill Clinton, it's the workforce, stupid. The most important thing—why we are now in the financial mess that we are in and what we need to do—is workforce issues. The NHS was planning on needing fewer workers; its plans were not to grow the number of workers. We reduced the number of nurses we brought in from other countries in the early years of this decade, we reduced the numbers in training and we have also seen many fewer numbers coming through on return to practice. That was predicated, in essence, on both ability to reduce demand—the number of admissions that would come into the system—and a belief that we could work those nurses harder through reducing ratios. That proved to be unsustainable. We saw the numbers of nurses employed falling; then from 2013 onwards, crudely, we re-employed them but we employed them more expensively. That failure to have a fit-for-purpose workforce strategy, I would argue, is an underlying issue at the heart of the deficit.

The second thing, which I think has been quite important, is that the NHS and policy in this was too focused—and your Committee has made this point over and over again—on short-term tactical solutions. We reduced admin costs. Andrew Street’s work at York shows that we have some ostensibly good productivity numbers when you look at the system as a whole for a few years, but they are driven by things like abolishing PCTs and SHAs. That is fine if you have a short-term problem, but you cannot re-abolish them over and over again. They should have bought time in the system for that underlying work, which is hard to look at, the mix between prevention and reactive care and the way we deliver services. We did not make progress on that. We dealt with it as a short-term problem to get through and then thought everything would return to normal rather than tackling the underlying challenge of embedding improvement in the way we work.

Q48 Mr Bradshaw: I will come on to that in a second, but can I get some of these big ballpark figures on the record? We heard earlier, and I think in our evidence from our own advisers, that by the end of this Parliament, health spend as a proportion of GDP will be down to 6.7%, I think down from a peak of 9.9% in 2009—somewhere in the 9s. You are shaking your head; you can give us a figure in a minute. I also want the comparators with the OECD and the EU averages if you could provide those.

John Appleby: I will have a go. As to the projection, taking what the spending review has told us about the amounts of money for England—we do not know about Scotland, Wales and Northern Ireland, by the way—our joint projections are that for the NHS, not private but for the NHS, it would decrease from about 7.2% or 7.3% of GDP this year down to about 6.7% or so. The economy is growing, the money is growing at a very small real rate, but the economy is outstripping the growth in spending, so it is 7.3% to about 6.7%.

Q49 Mr Bradshaw: That is from a peak of what and when?

John Appleby: The peak for the NHS was probably in about 2009, probably at something like 7.7%-7.8%. The international comparison stuff is a bit complicated because you have to add in private spending as well because of the different ways that countries are funded in their healthcare and so on. When you start to ask the question, “What about the OECD, what about, say, the old EU15 countries?” and so on, you have to bear that in mind. In terms of the OECD, the most recent figure is, I think, from about 2013: if you exclude the US, which is a massive outlier, the average is around 9.1% of GDP. That is public and private. The EU15 is about 10.1%, public and private, and the NHS, on this public and private basis, is around 8.5%-8.6% or so. There is a significant gap between what the UK is spending, what the EU15 average is and what the OECD is.

Q50 Mr Bradshaw: Is that gap projected to open further?

Nigel Edwards: Yes.

John Appleby: I would have thought so, given the numbers we know from the spending review.

Nigel Edwards: As to what the other EU15 members are doing with their health expenditure, they will move away from us whatever we do on current projections. It is just worth mentioning that you should also look at the social care spending as well, and the

EU15 countries, on the whole, spend a larger proportion of their GDP on social care than the UK as well.

Q51 Mr Bradshaw: What is the gap on social care?

John Appleby: It can be quite large. We are 0.8% of GDP, roughly. Some of these comparisons are quite difficult to make given questions of “What is social care?” and so on, in different countries. I think Holland is 3%.

Nigel Edwards: It is just under 3%.

Q52 Mr Bradshaw: So there is an even bigger gap on social care than on healthcare.

John Appleby: It could be, yes.

Q53 Chair: Can I clarify one thing? When you are talking about the figures for public and private together, is that UK, when we look at the UK figure, because we cannot separate that out?

Nigel Edwards: Yes, it is the UK.

Q54 Chair: The 8.5% is the whole of the UK and that is public and private. Those are the two separate comparators we have to use, whereas when we are looking at just NHS it is only England that we are comparing.

Anita Charlesworth: No. As to the 6.7% and the 7.3%, we have assumed that Scotland, Wales and Northern Ireland make spending decisions in line with England; so they get Barnett consequentials, but obviously it is open to them within that to choose how to spend. Wales, I think, over the last Parliament chose to prioritise social care slightly more than healthcare compared with England. We have assumed in these numbers that the increase for England is mirrored through.

Nigel Edwards: It does not make that much difference given the difference in the comparative sizes.

John Appleby: England is 85% of all health spending. Wales is important, by the way, and Northern Ireland is important, but it is just the scale of this.

Q55 Mr Bradshaw: Can you have a go at answering the question that the previous panel, if I am honest, did not really answer, which is: how do you explain the huge gap in productivity between different hospitals and, if you can explain it, what can be done to address it?

John Appleby: You made a point about the difficulty we have in measuring productivity. In economics, there is a fairly straightforward concept of outputs divided by inputs, so “What is your bang per buck?” Outputs are not outcomes; they are activities, as it were—visits, drugs prescribed and so on. Ever since we started collecting unit cost data from hospitals over the last 15 or 16 years, we have always known that there is a tremendous variation in the costs that hospitals seem to incur in doing what we think are the same things—a hip, a cataract or whatever. Nobody has quite got to the bottom of some of these

differences. There will be artificial differences because the data are not that good, for example. I am not aware of much data in showing the variation in productivity, though, by hospital. It may be that Anita can say something about that. This whole issue of variations is not just in productivity. Everywhere you look, day-case rates, lengths of stay—pick any metric you like—you see this variation. In some areas, it has got a bit smaller; in many areas, it has stayed the same. Admission rates for what you would think are routine operations—hips, knees and cataracts and so on—also vary and there is this unwarranted variation. It has always been a big issue for the health service, not just in this country.

Anita Charlesworth: We have analysed crude productivity; York have analysed a more sophisticated measure of productivity and the variation within that; and then Lord Carter's work gets under the skin of that to look at what happens in providers. There are some things, which may well be some structural factors, which are really quite important. Monitor, for example, did some work looking at the experience of hospitals that are near the edge of the country and a long way away from other providers. They do seem to have particular problems and challenges, probably linked to recruiting and retaining staff. Where it is very difficult to attract staff, it will be, in those contexts, more difficult. Some areas may need, because of sparsity, to run providers that are smaller. In some areas, deprivation may be a factor. People will have experienced in their own areas that it is very different to discharge an elderly patient into a comfortable home with a good social support network and things like that compared with discharging to environments where the social infrastructure and the social capital are very much weaker. Those factors would play out into productivity and we almost certainly do not measure those well enough.

Undoubtedly, we have an issue, on which Tim Briggs did some work, which underpins the Carter review, from looking at the experience of orthopaedics—the good, clinical evidence about cemented versus uncemented hips and the way in which there is variation in that, which is both not good value for money and poor for outcomes—that we do not seem to have a mix of policy that is very good at diffusing best practice quickly. That is true clinically and it manifests itself in productivity. There are some things that do appear to be associated with higher productivity. It looks like relying on a very low-skilled workforce is an artificial saving and that a richer skill mix may well be associated with higher productivity. I certainly do not understand, I have to say, why at least six years into this challenge we have not done more work as a healthcare system to identify and roll out the sort of things that Tim Briggs was talking about, which are quality enhancing and productivity enhancing. In a constrained system, as the system always will be, and a nationally run system, it seems to me pretty unforgivable that we are not supporting people to roll that out.

Q56 Mr Bradshaw: Is that not what the Simon Stevens challenge is supposed to be all about?

Anita Charlesworth: What is perplexing is that we have all the work on vanguards and on innovation, which is very important, but we do not have a concerted plan on how we spread the stuff that we know that is clearly important to improving our productivity and in many cases improving our quality.

Chair: Just before we bring everyone else in, Andrew has to leave, and he has a quick supplementary.

Q57 Andrew Percy: I have two supplementary questions to ask now because I have an APPG, which I chair, so I apologise. It is frustrating that we have sat here for years being told this. On the spending issue, would you be able to provide us with a breakdown for those comparator countries of public and private as well—the combined public and the private? That could be really important. Just on the workforce planning issue—and I suppose this is a question looking at my own trusts—after the Nicholson challenge, the first thing my trusts seemed to do was cut numbers of nurses. The Nicholson challenge was 2007 or 2008, whichever it was, and also nursing numbers dropped and then they started increasing them again rapidly in 2011. Has anybody quantified the cost of that to the NHS, because we went through this really disruptive period of the workforce falling and then suddenly rising quite rapidly in the case of one of my hospital trusts? That seemed a short-sighted way of trying to meet the Nicholson challenge. Has the cost of that to the NHS been quantified?

Nigel Edwards: Yes. I do not have that to hand. It is worth mentioning that our analysis seems to suggest that, although the workforce has gone back up again, it has gone up less quickly than the level of activity. If you weight the activity for the acuity and case mix of the patients, we are now working the staff we have quite a lot harder, and that may start to explain one of the problems that we are seeing with staff burn-out and people wanting to do increased amounts of agency work, so there is that.

Q58 Andrew Percy: It is such a false economy.

John Appleby: The data are there to do that calculation, by the way. We have wage data and employment data, so you could do a crude calculation to see what the extra costs and the savings were and so on. On the labour productivity, different groups exhibit different levels of productivity. At a crude level, consultant numbers have outstripped the growth in activity, by the way. Nurses have not. If you just divide change in nurses by activity, you will see they are doing more work per nurse, as it were, in very crude terms.

Q59 Andrew Percy: You are not saying consultants are doing less, though, are you?

John Appleby: Yes. It is a question that requires further investigation, obviously, but I think Matt Sutton pointed out that the crude aggregate level of increase in consultants versus the increase in activity—the NHS has done remarkably well over the last six years in terms of increasing its activity—has outstripped the aggregate real change in money going into the system, at a crude level. But, yes, further detailed examination—

Nigel Edwards: We do not have a very good measure of what consultants do, which is one of the problems.

Andrew Percy: That is what my trusts tell me.

Mr Bradshaw: Maybe we should put chips in the wall.

Anita Charlesworth: Monitor I think have estimated that this year—and it is only this year—if the agency staff were permanent staff, the saving would have been about £700 million. It is a sizeable chunk of money.

Q60 Chair: We do focus a lot on the agency costs, but, as you have pointed out, there has been the change and the hoovering up of all the money in the NHS into secondary care and into staff budgets. How much of that has been the increase—the expansion in consultant numbers in the NHS?

John Appleby: I do not know, but we could supply you with the information.

Q61 Chair: I wondered because we do focus rather on agency costs. Would you say that the expansion in consultant numbers has also been a significant cost or not?

Nigel Edwards: The direct cost of consultants is probably not that large. The more significant issue is that, despite our slightly disparaging comments, they do like doing work, and if you employ them they start doing procedures. There is some evidence that this increase in activity we have seen has been particularly in areas like orthopaedics. There has been an enormous increase in, for example, knee arthroscopy and hip replacements, some of which may have been driven by the employment. So the relationship between whom you employ and how much cost they drive is much more than just the cost of employing the consultant; it is the whole tail of activity that will tend to come with them, which, of course, patients benefit from. The cost of employing a consultant in terms of their salary may be £140,000 or £150,000, but they may generate you £3 million or £4 million-worth of costs very easily without working too hard.

Q62 Andrew Percy: Given that we have been out and looked at vanguards in the last session—we have done all this—where is the delay in getting this best practice rolled out? We have been talking about it for years. You have been here before and we have talked about this, and all the time we get told there is this huge variation but we are not getting this right. Is it a policy issue centrally or is it local decision making that is failing? Where is the failure?

Nigel Edwards: It is just worth pointing out that this is a population of 200-plus different organisations that will have significant differences, both in their starting point, the estate they are operating at, and their ability to recruit good managers, good doctors and high-quality staff and the funding of their local environment, so there is a large set of reasons already for natural variation. The other thing worth remembering is that Lord Carter, who spent a lot of time and effort looking at this, has managed to identify £5 billion-worth of opportunity, which sounds like a lot but is only the cost improvement that we are requiring trusts to make in their normal course of business over the next five years. So it is possible to exaggerate this. The third point worth making is that I have worked in systems that have tried to eliminate variation by standardisation across very large tracts of the health system. There is a system called the Semashko model that was devised in Moscow and it really did not work, although we may be rapidly returning—

Andrew Percy: It will be their policy soon under Jeremy.

Q63 Chair: John, you were sitting in on the last panel and their view seemed to be rather gloomy about the prospects of addressing variation. Would you agree with their assessment?

John Appleby: I am slightly more hopeful. We were talking about the Carter report. We can go back 30 or 40 years and we have had reports like Carter's pointing out the variation, so we know these things have existed. We have been able to explain a little bit

of the variation that seems legitimate, and there is a big chunk that does not seem legitimate. Yet very little seems to change. Some things do change a bit. I detect a slightly newer mood at the moment in that you do need a concerted effort, both politically and managerially, it seems to me. An analogy would be the success in reducing waiting times after the turn of the century. It was a combination of not that much money, a real focus on the problem, both politically and managerially, and then some practical things to help trusts make the changes. I think it is similar with variations, wherever you look. It is going to require that real focus by the whole system.

Nigel Edwards: But does that not run into exactly the problem that we have been arguing we have a difficulty with now, which is that, if it requires managerial and clinical bandwidth and good will, we are not in a good position to be asking for either of those two things, particularly the latter right at the moment? The second, as with healthcare-acquired infection, is that these were very targeted things. We are picking off a relatively small number of things. The difficulty with trying to eliminate variation across the several hundred different product lines a hospital would have and the tens of thousands of things it buys is probably the inability to provide that sort of laser-like focus that, as John said, was very successful in areas like waiting time reductions.

Q64 Helen Whately: In this conversation none of you has mentioned NHS Improvement as an organisation that could be a helpful catalyst to achieve some of this. I would be interested in your perspective on that.

Nigel Edwards: That is not a coincidence.

Anita Charlesworth: It seems to me it requires quite a big mind shift in policy. I sat in and listened to the last panel and I was quite interested in the focus on the tariff. In the UK, we are quite interested in the external prods on organisations, which assumes in a way that it is a matter of will—that organisations are not doing this because in a sort of somewhat bloody-minded way they do not want to—whereas when you look at even quite apparently simple things, like the breach of A&E four-hour targets, you understand how that is about the flow of a patient through the hospital and the links to the wider hospital system, and we do not talk about that as transformation. We talk about vanguards and all of that as transformation, but if you look at organisations, hospitals and healthcare systems that have tried to tackle how patients flow through the system, starting with fairly simple problems, it is a really complex change process that involves hundreds of people working differently, and systems and highly interconnected bits of the system all having to work differently in a concerted way. That is a huge change task. We do not often support that.

I would argue—and Lord Carter’s report is very interesting in this—for example, that we have in many parts of the country invested in e-rostering systems, and he talks about that, but inputting the IT is the easy bit, even though the NHS often makes it look like the difficult bit. The bigger task is working with staff on how you use that system to match your staffing need. That is quite a big and complex change process and it takes time and resource away from the front line. We do not do that. One thing that was quite shocking for me about Lord Carter’s report was how often what seemed to be quite basic data and information were not well known and understood by organisations. The NHS has a lot of data and it spends relatively little on turning that into meaningful management information. It does very little to work with clinicians and others on how to use that to

guide the way they manage services. We need to look much more not at the external lever on organisations and how we structure organisations, and whether we vertically or horizontally integrate in all of that, which research study after research study shows does not make that much difference, but at how we help organisations internally with the real tools to improve. It is rather long term, rather tedious and less exciting in one sense and much less amenable to instant announcements.

Nigel Edwards: Changing the name of an organisation does not change its purpose and culture. NHS Improvement, of course, is not technically an organisation because no one wants to legislate, so in fact it is a merger of two organisations with quite different statutory bases and purposes run by the same people—with some honourable exceptions, including its new chief executive—who have been used to running a performance management system. There is a real question also about the extent to which an organisation that is central and a long way from the clinical front line necessarily has the wherewithal and skills and, indeed, again with the problem of the bandwidth and capacity, to provide support. While the rhetoric is that NHS Improvement will work alongside NHS providers to help them improve, the question is: what value do they bring to that relationship and how does that work when they are also holding their feet to the fire and increasing the centralist and directive method of performance management?

The big challenge is that we have been given a set of improvement challenges and efficiency challenges at a very macro level, but what you do not hear, and what I have not yet heard locally, is a narrative from the people running organisations about what proportion of their share of the £22-billion problem that the NHS has is cash that has to be saved—in other words, staff who have to be fired, drugs that do not get bought—or productivity. That is a fairly basic gap in the narrative about what we are trying to do. I would think it is not a particularly compelling explanation—vanguards and the rest notwithstanding because I do not think that is where all of that explanation sits—about how you are going to do that: what do you then do? Carter gives you £5 billion. That is great; there is £17 billion left. Where is the rest of that coming from? Again, I do not hear that narrative. Then, where does NHS Improvement fit in? That is holding them to account for delivering something that they are not clear what it is and do not necessarily have a method to know how to do it, if one was being slightly cruel about how one sees it.

Chair: I know John wants to come in here.

John Appleby: There are two things going on here. There is a medium to longer-term issue, and we talked about the Five Year Forward View, although I think it is now the four year forward view, as we have had a year or so of it.

Nigel Edwards: It is three and a half years.

John Appleby: We have a very dramatic short-term financial issue. The spending review has not provided the apparent £8.4 billion headline figure that gets quoted; it is £4.5 billion for the whole of the NHS. The £8.4 billion is constructed from extra money from the Treasury but with some fairly deep cuts in other parts of the NHS budget that will be channelled through to the provider sector in the NHS. We are looking possibly at an overspend, going back to the beginning here, of £2 billion to £3 billion. Next year, something like 44% of the entire budget for the whole of the Parliament is being allocated to the NHS. That is coming next year, so it is front-loaded; it is what the NHS asked for.

In terms of the sort of size of money, that is £2 billion in real terms, but the NHS has already spent that and more. The plan is to eradicate all overspends by the end of next year. The numbers do not add up in that sense. The Committee earlier asked questions of the previous panel about transformation money, health and so on. I am at a loss to know quite where those resources are going to come from to do the sorts of things we are talking about in terms of Carter's report and so on.

Q65 Mr Bradshaw: If the wheels are not going to come off from this, the Chancellor is going to have to find a huge extra whack of money, is he not? You are nodding.

John Appleby: One other thing to bear in mind—and I meant to say it slightly earlier—is that while the NHS has done remarkably well in terms of many of its headline performance measures, the latest figures from Monitor and NHS TDA or NHS Improvement suggest that something like seven out of 11 key headline performance measures are not being met now. These are not just A&E: the first-time elective RTT wait target has not been met in aggregate across the whole country; I do not think any ambulance target has been met, and so on. We are beginning to see the NHS really struggling, it seems to me. It has done well, but it is now struggling.

Anita Charlesworth: The other thing to add to that is that those are the things that are prioritised and visible. As to mental health care, that is much less visible. There is a very serious intent and desire among people to see parity of esteem, but we are consistently seeing that at the beginning of the year the NHS plans to spend more money on mental health and then it does not because the money is sucked into the acute sector and those challenges. We know something about mental health—which is a biggie—and community nursing services, but we really know nothing. What I am quite worried about is that, if we cannot stabilise the acute sector, then we will continue to suck in resources from the less visible areas that are nevertheless important for very vulnerable people.

Q66 Mr Bradshaw: Can I go back briefly to the question Anita raised about the failure to share best practice? In the Nicholson era, there was a cadre of the best chief executives and managers who used to meet regularly to share best practice. Does this still happen?

John Appleby: This is partly NHS Improvement. There is an attempt now to have a slight change of culture here. We used to have something called the NHS Modernisation Agency. It was integral to reducing waiting times with a focused approach to diffusing best practice, actually helping trusts and the consultants tackle waiting times. There is an attempt now to turn a corner with Monitor and be, in a sense, more supportive of the system. We will wait and see. I hope that comes off because that is the way to go. I have just one other thing, and Anita raised this. It is not that there are recalcitrant consultants and managers who want to do a bad job—quite often, they may not even know they are doing a bad job: they are not aware of the data, or if they are they are finding it difficult, for various reasons, to do what they know they need to do. Support from people like NHS Improvement would be great.

Q67 Helen Whately: You sound a bit more optimistic on that.

John Appleby: Yes.

Anita Charlesworth: There are two things. The opportunity cost of a big restructuring with the reforms was that a lot of people were moving job, a lot of people were focused on reorganising rather than on some of these underlying issues. Then, many people are, somewhat in surprise to themselves, bemoaning the loss of a regional tier—Nigel's point about how distant this is. Lots of people say, "I would never have believed I would say this, but there was a point to SHAs." It is quite difficult to run a system on a whole-country geography and it will be very interesting to see what Manchester does in relation to this. Much of what might be interesting about Manchester is less about the formalised structures but more, to some extent, recreating that bigger 3 million to 5 million population geography. What Manchester is doing a lot is bringing people together, building those relationships and opportunities to exchange and share, which has reduced—an unintended consequence, I guess.

Q68 Chair: Certainly in the last Parliament I remember all members of the panel coming to tell us that it was the SHAs that did the heavy lifting with the levers to make system change happen. So that is still missing, in your view, is it, Anita?

Anita Charlesworth: Yes, and I think Nigel's point is right. NHS Improvement is very distant and a lot of these issues are very different. The right solution will need to be tailored to different geographies, and understanding that and the network of relationships and capabilities and all those things is quite different. The new requirement to have a strategic plan on a more sensible geography will be good, but quite how they will be able to manage that interface I think is very difficult.

Nigel Edwards: Developing a sort of plan and that type of leadership, particularly given the experience of when they did various types of larger regional plans about two years ago, means that we are already rather late in terms of those plans having some chance of an effect. They are too late for this year; they might start to have some effect next year. If they involve major change, they may already be too late given the way the electoral cycle works.

Q69 Chair: How optimistic are you about systems like, for example, success regimes in leading system change?

Nigel Edwards: There are three success regimes and there is at least one official success regime in south-west London. These problems are wicked problems. They seem to be having mixed success. Some of these systems need very fundamental change. One obstacle to that is that anything that requires centralisation, and particularly the moving of obstetrics and acute medicine, requires very large amounts of capital and, therefore, time. Neither of those two things is available.

Q70 Emma Reynolds: John has answered this question, but I would not mind the thoughts of others on it as well. To what extent will the additional money in the CSR help meet the financial needs of the NHS? Obviously, there is a fear that it will just be absorbed by deficits, pension costs and rising demand. In your view, will there be anything left for the kind of transformation that we need in the longer term?

Anita Charlesworth: If you go back to 2014-15, the additional £8 billion was the minimum that NHS England identified as necessary and, as Simon Stevens has said, it was

predicated on a number of things. The first was some of that money coming up front, which has happened, but there were two other things that are really important that it was predicated on. One was effective action and a strategy on public health and population health, and, as he has said, there are real questions about that now. The second was an effective, sustainable social care system. Again, although this spending review settlement is more generous for social care than the previous Parliament spending resettlement, the work that we three organisations have done suggests it leaves a very big gap, and while the health settlement is front-loaded the social care settlement is back-loaded. Providers are already saying delayed discharges of care are a big part of their problems at the moment. In terms of the failure to meet some of the targets that John talked about, we have very high bed occupancy rates and, from the work that Nuffield have done, we are running very hot in summer, not just in winter. There are two things that are really worrying—social care and population health. Then, we are so far back that we have gone backwards since then.

Nigel Edwards: It was presumably predicated on the system being close to financial balance.

Anita Charlesworth: Exactly so. So we start far back. The underlying finances are worse than the current financial picture looks because much of the current finances are predicated on capital-to-resource transfers. That is fine for the short term, but we are overtrading and we are using what should be investment funds to bail out day-to-day running costs. Our run rate, in the jargon, would be even worse than it is now.

Q71 Mr Bradshaw: Also a lot of hospitals have had surpluses, like mine in Exeter, which was very well run and very efficient. They have been using their surpluses to avoid a deficit until recently, but now they have a deficit and these surpluses must all be running out.

Anita Charlesworth: Yes.

Nigel Edwards: I think they have gone.

John Appleby: One consequence of, in a sense, giving NHS England that bit of the Department of Health, the £8.4 billion, is a £1.7 billion or so cut next year in capital, the Health Education England budget, the Public Health England budget and seven or eight arm's length bodies as well. Quite how that is going to pan out we do not know, but picking up on Anita's point about the original £8 billion ask, as it were, from Simon Stevens being predicated on social care being reasonably funded, starting not from £2.8 billion down but from a reasonable base, and also public health as well, you can see that the sums and the sort of directions do not seem to add up very well.

Q72 Julie Cooper: Moving the focus on to social care, you have touched on it and you were saying that the budgets for the NHS—"the ask"—were predicated on a fully functioning social care system. Given that, what will be the effects on the NHS of the funding constraints on the social care budget?

John Appleby: It is difficult to know quite what will be spent on social care in the future because global budgets are not decided in advance in that sort of way, so it is going to be up to councils, it is going to be up to the demand and so on. Also, as the previous panel mentioned, there is this precept up to 2% each council can levy. Will they all do it?

Something like 90% are maybe planning it this year. Whether they will do it again next year and the year after, we will wait and see because the tax starts to rack up and the grant from central Government to local government is tapering down. It certainly does not make up for the huge real cut in funding and activity in social care over the last five years.

As to quite what the impact will be, I agree with the previous panel. Social care is starting from a different position than it was in 2010—a much more difficult position. The precept will be unfair and inequitable in terms of the amounts of money raised per elderly person who needs social care. That is well recognised and was recognised in the spending review, so that needs to be fixed in some way. It is difficult to predict at the moment, but it does not look hugely hopeful.

Anita Charlesworth: The social care position is worrying. If you look at what happened over the last five years, essentially there were two big things that helped councils get through. Obviously, they reduced eligibility very substantially: 25% fewer people are getting care now than were getting care before and packages of care were reduced. They bore down on the amount they paid to the providers of social care. Some of that was managed by keeping wages very low, and then particularly we see in residential care that essentially those paying privately are cross-subsidising. It is very difficult to see that there is scope for that to continue. For a start, we have the new living wage policy, which is a very positive policy, but it does add significantly to social care costs. There is very little opportunity probably in social care to react to that by skill mix because most people are already right on the bottom, which is something they might have done. There is a sense from a lot of social care providers that the ability to cross-subsidise from public and private is at its limit. The gap now for residential care places between public and private is large. Then also, in terms of reducing eligibility, where else do we go?

I am worried about the impact on the NHS, but I am most worried about the impact on vulnerable individuals. The health survey for England, which is a bit of data that we have, shows that, if you look particularly among low-income men and women who need help, there has been a growing gap in those who are receiving help. That could be state, private paid or it could be informal care. Obviously, for better-off people, they have some opportunity to pay themselves, but we are seeing a growing gap and people living in what I would call silent misery. That is very worrying. At some point, some of those might turn up on the NHS's door, but that should not be the only criterion for action.

Q73 Julie Cooper: One thing I am seeing in my constituency is that people having unmet social care needs, particularly the elderly vulnerable living alone, pick up the phone and dial 111 or the doctor's surgery and the next thing they know they are in an ambulance off to hospital, taking up a bed and they are miserable; the NHS cannot cope and that is backing on to the A&E, it is backing on to the elective and so on. Do you think that the CSR is a barrier to integration of these services, and if they were better integrated we could see some better patient outcomes?

Nigel Edwards: The problem, as Simon Stevens said, is if you put two leaky buckets together you do not have a waterproof container. The quantum of cash available is probably the issue. There may well be some opportunities to use health service money more imaginatively to intervene earlier, but the evidence that that is effective in reducing demand is not very compelling, I have to say. There is probably a better investment to be

made in getting people out of hospital once they are in—that seems to be more effective—but it seems you need to spend an awful lot of social care money to get very significant reductions in healthcare spend. Although, if I remember rightly, there is a positive multiplier, it is less effective than you might hope, particularly given that we are starting from such a low base in terms of who is eligible to receive it. It is worth remembering that there are still a lot of people who are not eligible at all, who are self-paying.

Q74 Julie Cooper: Where does the Better Care Fund fit into all this? It does seem to me—and I stand to be corrected—that it is a bit like robbing Peter to pay Paul, a recycling of the same funding.

John Appleby: I think Peter is asking for his money back as well on this.

Anita Charlesworth: There is a real question with the integration that, with an ageing population with chronic disease, we clearly need, whatever the financial situation, to make sure that we provide care that treats people as whole people and responds to their goals and aims so they can live a fulfilling life. It is very difficult, given the change in underlying need, to imagine a system that is effective that is not more integrated around the individual. It is an absolute imperative and all countries are trying to do this, are they not, to find ways to shift our system towards that goal? Trying to almost hijack that agenda to save short-term funding is potentially unhelpful. There is very little evidence that you can do that. The thresholds in the system are very different and the cultures and all of that. There is very little evidence that this is a way of saving money, and we might damage the integration agenda, which is a really important fundamental agenda, because we are almost setting it up to fail if we are giving it the task of saving lots of money.

John Appleby: Can I add something to that? If the NHS was getting lots of extra money, so if this had been 10 years ago, or whatever, you could see this redistribution, coupled with the sort of galvanised desire to integrate in whatever way, beginning to help and work, but the fact is it is the leaky bucket thing: you are taking money away from a system that has collectively overspent, to do what? A lot of that money will have to come back in some way to help with acute trusts that have overspent. It is a sort of strange halfway house and a very difficult situation. The King's Fund commissioned Kate Barker and some other people to look at the future of health and social care, and, like most people, when you look at it, it would be good if these systems worked together. It is not a magic bullet for anything, but we can see that care could be better for people, but it requires money. The commission has suggested, into the future, that we should be looking at spending 11% to 12% of GDP on health and social care. It is that sort of resource that you need.

Q75 Julie Cooper: You would agree with the other panel that, far from being a way of saving funds, the integration budget would have better patient outcomes but would merely uncover more demand and maybe be more expensive.

Nigel Edwards: That is certainly how it seems from experience. You find things you did not know were there. That is definitely a risk.

Q76 Helen Whately: Coming now to the potential to achieve efficiency savings—and you have just given a view that integration, in your opinion, is not really the way to do

it—could you give your view on how achievable the £22 billion efficiency objective is; if not £22 billion, what do you think would be achievable, and where do you think the main opportunities are for the health service to achieve significant efficiency savings?

John Appleby: First, I do not think anybody really knows the extent to which it is achievable or whether the NHS will manage to achieve it. It just about scraped by with the last go at doing this over the last five years. The target was something like £20 billion. The figure that was officially published was something like £19.5 billion. There are three reasons why we might have to be worried about whether the NHS will close this gap. One is that, when you look back at how it achieved the £19.5 billion, part of it was through, in a sense, shooting first and asking questions later by cutting the tariff in real terms. The presumption was, down on the ground, that an equivalent notional amount of money was saved in some way, but we do not know for sure. The other tactic was to freeze pay, so there are groups in the NHS now who have had a pay freeze for, what, five to six years? That may carry on and we may be able to cut costs in that way. I just have my doubts as to whether we could do that for another four or five years.

Nigel Edwards: Particularly given the state of private-sector earnings at the moment.

John Appleby: Exactly. Also, there is the fact that in the short term there are always things that hospitals and organisations can do to save money. The NHS is a past master at getting as far away from the patient frontline as possible, such as “Do not replace that guttering for a year or change those lightbulbs,” and all that sort of thing. Once you have done that sort of thing, you cannot do it again and again, and we have reached a point now where many organisations are up against it. It is not that they cannot see perhaps how to be more efficient and it is not just within their own organisation. I think I have said this before to the Committee, but let us say it is across the whole of London for all cancer services: that is a much more difficult thing to start to get to grips with and will require, quite often, capital up front. For those three reasons, the NHS is in quite a difficult position now in terms of the £22 billion.

Q77 Helen Whately: Before Anita and Nigel respond to that, can I pick you up on that, John? You are pessimistic about the opportunity, but do you see some areas to be optimistic? For sure, there is huge potential for the NHS to make better use of technology and with that will come great efficiency. Do you see that as an opportunity?

John Appleby: Of course I see it as an opportunity and I would certainly not say that the NHS is now at the sort of limit of what it can do, but some of these things take time. If you look back at how the NHS has improved productivity in the past, and in fact any healthcare system, one major factor has been to reduce the length of stay of people in hospital. That has allowed hospitals partly to reduce the numbers of beds—they do not need so many beds because people are going through quicker—which allows them to treat more people. But there was not a “big bang” moment when suddenly length of stay dropped. It happened almost over a generation. There are other examples. Generic prescribing over the last 30 or 40 years has managed to save a lot of money, or allow more activity to be done, but again it has been bit by bit. I would be optimistic over the longer term; it is just that three or four years is quite short term and it is very tight. We do a survey of finance directors every quarter and the stress coming through from these people having to grapple with the day-to-day finances, trying to make ends meet, is palpable from what they say.

Paula Sherriff: Not to mention the stress on the ground too.

Nigel Edwards: The international evidence on the use of technology in healthcare is less than encouraging. Quite a bit of healthcare technology increases cost. The use of digital technology also, at least in the short term, seems to have not made as much of an improvement in cost as you might hope. If you are in the US, it has allowed you to be more effective about billing, so it has increased your income, but in terms of cost reduction it has been less impressive. Healthcare seems to be, as usual, a bit of an exception to the rule that you can replace labour with IT. Obviously, there are opportunities in the back office, but they are a relatively small proportion of the total cost. Some of that £22 billion is driven by some very expensive new treatments coming through, which the NHS at the moment will probably choose to use. That is unavoidable. Some of the £22 billion is to be made by a further freeze on pay for the next four years, similar to what happened before, and, as we were saying there, that does not seem plausible. A proportion of it is assumed to be achieved by improved prevention and reductions in admission to hospital. Again, the evidence that that is easy to do is quite limited. Then £10 billion or so is just a simple turn the tariff down and hope that the providers will improve efficiency, of which Lord Carter provides about £5 billion-worth.

That is a top-down view of what the world looks like. It is what I was saying earlier, that I do not see particularly at the moment a terribly clear bottom-up picture, at a hospital or a system level, of how that translates into action. My account there is an accountant's view of the world; it is not actually a real one. How that translates into real action I do not know. Length of stay does remain still an area where we could do something by international standards. Our lengths of stay are not as good as they should be, but length of stay has plateaued over the last five years. This may well partly be because of the financial pressures that have been put on social care and community services because you can go round a hospital and certainly find 40% of the patients could go home, but you would not send them home without some help or they would be back again. That help may not be forthcoming. Many of the easier wins have gone. Some of the bigger changes, as John was saying, will take time, and, as yet, I do not see a good account of what that all looks like on a local level or a willingness to say that we are not prepared to see the specialist commissioning budget go up by 7% or 8% this year. There are a whole lot of new things, particularly in the cancer drugs pipeline, that are likely to add to costs.

Anita Charlesworth: I would say two things that I think would be helpful to our ability to make progress to the £22 billion, even if we do not get there. One is a clear workforce plan. There are things that the NHS, probably with national co-ordination, could be doing that would help no end. We had in 2014, according to the NAO, 800 nurses return to practice, whereas in previous decades I think over a five-year period at the beginning of the millennium we had 15,000 or 16,000 nurses return to practice. We lose something like over 18,000 nurses a year from the NHS at pre-retirement age. A really concerted return to practice would help—an understanding of why so many nurses leave and a concerted programme of work to address some of those concerns and reduce that. These are the sorts of things that you would expect, because critical to being able to hold down the pay problem and to hold down the agency costs problem is being able to recruit and retain, and the nursing workforce is the big part of that. While it takes three years to train a nurse, there are things you can do about return to practice. We could get on with training more of them now as well. I am perplexed by why we do not have, 16 months after the Five Year

Forward View, a really good co-ordinated plan of what to do to address the workforce problem when we know the workforce is at the heart of many of our cost issues.

The other important thing to do this is to give organisations in the NHS some sense of a doable task and a meaningful horizon. I would advocate probably for providers a multi-year budget that realistically tells them how they are going to get down and back to balance, which gives them something on which they can begin to succeed. They can give people a sense of hope and create something that is galvanising. If you go round the NHS at the moment it is full again of short-term efforts. All the instructions around managing the year end are short term and tactical; there was a letter issued. They are all tactical, technical adjustments and then, “Shift your capital resources.” They are not, “Get on with the day job of galvanising everyone in your organisation to identify where the improvements are and focus on doing that.” That does not create a way of getting people to get behind change and really support it. We leap then from crisis to crisis. We end up spending the same amount of money but just bail it out as failure, rather than planning to inject it into something that could create value.

Q78 Helen Whately: That is incredibly helpful and takes me on to the next question, which is essentially: how can the system shift from that tactical response to a more strategic and transformational response? You have talked about the transformation fund and the need for that. How can that shift be achieved? Is the transformation fund that is proposed going to help? What is your perspective on that?

Anita Charlesworth: Annuality is one thing that is bedevilling the NHS at the moment. People are supposed to be having a strategic conversation for this sustainability and transformation plan, developing grown-up and mature relationships that enable them to think about how, together, they can unlock value locally, at the same time as they are about to be locked into ever more bitter contractual disputes about the short term in the normal planning round where providers will be saying, “Under this better tariff I am entitled to this money,” and commissioners will be saying, “Yes, but it is not in my budget; I do not have it.” You go round the constant transactional relationship. We should try and get out of that. It has not served us very well. If we are going to do these new plans, we should try and identify some longer-term budgets for providers because, in the end, the tariff does not deliver you a penny of saving. It says whose job it is to deliver the saving, but then you have to unlock that saving and that requires you to redesign some pathway or care where you organise care within a hospital and, by and large, that takes quite some time to do. I would shift significantly out of the annuality. As a Department as a whole, we know the budget for four years so we could cascade that through the system and get people to spend their time focusing on how to move from here to something that is more sustainable.

Nigel Edwards: In fact, I do not entirely agree with that because the new planning process breaks the link between the contracting round and the planning process. They are separate. The real problem is that there is an ingrained habit of annuality and a lack of planning skills. In the last planning round I referred to, a lot of the planning was outsourced to management consultancies, which is where some of the better people who used to do planning have probably gone to work, but of course they are not really embedded and you cannot outsource strategy and planning, so there is a skills shortage and there is a very ingrained culture. The attempt to try and separate the process of these STPs from the

annual contracting round is a first step and it meets some of Anita's objections to the previous process, which I entirely agree with, but the problem runs very deep in the psyche of the system and the very short-term way in which it is run. I do not think there is an easy answer about how to break that cycle, I am afraid.

John Appleby: I am not sure what to say. I just go back to how focused the whole system is, and has to be, in a way, on the short term at the moment. If we look forward—literally look forward into the future—to 2018-19, the real increase is something like 0.2% and, for 2019-20, 0.1%. It is very hard to think how you could be strategic when you are looking ahead to that sort of funding. I am not saying it all comes down to money, but clearly some of the changes that are going to be required and could be done do not come for free, at least in the short term. I certainly agree with Nigel about the loss of skills in planning.

Q79 Chair: I know in your joint submission you were not able to say much at that time about the impacts on public health. Do you feel that you are able to go further during your submission now?

Anita Charlesworth: Yes. There have been draft allocations issued for consultation on public health¹ and the numbers are quite confusing, because, as the Committee may be aware, services for under-fives have moved into the public health budget. So it gets bigger, apparently, because of that transfer, but basically in real terms the public health grant to local authorities at the moment will reduce from £3.5 billion in 2015-16 down to £3 billion in 2020-21. That is a very sizeable cut. If you look, though, there are two other things to add to that. One is the proposal to take the ring-fence away from the public health grant during that period, so obviously it will then be open to local authorities to spend less or more than that, but, given the other pressures that we have talked about in relation to social care, there must be a strong temptation for them to cut further than that.

Secondly, many of the things that are within the public health grant are things that most of us would traditionally have considered core NHS services, like health visiting, drug and alcohol services and sexual health services, and those are to be protected, which means then that genuine prevention—population health work—will probably take an even bigger cut, so it will be reliant on local authorities to be very imaginative in the way they use this money.

Thirdly, much of that money flows back into NHS providers. Over the last few years, in many cases, local authorities, for understandable reasons, have been reducing the value of contracts and NHS providers have been saying, "We will carry on with the service spec." But as NHS providers are under more pressure it will be very interesting to see if we have more contracting rounds where people start to say, "Actually, we are not bidding at that price, or we will have to change the spec on the services." We are worried about this, but, as Simon Stevens pointed out, it is not just about those local funds; it is also what the concerted national action is. He has talked, obviously, about the forthcoming obesity

¹ The witness asked for the following addition to be added to the transcript: The allocations for public health funding in 2016/17 are not out for consultation, however the government's circular to local authorities (dated 11 February) states on p.15: "The government will shortly consult on options for fully funding local authorities' public health spending for current public health duties from their retained business rates receipts as part of the move to 100% rates retention. The current ring-fence on public health spending will be maintained in 2016-17 and 2017-18."

strategy, and quite what is in that and how we galvanise all parts of society to help on that, and all the different array of measures that might be available will be very important as well.

Chair: Thank you. Do John and Nigel want to add to that?

John Appleby: I have nothing to add on that.

Nigel Edwards: There are some early and alarming signs in one or two councils, looking at things like health visiting. Harrow recently withdrew a proposal to completely remove all of its health visitor services. That was something of an outlier. We have been surveying directors of public health on this. I am not in a position to share the results of that with you. Of course this is confounded by the fact there has also been a move of a lot of these services, so picking up the different effects is quite hard to do. Local authorities also have a different approach to procurement from the NHS in that it would be much more sensitive to price as a determinant for whether or not they award contracts than the NHS has tended to be in the past. All those different effects going on at the same time make it quite hard to unpick what is going on. But it is something that I think is very well worth keeping an eye on, because, as Anita was saying, a significant amount of this money ends up going back into the NHS. It is not quite true to say that the NHS front line has been ring-fenced because a large chunk of it comes back in. There is a more worrying longer-term concern that we have significant cuts being made to preventive services, particularly when the ring-fence ends. It is something to be keeping an eye on, I think.

Q80 Chair: Was it your view as a panel that the ring-fence should stay, or did you feel there was a strong case for removing the ring-fence?

Nigel Edwards: It is very difficult. I am, on the whole, not in favour of ring-fences.

Anita Charlesworth: It will have been a very short period of time since the transfer of funding and responsibility for the ring-fence to come off. Ring-fences cause distortions, obviously, and, by and large, local government would argue coherently that the more ring-fences it has, the less able it is to generate overall system-wide efficiencies. That is an important point. Offsetting that, the rest of the local government budget is under intense pressure. We have seen in all countries that are suffering financial pressures in their healthcare system that so often it is very tempting to cut the prevention and health promotion bit of the budget because it is the one whose impact is not felt immediately, but it is a false economy. From a system point of view, looking at the value of our system as a whole, especially when they are under pressure, ring-fencing your population health, almost to save you from yourself, may be quite a sensible thing to do. It is a bit like why you keep capital budgets very separate from resource budgets during periods of constraint because you know the temptation always is to raid the capital budget, but you know that in the long run you are storing up trouble for yourself. The Treasury, for good reason, has argued that in terms of long-run productivity we need to protect capital spending for UK plc during the downturn because that will be key to growth. I think the same argument could be made for a further ring-fence on prevention.

Nigel Edwards: I would agree with that. We are already seeing some very worrying signs in terms of upturns in sexually transmitted diseases. I am concerned that some of the gains we have made in teenage pregnancies over the last few years might start to get reversed as

well. It is equivalent to a capital investment. Certainly, the machinery for holding local government to account for these decisions needs some thought because these are new; they have not been asked to operate in this area since 1974, so there may be a need for some strengthened oversight and scrutiny of those decisions as well.

Q81 Chair: Thank you. Another area where money goes back into the NHS but the budget is being cut is Health Education England. Are you able to comment on that briefly?

Nigel Edwards: Postgraduate education of doctors is the largest single item and it is effectively used to support the training component of junior doctor roles. That bit, as I understand it, is being frozen—the effective subsidy to having junior doctors on your staff. You get a service from junior doctors but they are also being trained. They cannot work unsupervised in a number of settings, so there is a cost associated with having them; you are also required to provide education and training support, and there is a payment associated with that. Those are likely to be held. That represents a further squeeze on the provider sector, but, rather more significantly, if part of that £22 billion is to get the existing staff to treat more patients without burning them out and you have set fairly prescriptive staffing ratios, which we have done, the only way that you will get that probably is by some shift in the skill mix. It will also be necessary to deal with some of the shortages we have in geriatric medicine, psychiatry, A&E and, increasingly, in general practice. The money to do the retraining of different types of staff to allow you to do those sorts of skill-mix changes sits in Health Education England. So here we have another example of plundering a budget that could be used to facilitate but is not because, unfortunately, the NHS's history on workforce planning and the imaginative thinking required to do that sort of thing is very poor. The potential would have been there, but that budget, of course, has been very significantly squeezed as a consequence of the spending review.

Q82 Chair: Returning to Anita's point earlier, when you are having a returners' scheme, presumably that comes out of that budget too.

Nigel Edwards: Yes. Returner schemes would be paid for by Health Education England.

Q83 Chair: So it is a concern for you in terms of the cuts to that budget.

Nigel Edwards: Yes.

Q84 Helen Whately: Before we finish, can I ask for your perspective on the spending review for mental health and how it will support the objective of parity of esteem for mental health? Clearly, since then there has been the report of the taskforce and the Five Year Forward View for mental health with extra funding mentioned, so you might want to refer to both, though that has been very recent.

Nigel Edwards: We are not sure if it is extra funding. It looks like the mental health sector's share of the £8 billion. If mental health is around 12% of the total spend, 12% of 8 is 1, and now that—

John Appleby: There is no extra money for mental health in that sense. It is getting its share of the extra so-called £8 billion for the whole of the NHS. The taskforce report is not my area particularly, though some colleagues who specialise in mental health certainly

have welcomed this, but money is an issue. Going back to public health, for example, there are public health issues around mental health and yet that is a bit of the budget getting cut. It is all within the same envelope. I would not go away with the idea that this is £1 billion on top of the spending review money, by any means. It is within the same spending review envelope, and, as Nigel said, it is broadly what the NHS spends on mental health as a proportion of the NHS budget anyway.

Anita Charlesworth: I agree very much that the £1 billion does not appear to be extra. It is a re-announcement of the funding within the spending review. What is critical here is the ability to deliver and follow through on that. We did an analysis looking just at mental health providers, so that is a subset, and looking at the difference between commissioners' intentions and what actually happened. Intentions are clear and planning guidance again reiterated that commissioners were to plan to spend at least the increase in their overall allocation on mental health, but we are repeatedly seeing that not being borne out in practice. The number of nurses employed in the acute sector has risen over the last couple of years following Francis, and so on, from 2013. It has been falling still in mental health and it does appear that it is the most experienced nurses that have been leaving. That raises questions of the capacity in the system.

Mental health trusts have seen their income fall and—we do not quite know overall—their costs have fallen more sharply, and we do not know what has been going on with quality within that. There are some areas highlighted for concern, but we have an incomplete picture and I would like to see, alongside what has happened there, the work that I think the taskforce highlighted, which is important and not very exciting, about making sure that we have—and Norman Lamb makes this point over and over again—good information on the quality of mental health services. What is happening in access is one important measure, but we want to see a range of quality measures. We no longer know what we spend overall on mental health. We know what CCGs spend. NHS England is an important organisation for spending on mental health. We no longer know. It is now impossible for, let us say, the population of Liverpool to say what is spent on the mental health of the people in Liverpool, so how we can move forward, plan services and make the sort of reality and then hold to account for the sort of system that is envisaged there without that underpinning, I do not know.

Q85 Helen Whately: Transparency on the spending and quality are what you want to see.

Anita Charlesworth: Yes. It is important to put that in place.

Chair: Thank you very much for coming this afternoon. We appreciate it.