



Health Committee

Oral evidence: Impact of the Comprehensive Spending Review on Health and Social Care, HC 678

Tuesday 8 March 2016

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

Questions 86-193

Witnesses: **Chris Hopson**, Chief Executive, NHS Providers, **Julie Wood**, Chief Executive, NHS Clinical Commissioners, and **Professor Tim Briggs**, Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital Trust, National Director for Clinical Quality and Efficiency, gave evidence.

Q86 Chair: Good afternoon. Thank you very much for coming to this session of our inquiry into the implications of the CSR on spending in health. For those following from outside the room, could the panel introduce themselves, perhaps starting with Julie?

Julie Wood: Yes, thank you. Good afternoon, everybody. My name is Julie Wood. I am the chief executive of NHS Clinical Commissioners.

Professor Briggs: I am Tim Briggs. I am a consultant orthopaedic surgeon at the Royal National Orthopaedic Hospital and also the National Director for Clinical Quality and Efficiency as of October last year.

Chris Hopson: Good afternoon. I am Chris Hopson, the chief executive of NHS Providers. We are the membership organisation and trade association for the 240 NHS community, mental health, acute and ambulance trusts.

Q87 Chair: Perhaps I could start with you, Chris, by asking what you see as the root causes of the deficits in the provider sector.

Chris Hopson: There are three or four different things that it seems to us are going on here. First, you have the 10-year financial squeeze in that, as you know, costs and demand in the NHS tend to rise by somewhere between 3.5% and 4% a year, and yet we are in a funding period where effectively the real-terms increase is, on average, 0.9%. The second bit, as I think you know, is that our members were asked to make 4% efficiency savings a year through the tariff over each of the last four years. That is a level of savings that no advanced western health economy has ever made, which the new chief executive of NHS Improvement described—correctly, in our view—as unachievable. You then had the addition of, we think, somewhere between £1.5 billion and £2 billion of extra staffing cost following the Francis inquiry into events at Mid Staffordshire. Again, as you know, the problem was that there was not the permanent supply in place to meet that extra demand, so we have had to go for expensive agency staff. Our argument would be, particularly given that we have 90% of acute hospitals in deficit, that this is not a problem of individual providers—recognising there are a few that do have structural challenges—but a systemic problem that is caused by the way the tariff has operated, and the addition of that extra cost on staffing.

Q88 Chair: In your view, it is unrealistic, would you say, to address this deficit without more money coming in, or do you think there is any responsibility that providers bear for the situation?

Chris Hopson: Our members would say, were they sitting here, that they feel a very clear responsibility to deliver the appropriate quality of services, appropriate access to those services, but, crucially, in financial balance. However, they would argue they have been set an impossible task and they have somewhat inevitably fallen short.

Looking forward to how we address this, the front-loaded settlement in 2016-17 provides the beginnings of a good plan. We would describe it as reversing the car out of the financial ditch into which it has been driven. However, our view would be that, if you look at the sums of money involved and at the likely size of the provider deficit, it will be a struggle to get back to surplus in 2016-17. It is more likely that you will get back to surplus in 2017-18. If you look at the degree to which the financial pressures are building on our members—there is £1 billion extra national insurance-related pension cost—if you look at the increases in demand, there are a whole number of different issues that mean that, if you were to ask what would be our best guess for the provider sector's overall position in 2016-17, we would probably say a £0.5 billion deficit is about as far as we can

get. However, if we end the year, as we probably expect, at minus 2.8 million, there is a lot of progress to have got from minus 2.8 million to minus 500 million.

Q89 Chair: That is your current estimate, or your current best estimate?

Chris Hopson: That would be our current estimate based on the intelligence that we are able to gather. If you talk to our colleagues at NHS Improvement and to the Treasury, there is a presumption that we will be able to wipe out the entire minus 2.8 billion in 2016-17, but we think that is too much of a stretch.

Q90 Chair: Thank you. Do either of the other members of the panel want to add to what Chris has said?

Professor Briggs: I come at it from a slightly different angle, in that I am a clinician. As far back as 2010, we could see what was coming down the track. We have an ageing population who are living longer, the demands on the health service are going to increase, and the question that I want to know the answer to is whether we could do things better. Could we reduce variation across the country? We used that as our starting point and that was how the GIRFT methodology evolved. We were able to get a team together, get it funded—after the report came out in 2012—to use orthopaedics as a national pilot to look at the variation in practice across the country and to see whether we could improve quality, reduce complications and, with that, make a contribution in terms of making savings. We got 12 different datasets together on every single trust. We got that together into a unique dataset—the first time it has ever really been done—sent that to every single trust and then went to visit them. In the past two years, I have been to 248 hospitals in England, Wales and Scotland to look at data, which tell a very compelling story about how we can reduce variation, improve quality, do things better and make some savings. There are other ways we can help to do that.

Q91 Chair: How much could that impact on the overall figure? What is your estimate of the impact?

Professor Briggs: Looking at elective orthopaedics, I will give you three examples. The variation for deep infection rate for hip and knee replacement across the country—just England—is from 0.2% to as high as 5%. Every infected hip and knee replacement costs on average £100,000 to treat. If you could reduce the deep infection rate, which can be done, across the country and make it consistent to 0.2%, at a stroke you would save the NHS £250 million every year. You can see that the numbers there, just in elective orthopaedics in hip and knee replacement, are quite significant. We saw huge variation in cost of implants, for instance, in just hip and knee replacement. You could make significant savings of up to £40 million a year if we all paid the best price for the right prosthesis for the patient.

Another example is litigation. The cost of litigation is going through the roof, and in 2003-04 in orthopaedics the NHS paid out £37 million. If you fast-track to 2011-12, we paid out £187 million in one year, so it is rising at the rate of about £30 million to £40 million a year. We have drilled down into that with the NHS Litigation Authority, in terms of what is going on, into what we call an orthopaedic spell. For every orthopaedic

procedure taking place around England in 2011-12, the cost on average was £54 per orthopaedic spell, but the variation between hospitals ranged from zero to as high £154 per orthopaedic spell. There is huge variation. In hospitals where it was high, it tended to be high the following year and the year before, so there is a significant amount we can do on the provider side, from the clinical perspective, to drive the agenda to reduce the variation—high quality, right cost, best outcome—which can make a significant improvement for the service and for the taxpayer.

Q92 Chair: Thank you. We are going to come back to that in more detail in a minute. Julie, is there anything you want to add in at this stage?

Julie Wood: Yes. I want to add the issue about rise in demand. To add to Chris's explanation about why we have the deficits, we have also seen a rise in demand across the system but with access standards not being flexed very much. Commissioners are trying to deal with that rise in demand, in terms of contracting for it, and providers are seeking to deliver services with more patients going through, and that has also contributed in part to the deficit that we see. If you look at what has been happening on funding over recent years, funding in GP services has declined at the expense of funding increasing in other sectors. That is playing its part in how that is translating into spend.

Q93 Chair: Thank you. Moving on with that theme, how far do you feel that the deficits in the hospital sector, and using up the funds from the transformation and sustainability fund to address that, are, if you like, blowing out of the water our chances of bringing into place the new models of care and the other aspects of the Five Year Forward View?

Julie Wood: Our members are quite concerned about that because, although the front-loading is welcomed, there is absolutely a need to transform out-of-hospital care, so we have to do the "T" part as well as the "S"—the sustainable part—to make the provider side of the system not operate in deficit. The trick is how you can do both at the same time, both restore the finances and transform out-of-hospital care when the deficits are in the hospital sector but some of the solutions are outwith the hospital sector. That is going to need good planning, discussion and agreements across these new sustainability and transformation footprints about how we best use the resource to deliver the sustainability and shore up the position now but also transform for the future. Some of the focus on the efficiencies, finding the £22 billion, is back-loaded to the end of the parliamentary period, and we have to think about how we do some of the transformation now that enables us to pull out those efficiencies towards the end of the Parliament. When we put a lot of money into the sustainability, it risks some of that, so, yes—

Q94 Chair: The figures we have been given are that, in 2016-17, £1.8 billion of the fund will be on the sustainability side, which leaves very little.

Julie Wood: It is a tiny amount of money.

Q95 Chair: Some of that seems to be an amount for other parts of the system as well. How optimistic do you feel about whether we can get on with the transformation side?

Julie Wood: Some of the balancing money—the £300 million—is going to help unlock some of the new models of care, but they have to be able to deliver that transformation and they are not happening everywhere across the country. The vanguards are leading the way, but we have to be able to get those new models of care working very differently, transforming care out of hospitals, which is going to need aligning different behaviours across our arm's length bodies so that they can deliver in the way that they need to, to do that transformation such that Chris's view about when we hit a balanced position is brought about sooner rather than later.

Q96 Chair: How much control do commissioners have in directing where it should go and on your priorities?

Julie Wood: The £1.8 billion for the sustainability fund is with NHS Improvement and NHS England to direct, but in future funds, again, NHS England will play a key role in allocating transformation funds to those parts of the system that have the best STPs—sustainability and transformation plans. At the moment, across the 44 footprints, they are coming together with their sustainability and transformation governance arrangements to say how that is going to work. Over the next few months, they will develop the plans that say this is the size of the gap across this footprint in order to achieve the triple aim, in terms of sorting out the finances, the care models and the emphasis on prevention and wellbeing, and coming up with some solutions for how they are going to deliver that change. They will need some support from the arm's length bodies to be able to deliver that. It is going to require much more collaboration across systems—so commissioners working with providers, working with local government, but also energising local communities to have a different balance between formal care, informal care and community activation. All those sorts of things are going to be essential if we are to truly deliver the Five Year Forward View and get the transformation that we need.

Q97 Chair: Do you feel it is achievable with the money that is left over, or not?

Julie Wood: It is very risky at the moment because such a big amount of money this year is going to be spent on sustaining the position while also trying to use a tiny amount of the money to do the transforming.

Q98 Chair: Towards the end of the settlement, there is less there.

Julie Wood: Absolutely. It is front-loaded; so we have this year and next year to be able to do the transformation that we need to.

Q99 Chair: I do not know whether Chris or Tim want to add anything.

Chris Hopson: In talking about transformation, we need to be careful about just talking about it being a money issue. I do not think it is just a money issue: it is a capacity and a timing issue. Our members are currently being asked to keep a very unstable operational day-to-day ship upright, being asked to find their pretty stretching share of £22 billion-worth of savings and, at the same time, being asked to move to new care models, which, to be frank, in most other advanced western health economies have taken 10 or 15 years to deliver. If you ask our members whether they think they can deliver all that at a

time, as I said, when we have some interesting issues with the workforce, our sense is they would say they are nervous about their capacity to do all that. I think they would argue that the timescales within which we are trying to do this seem to be somewhat unrealistic. As I said, if you look at the profound changes that moves to new change models take and look, for example, at how long places like Northumbria, Salford and Yeovil, which are quoted as the vanguards, have been at this task, this is not a five-year task: this is a 10 to 15-year task. Our sense is that there are lots of good things going on—we are quite optimistic about what is happening in the vanguards—but we need to be realistic about what capacity it will take to deliver that change and how long it will take as well as the need for the investment.

Q100 Chair: One other issue, I presume, is that there is money for the vanguards, but where is then going to be the money for everyone else involved to roll this out?

Chris Hopson: The hypothesis we might have would be as follows. If you buy my argument that we may not get there in 2016-17, in terms of provider surplus, it means you will probably need to take another chunk out of the 2017-18 sustainability and transformation fund to get providers back into surplus. You then have the worrying-looking 2018-19 and 2019-20 settlement where, in our view, the NHS is being asked to deliver what it needs to deliver on a wholly unrealistic level of real-terms increase—so 0.4% in 2018-19 and a 0.7% real-terms increase in 2019-20. My hypothesis at this point would be that, if you were not to get more money into the system, you could not afford to spend the money on sustainability and transformation in those years because you would need to keep the day-to-day ship upright. Our argument is that, at the moment, it is difficult to see how we can cope with all these extra demand increases and deliver the new extra policy commitments that have been made. We pointed out in our supplementary evidence that we think people are asking for far too much extra with far too little extra money, and then you have to cope with the transformation on top. While in comparative terms with other public services it has been a relatively generous settlement, to fund all those needs feels to us to be a pretty big ask.

Q101 Emma Reynolds: We are hearing slightly different things from the panel. Professor Briggs, you talked about what had been done in orthopaedics and how you were able to make some efficiencies while at the same time not only maintaining patient care but perhaps improving it. Is it possible to generalise the methodology and the philosophy that you apply to orthopaedics to other areas?

Professor Briggs: Yes. On the basis of the report we produced in 2015, we have now been provided with a sum of £2.5 million to use the same methodology in all the other surgical specialties. We have now appointed nine clinical leads, and we have one more to go. We have already started with general surgery. We are then doing urology, vascular and ophthalmology. From the information that we have and the data mine that we are beginning to undertake now, we will get similar findings in the other specialties. In talking to the specialist associations and the college, there is a lot of support for this because we need to make sure that we get the highest quality care at the best value with the lowest complication, which means the taxpayer gets best value for money. So I think the answer is yes. At the moment, we are waiting to hear whether we have a grant to move into

general medicine and even dentistry. I think we will get that because the reality is that we have to improve quality but at the same time make sure we get best value. If we can get the providers right, where a huge amount of the cost is, that makes commissioning, to a certain extent, a lot easier. If you asked me whether at the moment I could guarantee the same outcome at best value for a hip replacement in the north, south, west or east of England, I could not, but hopefully, by the time our project is finished, we will be able to do that.

Q102 Emma Reynolds: It is possible to bear down on that variation.

Professor Briggs: Yes.

Q103 Emma Reynolds: We heard different things in previous evidence. You are confident with the methodology that—

Professor Briggs: The reason the GIRFT methodology works is because it is clinically driven: it is a peer-to-peer review; it is going out there with the dataset to meet all your colleagues. In the last two years in orthopaedics, I have personally met over 1,700 consultants, sat in rooms with them with their unique dataset to talk about what they are doing, the load volumes, their infection rates and their readmission rates, et cetera. When you have that conversation, the solutions become obvious. If you have surgeons doing two or three procedures a year, they are getting kit in from companies, so there are loan kit costs, and that is not the best outcome for the patient and not best value. We found, on average, that trusts were spending £250,000 on loan kit costs. The highest loan kit costs trusts were spending £1 million a year. We have to wipe that out of the system, and by getting the right patient with the right condition to the right group of individuals with that expertise, where it is on the shelf, you will get the best outcome and the best value.

Chris Hopson: I do not think there is disagreement as to the opportunity that this presents, and we think Tim has done a fantastic job in identifying this variation that could be eliminated. We would say probably two or three things. First, please do not underestimate the time and investment that it will take to realise that, but, secondly, let us put it in context. The Lord Carter report has identified up to £5 billion-worth of savings by 2019-20, but, as we all know, the NHS needs to make £22 billion-worth of savings. What we are saying is that Tim has identified some really good stuff, and in the Carter report it talks about £362 million of savings on obstetrics and gynaecology, £286 million on non-trauma orthopaedics, et cetera, so, in a sense, we have already banked that and made the assumption we are going to realise it, but it only gets us a quarter of the way there for the overall level of savings that is required.

Q104 Mr Bradshaw: Does Professor Briggs agree with that?

Professor Briggs: Yes. We can make a significant contribution to improving the clinical outcomes, which will make a significant contribution to Patrick Carter's savings, but there is a £22 billion savings package that has to be identified and, from the clinical picture, we are trying to do as much as we can within that.

Q105 Mr Bradshaw: You have already contradicted the evidence that we had the other week from people who said there was basically nothing you could do about these variations, but they also said that they did not have any idea why they existed in the first place. What is your view as to the reasons? Are they geographical or are they poor management? What are the reasons behind them?

Professor Briggs: It is multifactorial. It is partly where you have trained. If you go back to before 2010, there was an 18-week target, which was the driver, and there was not the focus on quality. It is now that we have the financial deficit, but, with an ageing population and having to do more, we have to make sure that we get best value because there is no doubt that quality does represent best value. If you have a hip replacement that costs £5,500 and it lasts 15 years, which is what it should do with a 90% outcome, it works out at £7.50 per week, which is really good value. If you have a hip replacement that lasts two years, that is very poor value. There is now a real focus among the clinical community about not only managing the resource but how we are going to maintain best value and best quality within the financial envelope.

Q106 Mr Bradshaw: You seem to be suggesting that this is about individual management of individual hospitals and ensuring that best practice is shared, but if there are not enough good managers to go round—

Professor Briggs: I do not think it is down to the management; it is down to clinicians. Clinicians have to drive this, working shoulder to shoulder with managers. Around the country, there is variation in good practice and outcomes, but there is also variation in relationships between the clinical and the non-clinical staff. If we are going to make sure we provide a comprehensive high-quality service, managers and clinicians have to work together shoulder to shoulder. I think it is both.

Chris Hopson: We need to be careful not to mix up two different levels. One level is about the detailed clinical practice as to how you do an orthopaedic operation, which Tim is talking about. There is also a very different issue about the level of the whole trust. Let me make a comparison between the hospital I visited yesterday and your local hospital. Your local hospital, the Royal Devon and Exeter, effectively has a single site: it has all of the key services on one site. I visited Southport and Ormskirk Hospital yesterday, where effectively they have their sites split across two, and, in their words, the configuration of services across the two is about the worst you could have. In Ormskirk, you have maternity and paediatric A&E, and then in Southport you have A&E itself. To be frank, trying to compare efficiency and productivity between Southport and Ormskirk on the one hand, which has quite an old site that needs investment, and effectively they are trying to run separate sites, and the Royal Devon and Exeter is like comparing apples and pears.

Equally, it would be completely wrong to try to compare it with United Lincolnshire Hospitals that I visited six months ago, where you have three DGHs, each an hour's drive apart, all trying to provide full services where they are struggling to get the workforce to staff all those three sites and have to pay agency and locums to get the three sites filled.

The answer to your question about why there is variation is that there is a complex mix of factors. I have talked to you about service configuration and age of building. I could very

easily throw in case mix and complexity. It is very clear to us that if you go to Wye Valley in Herefordshire, which I visited about a year ago, there is simply not enough volume of casework to put through that particular hospital to make it work under the tariff. Because it is a classic small DGH, it has very high levels of A&E and relatively low levels of elective, so it gets penalised under the famed marginal rate. Even if you had Sir Robert Naylor running Wye Valley, you would find it very difficult to make it profitable.

All I am saying is that we find this debate around variation somewhat simplistic on occasions, none of which is to say that leadership and management is not an issue in any system of 240 hospitals, or provider institutions; you will get a distribution curve. However, the idea that somehow these factors are not a big and important part in this and that we are somehow comparing absolutely similar apples is not the case.

Julie Wood: We have focused so far on variation within hospitals. If we think across the wider system, commissioners, in order to play their part in finding and realising the £22 billion, have to look at variation across the whole system. The Atlas of Variation highlights, looking at each CCG, where you have that variation and starts the conversation that you then need to have. Clinically, Tim is absolutely right to ask why this is so. Is it to do with our geography? Is it to do with where you have trained? What is it that is causing this difference, and, if it is not warranted and justified, what can we feasibly do about it so that we can drive out the unwarranted variation and get the right thing happening? That may mean making some difficult commissioning decisions about what you do and do not do, and we need to support commissioners in doing that, but also by working with their providers to say, “This is how we are going to make the very best use of the public pound that we have in this patch, given what we have to deal with.”

If you think of something like diabetes, we know the evidence is there that we need to look at the nine key care processes for diabetes, whether they are being managed optimally and the impact that will have on what then happens to the diabetic in terms of looking after their long-term condition. We know that the rate of complications gets higher and that will mean people going into hospital for things that they perhaps otherwise would not need to. We have to look at all these things and make sure that we are working optimally. That is where the greater collaboration between commissioners and providers around a local footprint should be useful, but also using tools that are evidence-based, such as the Atlas of Variation, Right Care, the work Tim has talked about and the Commissioning for Value packs, which begin to say, “It seems you are doing well here, but there are some areas here we think you need to spend some time thinking about why that might be and what you can do about it.”

Q107 Chair: Last week, we heard in our public health inquiry from directors of public health, who commented on the difference between their experience of commissioning within the NHS and the liberation they felt when they moved into local authorities, because they felt they had more power over what was delivered and they could deliver better value for money and what people wanted. How much do you feel a similar kind of process needs to happen to give commissioners more say and power over what they commission?

Julie Wood: We absolutely need to have that. They need to have the tools to use. We need to work very closely with public health on what we talked about last time as to the joint

strategic needs assessment, that that points out where our needs are across our population, but then what we can do about that and how we can change the age difference between when someone dies in one part of the patch compared with another. Also, CCGs need to have the tools to commission differently and effectively. Again, that is where we need the Five Year Forward View to help them do that.

Q108 Dr Whitford: Professor Briggs, I was involved in developing the clinical standards for Scotland on breast cancer, so it was very much the same thing, but that was back in 2000. We felt that the key thing was having measurable and comparable standards that, if you like, the profession accepted—the things we know change the outcome. Then, if you get a bad report, you cannot ignore it. You talked about visiting lots of surgeons, but do you have the ability for them to visit each other and share? In our physical visit, it was never one great and good person who judged everyone else. It was different teams. Now, once a year, all of our data are put up—all the dirty washing—and we sit and talk and share answers.

Professor Briggs: That is absolutely right. If you go around and take the whole of the country, including Scotland and Wales, there are pockets of good practice going on that just have not broken out into the wider world, and some of the good practice I saw was in Scotland in terms of length of stay and enhanced recovery—the sort of things that we can learn from. We have already put hospitals in touch with those. The beauty now is that, because the methodology has been accepted by the clinicians within the provider service, we rerun the data, their next lot of data, and we are visiting the top 25%. We are going to visit the bottom 25% to see what has been really good practice and what other people should share from the top 25%, and see why the bottom 25% have not done anything—and some of them have not. We are going to produce, by the end of March/beginning of April, a dashboard for every single trust, which will include their deep infection rate, cost of procurement, loan kit costs and readmission rates. It will be out there.

I want trusts to be able to see what other providers are doing, and eventually I would like it to be available for the public to see so that that will drive the agenda. Why is hospital X paying a certain amount for an implant, but hospital Y is paying twice as much for that same implant? Why is their infection rate three times what another hospital's is? That will drive the agenda. We have just sent out a questionnaire to all providers asking about it. We have some pretty good evidence that has come back on what trusts have done, with the £200,000 cost of the initial pilot—and we have only had 50% of trusts respond yet—and we have probably made £30 million of savings; by the time it all comes back, it will be about £60 million. We know that people are engaged. They want the data and we know they are beginning to act on the data. With a dashboard, that will drive the agenda. In regard to places that have exemplar practice, we will tell hospitals that cannot quite demonstrate that where to go to get that knowledge.

Q109 Dr Whitford: Is there a way of getting the top 25% and the bottom 25% physically in contact with each other, rather than through yourself, so then perhaps people might accept the things more with the focus on clinical and clinical standards rather than the buying? In Scotland, we have central procurement—largely, anyway—which is what, I know, Carter discussed. Sometimes it is easier; as you say yourself, preventing disaster is what the patient

and his or her family are concerned about, and it saves money anyway. The other things are coming in behind.

Professor Briggs: We have already done that. We have suggested that some hospitals speak to hospitals in Scotland—for example, with Fife, about enhanced recovery. We are suggesting some other hospitals that they look at: one is the healthcare economy in Leicester, because in Leicester they had orthopaedics on three sites and they have now put it on one site, the general site—33 consultants with seven ring-fenced operating theatres.

Q110 Dr Whitford: Have you developed clinical standards for the common orthopaedic conditions—you mentioned infection rates—as in what results people should expect? For breast cancers, it might be use of certain drugs, what kind of operations and what kind of—

Professor Briggs: That will come out of the dashboard in April in terms of what we expect, and we want an infection rate of less than 0.5%. We want to set a standard that, if you are going to do elective orthopaedics with your joint patient, you have to do it in a ring-fenced bed. If you do not do it in a ring-fenced bed, your infection rate is significantly higher, and we cannot afford that any more. We have to make sure that those standards are robust, fair and acted upon. If people do not want to adhere to something like ring-fenced beds, then do not do joint replacement. So, absolutely, that is the plan.

Q111 Emma Reynolds: I want to go back to the bigger financial question as to whether the comprehensive spending review effectively will meet the needs or not. Julie Wood, you touched earlier on the discrepancy between the amount of money going into sustainability and transformation. If we are really to transform the services, it seems to me that the very little that is left over for transformation is not going to make that happen. What are the prospects—it would be interesting to hear from the three of you—that the CSR will effectively meet the financial needs going forward?

Julie Wood: I would add that the requests going into the spending review for the £8 billion were predicated on a few things, which was about no further cuts to social care and no cuts to public health. We have seen further cuts to social care, we have seen further cuts to public health, and more is to come. The £8 billion is, if you like, an underestimate of what the system needs and that assumes we meet the £22 billion efficiency saving. There is a real risk that, even with that front-loading and with the funding, that we will not get there for the reasons that we have talked about. That risk becomes higher because of the difficulty that we have in using so much of the sustainability and transformation fund on the sustainability piece, and pulling both off at the same time is a big ask.

Chris Hopson: You can judge the spending review through two different lenses. If you judge it through the lens of a Government that we elect, its responsibility is to decide what the overall level of public expenditure should be and how it should be divided between public services. It is very clearly publicly committed to a period of austerity. If you view it through that lens and the expectations, I think the view inside the service is that it was about as good as we could have expected. If you go down the famous spending review book and look at all the other Departments, there are lots of minuses, and the Department of Health is one of the only few pluses. However, having said that, if you look at it through the lens of historical NHS funding—again, Anita, John and Nigel will have given

you the figures—effectively, we are now in a 10-year period that is the longest and deepest financial squeeze in NHS history.

As I have already said, costs and demand tend to go up between 3.5% and 4%, and we are only talking about a 0.9% per year increase. We are deeply concerned that the NHS's take of GDP is going to be slipping back from 7.3% in 2014-15 to 6.6% in 2020-21. Our sense is that, by front-loading, we have given ourselves, broadly, the means of reversing the car out of the ditch. Please do not underestimate the degree of problem and the size of that ditch: a provider-side deficit of the amount we are talking about is unprecedented in NHS history. It is great that we have a plan to reverse the car out of the ditch, and I have said I think it will take us two years to get it absolutely on the straight and narrow. But if you then hit on current plans, in two years, which, to be frank, are the most squeezed years that we have seen for a very long time, our hypothesis would be that, unless you can very quickly change some of the fundamentals—in other words, do some of the very rapid transformation, reconfiguration, front-load the savings, all of which seem to us to be incredibly big asks—the car just veers straight back towards the ditch in 2018-19 and 2019-20. The argument would be on the one hand “great”, in terms of the austerity context, but is it sustainable? Our view is that it would be very difficult to see how.

Q112 Emma Reynolds: Professor Briggs, do you agree that it is just a question of driving a car out of a ditch?

Professor Briggs: It is difficult. We have an ageing population who are living longer and will have more needs, but this is an opportunity to make sure that we get best value for the taxpayer and highest quality. Once we have done that, there can be a further discussion. The days of competition have gone. If we are going to survive, it has to be in collaboration, and I want to see much more of that. We have to use the evidence base much more than we have been doing, both in primary and secondary care. There has to be much more collaboration across primary and secondary care. If you look at the provider side, which is where I come from, we have 129,000 beds, I think it is, and we have pushed a lot more work through those, but there is still more we can do. We have to enable our patients to get out of the hospital effectively and efficiently into step-down beds or have some way of doing that, getting them back home. There has to be much more integration between primary and secondary care to do that.

Then, at the front end, we have to try to stop patients turning up to casualty to be admitted to hospital, and there are things we can do to make that happen. An example I would use is Fife in Scotland, again. There, they have an on-call consultant surgeon who is the first person to see an acute abdomen that comes through the door. Their admission rate has gone down by 30%. If you had the appropriate senior colleagues at the front end, you could drive the agenda quite a lot by reducing the input into hospital. Further, when I qualified in 1982, and when I became a consultant in 1992, there was a thing called fundholding. That got clinicians and specialists out into the community to deliver care to try to prevent the crisis happening that causes the patient to come to the front door. I believe that there is a lot more we can do at the front end to provide better care out in the community—what was being said earlier—and we have to speed up what is going out of the back end. At any one time, up to 30% of patients are ready to be discharged. They are

blocking beds, which cost about £1,000 a day. We have to unblock those beds. By doing that, you make the whole system much more productive, more efficient and at the same time reduce variation. You can make big gains.

Q113 Maggie Throup: Can I add on to that? We have been talking about the CSR settlement and how it is front-loaded, and two great ways of making sure it is sustainable long term, even though there are some question marks there. Your role in that, Professor Briggs, is fantastic and it sounds like it should have been done many years ago. The way, Julie, you talk about what the commission is and how we commission it is important. Do you think you have buy-in for what you want to do to make it happen at every level of the NHS?

Professor Briggs: Personally, I think, yes, there has been a very big sea change. In 2010, when we started this project, I was coming from left field, if you like, with an idea, but now it is going mainstream. We have the support of all the major royal colleges, all the special associations and the DH. That is my new role. I am working with a guy called Professor Tim Evans, who is now the national director for clinical productivity, and together we are going to drive this GIRFT methodology in trying to reduce variation and improve the quality on the provider side. If you get the provider side right, that makes things a lot easier for everybody else. If you look at London, for example, it is a £16 billion health economy: £1 billion on primary care, £2 billion on mental health and £13 billion in the provider side. So we are big players in the game. If we get our act together and make ourselves highly efficient in terms of high quality and high efficiency, then we can make a big contribution. That is what we are trying to do.

Julie Wood: It is important to get local clinical buy-in. That takes time, but CCGs, as the constituent building block to do that, working with their providers and other clinicians across the piece, are the place to start. We need public buy-in as well to begin to drive out some of this unwarranted variation in what we do but also what we do not do. Then there is an issue about honesty, at the macro level, about how we use the NHS spend in the most efficient and effective way that is possible and what that means in what the NHS can and cannot deliver. So, yes, you have to build it up locally, but you somehow then have to do it at pace because we cannot allow it to go very slowly, for all the reasons that we have talked about. Having access to the right methodologies that you can grab, and not invent or reinvent, and use and then drive that through locally across systems is going to be important. Using NHS England and the support that it can give to help the improvement, looking at it through the improvement lens, and the right care and methodology, with clinical champions and all those sorts of things, is helpful in driving it through, but it will take some time.

Q114 Maggie Throup: Professor Briggs, you mentioned about bed blocking and the cost of that to the NHS. Obviously, we have social care funding restraints as well. What are your thoughts? Can we roll out what we are talking about into that?

Professor Briggs: Yes. Step-down beds are an absolute no-brainer and something we have to do. I was down at the Royal Devon and Exeter yesterday. They have taken Tiverton and they are using that for step-down beds. I was up in Carlisle and Cumbria last week and they have maintained the cottage hospital, when a lot of us have lost that. Let us say you had a step-down facility costing £200 a day and you are stepping down those patients from

a £1,000-a-day bed into a £200-a-day bed; it allows the acute provider to be very much more productive. There is no doubt, and I think Patrick Carter mentioned it in his report, that we are going to have to look seriously again at step-down beds, linking in between primary and secondary care, and then working with those step-down beds on how you get the patient home.

If you take a lady or a gentleman who falls over and fractures their hip, aged 75 plus, if they do not get their operation and get home within 30 days, they never get back to their pre-accident level of functionality. If we want the best effective care, we have to get the patient to the hospital—we have the best practice tariff for fractured neck of femur—get the operation done, rehabilitate them, get them into step-down beds and get them home. Then they will maintain independent living without becoming a burden, potentially, as a bed blocker in a hospital, an acute provider, for some time.

Chris Hopson: As I go round, a lot of our members are very concerned about what is happening to social care, but it is interesting that I see numbers of our members effectively saying, “This is not working and we are therefore going to take responsibility for making it work.” I will give you two examples. I visited Ipswich hospital about a month ago, and they effectively now have a licence to employ social workers. They have had a deal with Suffolk county council, and, effectively, Suffolk county council will now commission them to provide social work. They are very determined to use their employer brand—and we know some of the issues in the social care sector, such as relatively low wages and uncertain work—as a means of employing their own social care workforce that they can then absolutely link into the discharge process so that they know full well they can make that chain work much more effectively.

I visited Oxford about two weeks ago. They have bought 140 beds in the private care sector as a means of moving out 140 people who were medically fit to discharge. The really interesting bit is that, in most of the cases, they have probably only bought between a quarter and a third of the capacity in that private care home, but because those patients are still on the acute hospital trust’s books, they are providing a service to the staff to enable them in that care home to treat and keep people back in the care home. They say that they see, very interestingly, how quickly that capability and capacity rises so that they are not now just looking after those people who are still on the trust’s books more effectively, but looking after all the other patients more effectively. There are people out there who are doing some really innovative and different things.

The point to make, though, is that we are running our system very hot. The guys I saw yesterday in Southport and Ormskirk made the point that they are running at 98% bed capacity, which is a bed capacity that Germany, France, Holland or Spain, if you look at them, would think is mad. They simply would not run their beds at that level of capacity. It means, for example—and Tim is quite right to argue we should have dedicated beds for people who have gone through hip replacements because it dramatically reduces—

Maggie Throup: Who would then be having such a high bed—

Chris Hopson: However, at 98% occupancy, to be frank, the choice is whether you use that orthopaedic bed to have somebody who is stuck on a trolley in A&E or preserve it for

tomorrow's orthopaedic hip replacement. The issue is that, when you are running a system this hot continuously, there are some things that you would hope would be available to you that simply no longer are because you are running it at such a high capacity.

Professor Briggs: Can I come back on that? Chris is right, but there is a real opportunity now, if that is the case, to decide on how we are going to set up our networks, and the hospitals should be working in networks. I go back to the Leicester example: three hospitals all doing elective orthopaedics, all with the similar problem of trauma, so they say, "Let's put all the elective on one site." The result of that has been improved productivity, reduced complications, a fantastic increase in morale and much better teaching of the trainee. It is an absolute no-brainer. So we can do it and, if you do that, your productivity throughput increases. At the moment, £1.2 billion goes, or certainly in 2013-14 went, to AQP. If we are going to survive in the NHS, we are going to have to compete for that work and bring it back if we can. By doing that, by setting up our networks and setting our stall out in the correct manner, we can compete for it. We have to do that in order to survive.

Q115 Helen Whately: There is agreement, I think, that acute hospitals have many patients in them who could be elsewhere and high levels of delayed transfers of care. Chris, you talked about needing to make it "less hot" and lower bed occupancy. You have also talked about these effective methods of having step-down beds that the NHS can discharge to. Is it your view that this should be happening across the country at the moment?

Chris Hopson: Yes, but it is complex, in our wonderfully fragmented delivery system, where you have primary care, acute provider, community provider, social care commissioned through the council and you then have private care over here. One problem I see as I go round is how many systems are fragmented, and again in Scotland it is slightly different. For step-down beds to happen, it requires local health and social care economies to come together. The observation that I would make is that the places that have been able to make that happen are the places that seem to be making the most rapid progress.

Part of the problem, if I am honest, is that all the incentives in our system—the way the money flows, performance is measured, the leadership model and the culture—are basically impelling our individual provider chief executives currently to do the best for their institution, make sure they get a fantastic CQC rating, that they are in balance and that they meet all their performance targets. Quite often, our members tell us that, if they want to make the whole system work, they have, effectively, to throw a lot of that out of the window and come together to create a set of incentives that make people work together more effectively. So, yes, it should be happening, but please, again, do not underestimate the difficulty of what is required to bring this fragmented delivery system together into a single coherent integrated whole.

Q116 Helen Whately: The examples you mentioned sounded like they were very NHS-driven and, I think in the main, NHS-funded. Essentially, that is the NHS taking on the role of delivering the next level of care, and potentially even letting local authorities off the hook of having responsibility for social care for people once they leave hospital.

Chris Hopson: The answer that the Ipswich hospital chief executive would give is, “I am unable to do what I need to do in this hospital unless I step up and take a degree of accountability and responsibility for making this happen. I will do all that I can to make sure that Suffolk county council plays its part. I do not want to point fingers here, but if they are unable to do what we need them to do, I then face the choice of stepping up to that plate or letting this current situation carry on.” You all know what the figures on social care are; you look at how rapidly those delayed transfers of care are rising. That is the genuine dilemma that most of our acute hospital members in particular face. Take responsibility to make this happen or end up with something that effectively clogs up the back door, which completely ruins the ability to get the flow right and effectively means that A&E has a whole bunch of people waiting on trolleys.

Q117 Helen Whately: If they do not act, they are stuck with a large number of patients in acute beds who need not be, and so the flow—

Chris Hopson: Exactly. Tim is absolutely right. I am struck by the answer to one question I always ask an acute hospital chief executive, which is what percentage of people they have in beds medically fit to discharge. I have never heard anybody say a figure lower than 30%. So it is at least 30%.

Q118 Helen Whately: Julie, do you want to come in?

Julie Wood: We have to get back to a much greater sense of place as opposed to institution and organisation. Tim’s example with Leicester is great but they are all part of the same trust, so it is a bit more difficult at the moment, or has been, where some of the answers are about collaborating across different organisations and trust footprints. We are absolutely seeing this moving towards much greater collaboration around a place so that you get the leaders of all the different aspects of that place, clinical commissioning groups, trusts—foundation or otherwise—local government and the voluntary sector beginning to work through how they do this. If we have a situation where our gap is such that we are going to need to shift funding in one direction or another to enable the whole system to work more effectively, that has to be what we need to do. To pull that off, it requires different sets of behaviours locally and then alignment of systems and processes regionally and nationally.

Q119 Helen Whately: What is the role of the CCG in that process?

Julie Wood: The CCG has a clear role, as the commissioner of place, as does the local authority, working with providers round the table to find the solutions and find how we need to invest money, move money around, to begin to put the services where they need to be to liberate the transformation that we talked about earlier. That is critically important, but it needs different bits of leadership working together so that an acute trust chief executive is not just thinking about their institution—they are thinking about what they need to do to help the place deliver what it needs to deliver. The CCG is doing its bit, which may be investing differently, investing in primary care, community services or the voluntary sector, wherever it is. It is about all those different players playing their collective and individual part to deliver that.

Q120 Helen Whately: If the CCGs are playing a key role in bringing different groups together, do CCGs have the scale, the capabilities and resources within them and the leverage to play that key role?

Julie Wood: This is not everybody doing it individually, so not doing it 209 times. This is doing what you need to do locally, once. Some of the discussions about how you activate local communities and patients you need to do very locally, but this is CCGs working collaboratively with their colleagues across a place, where you may have two or three CCGs working with an acute trust. If you take Leicestershire as an example, you have one acute trust but you have three CCGs working collaboratively across that acute trust footprint to deliver what needs to happen for the population of Leicestershire, if you like. Then if you take that up another level, in terms of the footprint for the sustainability and transformation plan, making sure that it is working not just across Leicestershire but the other parts of that footprint, it is not just doing it in one place; it is mini footprints, working as a whole.

Q121 Helen Whately: I am trying to unpick a bit of that. I hear of the CCGs collaborating and working together. Given how critical I think they would be in this, do they need different resources, capacity and leverage? Do they have what they need?

Julie Wood: They certainly need to be supported to take the right decisions for their population at the right level, so we have coming the CCG improvement and assessment framework, which is going to provide a focus on how far the CCG is able to deliver its sustainability and transformation plan. That may come up with some support needs that the CCG will need to be given to help it to do the job it needs to, but it is not just about the CCG. It is about all the different players in that place playing their role. This is not about the commissioner with nobody else doing anything. It is about the players, the leaders, of those systems all coming together to say, “Our job, our bit to do, is this,” but the CCG is saying, “Ours is to invest in primary care, invest out of hospital and free up resource so that we can invest it in the right place for the population.”

Chair: We have a lot of questions to get through, so can you keep the answers very quick?

Chris Hopson: Our members would have a hypothesis that we think it is difficult for CCGs to do their job with quite so many of them. For example, certainly our members in London say they cannot see the logic of 32 CCGs, one per London borough. CCGs have a vital role to play, but they will be able to play it better and more effectively if there are fewer of them.

Q122 Dr Whitford: Just listening to the panel, and because the system is so different in Scotland, it seems that part of the problem is the fragmentation and all these negative feedback loops. Is this not an argument for going back to health boards that are geographic, that have a responsibility for all their citizens, right across? We got rid of trusts, primary and secondary has been broken down, and now we are trying to do the health and social care integration. Would it not be better to go back to geographical responsibility?

Chris Hopson: Our members would have a lot of sympathy with your argument, but they would go a very long way to avoid another structural reorganisation. The last two or three times that has happened it has just created complete chaos and prevented us from focusing on what we really need to do—the core task of delivering effective services for the right money. There may be some sympathy, but not another reorganisation, please.

Chair: We are about to have some chaos ourselves here in Parliament because we all have to go and vote, I am afraid, so we will be back shortly, and I will bring you in then Julia, if that is all right. Thank you.

Sitting suspended for Divisions in the House.

On resuming—

Chair: We will make a start. I know some members of the Committee are speaking in this afternoon's debate so will not be coming back. I apologise that that was a longer break than normal because there were two Divisions. We are going to move on, if that is all right, Julia, to the next section because we have another panel to hear as well.

Q123 Dr Whitford: We have touched on some of the structural things that make it hard to do what all three of you agree. It is really about where the tariff sits in that, and obviously the tariff was designed to meet “not enough is being done to meet waiting lists”, whereas now our problem is something different. What are the issues around the tariff that are going to make it harder to achieve this kind of transformation and efficiency? Starting with you, Chris, what needs to change?

Chris Hopson: We all recognise that to truly integrate health and social care, coming together and overcoming these artificial divides, the tariff is one way in which we can do that. It is very difficult to do it under a PBR tariff that effectively rewards hospitals for the amount of activity they have going through. I read with interest the session that you held last week. My observation is that there are two points that did not get mentioned at all. Our members would say they absolutely buy the argument to move towards capitated budgets, but there are two things. First, everybody thinks that changing the tariff and the payment mechanism has a greater impact than in reality it does, and all the international experience suggests that it is not the magic silver bullet that enables you for example, to move towards integrated care. The second thing our members would say is, “Please do not forget this is the engine oil in the engine,” and there is a slight sense of, “You mess with it at your peril.” A good way to completely seize up the NHS would be to rush into very rapid tariff reform and change all the methods.

Q124 Dr Whitford: How would you change it for the better?

Chris Hopson: I have to say that what the Government, NHS England and NHS Improvement are doing at the moment seems to us to be a very good idea, which effectively is saying, if you are a Salford, a Northumbria or a Yeovil and you are well advanced in your plans for integrating your health and social care economy, please feel free to disapply the way the current tariff works and invent a new way of doing it, and we

are very happy to endorse and approve disapplication of the tariff and for you to move towards new capitated budgets. I sit on the new care models board that oversees the new models care programme, and that is exactly what the vanguards are being encouraged to do. I would make the observation that that is very different from suddenly saying we are going to change the way the whole tariff applies right the way across the system, where I think you risk throwing the system into confusion. For me, it would be: allow those people who are clearly a long way ahead in moving towards these integrated systems to try new ways of doing this.

Q125 Dr Whitford: You mean, basically, a gradual move back towards the geographical and capitation system.

Chris Hopson: Yes.

Q126 Dr Whitford: I understand you throwing your hands up in horror at the idea of a big bang, but, basically, it needs to go back to a more joined-up, co-operative rather than competitive system.

Chris Hopson: Absolutely. As I said, my argument earlier is that that is just one of a whole number of different elements that we would want to see changed. We would want the CQC inspection regime to look at place rather than individual institutions. We would want to look at performance management based around performance of the whole area as opposed to each individual institution. There are a number of different ways—

Q127 Dr Whitford: It is going back to place—to geography.

Chris Hopson: Yes; effectively, we need to align the system incentives and the system framework to support the move towards integration. One of our chief executives put it absolutely brilliantly the other day. She said we are currently trying to move from this institutional focus to a whole-place, system-based focus, but we seem to be stuck because we are not going fast enough because we cannot get those bits of the framework changed quickly enough. She was saying, “Please speed up, as fast as you possibly can, some of those framework changes like inspection regimes, performance management and payment mechanisms.”

Q128 Dr Whitford: Things are stuck in silos.

Chris Hopson: Yes.

Professor Briggs: The tariff has always rewarded activity rather than quality. That is the big thing we need to change. There have to be real quality metrics at the end of the tariff price, not just measured on activity, because we have lost quality in the mix over a number of years. The best-practice tariffs have tried to do that, such as the fractured-neck-of-femur pathway. There is now a best-practice tariff for hip replacement. I would like to see much more real quality metrics driving tariff and price. Further, some of the complex work is not reflected in the true price of what it costs to do. Take infection of joint replacement. We have to concentrate that complex work in certain centres to do it to get the best value and best outcomes for patients, but if you have a tariff price that does not represent that in any shape or form, then there is a danger that those hospitals that take on that mantle of

work—for example, where I work at the Royal National Orthopaedic Hospital, where we have set up an infection unit and have seen over 2,500 joints, I think, already—can go bust with something like this because of tariff rates. Quality has to be at the heart of it, but on the complex work, we are trying to centralise and we have to make sure that the reflection really is what the work costs so that we can get it done well, because down the track that will work out best value.

Q129 Dr Whitford: Like, basically, the tertiary system, so re-do hips and things like that.

Professor Briggs: Yes.

Q130 Dr Whitford: You are talking about bringing different units together—three hospitals, et cetera. The problem is that there is always a reaction, and, Julie, you kind of referred to that. Do you think we do enough of having a conversation with the public about what 21st century medicine looks like? People do get very attached to a building, even if there is not a lot happening in it any more, because they were born in it or someone works in it. Do you think we do enough in all of this to take the public with us?

Julie Wood: No, I do not think we do. We need to do far more, building on what happens locally right up through to the national system, because we have to change the focus of delivery away from institutions into more community-based care, working with the voluntary sector, the community sector, all sorts of different providers, very much focusing on quality and outcomes, absolutely, but it may not be in big hi-tech buildings always. If that is what you need, great, but you will not have that everywhere. So, yes, we need to do far more than we are currently doing. The other thing I would say in terms of tariff, just to add to what Chris and Tim have said, is that we need to make sure that, whatever currency we use, it incentivises the right behaviours. If we go through to place, as we have talked about and want to see, we need to make sure that the place that care is delivered is different from how it currently is being delivered, that you can move the money to where you need to. I think that capitated budgets work for some things, things like Year of Care budgets works for other things, particularly long-term conditions, so it is about how we get the right incentives and the right behaviours that mean that the money will go where it needs to, to deliver the outcomes for the patient and not just the activity.

Q131 Dr Whitford: One thing that was referred to—we have a different structure, and, Professor Briggs, you mentioned it—was the cottage hospitals. In my county, they have rebuilt the three cottage hospitals, which already do work as kind of step-up and step-down hospitals. That can help people not to have a sense of things being taken away, if things are maybe going towards them, because a lot of care could be closer to people.

Julie Wood: It is about being clear about what is efficient and effective to be done in that local hospital and what needs to be at a different level.

Q132 Helen Whately: Talking about the importance of looking at place rather than such a focus on institutions and providers, the Carter efficiency opportunities are pretty focused on providers and what can be done within those institutions. There is a large amount of efficiencies that need to be achieved beyond Carter. Should the focus for those additional efficiencies be much more at a place level, at a system level, versus continually looking at a

provider level? Should the system be saying what we can achieve across a geography rather than providers for those, and what opportunity would there be if we did it that way?

Julie Wood: It is not “either or”; it is “both and”. So where it is driving the efficiencies, as Tim would say about what happens in a hospital, you need that to happen, but you need the support of clinicians in primary care as well, and then that needs to be reinforced through the commissioning process such that, if it does not happen, then commissioners can use their levers to make it happen. It is not “either or”; it is “both”.

Q133 Helen Whately: You are implying from that, beyond the £5 billion savings identified, that you think most of them would still be in providers but it is a system where it is—

Julie Wood: There will be things in providers but there will be things in commissioners. If you think about medicines, for example, we spend an awful lot on medicines. We know a lot of that is initiated in secondary care but impacts on primary care and primary care spend. What can we do to optimise spend on medicines that may not be happening in hospitals, so it is looking outside the institutions as well as across settings? We have to do it all.

Chris Hopson: The way you asked the question is very interesting, which effectively is that we have this £22 billion task we are going to have to complete. At this stage of the last Parliament, there was the Nicholson challenge in place that set out quality, innovation, productivity and performance. It was clear what was needed. Our members knew what was required of them. There was a sense of exactly where the money was going to come from and they felt a sense of ownership from it. My argument—and perhaps this is something you might wish to explore when you see our colleagues in the statutory sector from the Department and the arm’s length bodies—is that there is a sense from our members that we do not yet have that kind of clarity. Yes, Tim and Lord Carter have set out where £5 billion of the £22 billion is coming from, but there is a nervousness among our members that that is only £5 billion of the £22 billion, so where exactly is the rest coming from?

I would make the observation that these things work best as a combination of top down and bottom up. There is some work that has been done inside the Department to get a sense of where that money might come from, but in the end it is our members and Julie’s members who have to realise it. At the moment, there is insufficient clarity about how the rest of that money is going to be made up, and I would suggest that you can help us by getting some clarity on exactly where the rest is, because, if it does not come, effectively all that happens is that it just reverts back to our members who get given a tariff efficiency factor, as they did in the last Parliament, that is simply undeliverable. If we cannot fill that gap, we have a problem.

Q134 Dr Whitford: It has been noted that in fact we have had improving survivals for hospital admission year on year, and of course we have had a lot of discussion around the seven-day service and what is meant. Is it purely about making the emergency side more robust? But there is also talk about having routine work happening seven days. Do you think that that is where the bit of money should be focused when we have so little? Is that going to buy us a big step forward in improved survival?

Chris Hopson: Our argument would be the argument we made in our supplementary evidence, which is what we are nervous about, that we see a central Government and arm's length body machine that is throwing out a number of different extra new priorities, be they cancer task forces, maternity task forces, mental health task forces, IT investment, seven-day services, transformation—a whole bunch of different things. If I am honest, we see the £8.4 billion real-terms extra increase being spent several times over in a rather confusing way. Again, if I may be so bold, it would be helpful if this Committee was able to clarify with the Government and the arm's length bodies exactly where that extra money is going to be spent, on what, with a clear profile across the rest of the spending review period.

Our members have indicated very clearly what their view on the extra cost of seven-day services would be, which is somewhere between 1.5% and 2% extra. We cannot see at the moment, in that kind of list of lots of extra priorities, where that money is going to come from. So, again, we welcome the fact that extra money is on the way but we need pinpoint clarity on which priorities are going to be delivered when and, therefore, how much money is coming to the front line to deliver those priorities. At the moment, it is pretty unclear and woolly.

Q135 Dr Whitford: Professor Briggs, you are literally at the sharp end. Having been a receiving surgeon for 20 years, I see that in Scotland, over a long period of time, we have evolved things like diagnostics, getting access to the scans in the middle of the night or on a Sunday. That has been a very evolutionary thing over the last 10 to 15 years. Would you target it or do you think that you need to have everything running seven days a week?

Professor Briggs: Chris made some very valid points there. You have to define what you mean by a seven-day service first, whether it is Bruce Keogh's definition of a seven-day service as an acute, emergency service, which is really running at the moment. If you want an elective service across all the specialties over the weekend, there are significant costs in that in terms of OTs, physios, phlebotomy, radiology, the whole thing that keeps the hospitals running in terms of activity and ability to deliver that. Again, you have to make sure the costing is there and the money is there to do that. We only have so much money in the pot. We have to use it as effectively as we can.

Q136 Dr Whitford: This proposal was not particularly in there when the £8 billion was asked for. This has been added in. I do not think, certainly, most people would object to making the emergency side stronger. That is something that has to be done, but we do seem to go backwards and forwards as to whether we mean emergency and whether we mean routine.

Professor Briggs: Yes. We have to clarify exactly what we mean by the service.

Q137 Dr Whitford: If it was purely making the emergency service robust, then you would see that, I assume, as money well spent.

Professor Briggs: I think already with the general surgical clinical lead, who is now leading on acute emergency surgery, we are seeing variation in that, and we can do things to really change it. We can have a big impact on the emergency side of general surgery,

and, hopefully, we will be able to do that with medicine when medicine comes on line too. If you are going down the truly elective care service route, that is going to require an investment. You only have £8 billion, so the question is: how much of that £8 billion and, therefore, what are you going to lose on the other side?

Chris Hopson: There is a patient safety argument but there is also an elective flow argument here, is there not? When I talk to our members, I am very struck by one way in which they can eliminate long elective waiting lists, which is effectively to do weekend working, and certainly there is very clear evidence that the sooner you can minimise length of stay and enable rapid discharge, rather than having to wait for a senior decision maker to turn up on a Monday for people you have admitted on a Saturday and Sunday, it improves flow through the hospital. If we are going to continue to run our hospitals at 95%, 96%, 97% and 98%, you can absolutely see the argument as to why, for patient flow reasons, you would want to invest in a true seven-day service so that you could process patients more quickly and ensure that you are not waiting for diagnostic tests or senior clinical decision making until Monday.

Q138 Dr Whitford: But that also depends on what you mean. Having senior cover that makes a decision to let someone go home on a Saturday is quite different from bringing more people in on a Saturday and more people in on a Sunday. That would be a 40% increase in elective work.

Chris Hopson: That is why Tim is absolutely right, but one thing that is rather dogging this debate is our inability to define with precision exactly what it is that we mean.

Q139 Dr Whitford: Julie, do you want to come in?

Julie Wood: I would agree. We need to define what we mean and the implications of delivering it in terms of the resource and the manpower. We need to make sure we have the right manpower in the right place to do whatever it is we are defining it as, and that includes primary care as well.

Q140 Dr Whitford: Coming back to and focusing on making it safe, Professor Briggs, what would be your one strategy around the weekend? To me, having been a clinician, I would have guessed diagnostics might be a big part, but what would you say?

Professor Briggs: I think diagnostics, but also senior staff in at weekends.

Q141 Dr Whitford: Doing ward rounds?

Professor Briggs: Absolutely. That has to happen. We have to get our patients, as I said, into hospital—those who need to be there—and then out as soon as we can. That is going to require senior medical input, both surgical and medical, over weekends. The clinicians are ready to stand up to the plate for that, and talking to the colleges and associations, people understand that. That is one of the biggest wins we could make.

Q142 Dr Whitford: That is a focused solution rather than making everything run seven days and would cost a lot less.

Chris Hopson: Just to take the patient-flow argument, patient flow will not work if, in terms of discharge, you are unable to discharge—if you get people medically fit for discharge but then you cannot get the social care package or the step-down bed. This is Julie's point about it being all very well saying we can get our acute hospitals working seven days a week, but if you cannot get the rest of the service you are just going to end up with a bottleneck in the hospital.

Q143 Helen Whately: Can I bring us to mental health? Recently, we have had the publication of the mental health taskforce. Could you, please, give your perspective on the spending review for mental health and how it relates to the mental health taskforce and your optimism for the implementation of parity of esteem?

Chris Hopson: We think the mental health taskforce is an important report. We fully endorse the recommendations. However, this is a very good area for us where it is all rather foggy. We seem to have had sums of money that have been announced at least, in our view, three or four times and it is not absolutely clear how much extra money is going to be devoted. Is it on top of the £8 billion or the £10 billion, or is it coming out of the CCG allocations? The other thing we would say is that, while we very strongly support the recommendations, we have a pretty well-formed hypothesis that there is nowhere near enough funding to fully deliver all those recommendations.

Again, just as a point of policy making, we would argue strongly that the Department and its arm's length bodies need to have a rigorous process where, before they start announcing recommendations and new policy initiatives, they are properly costed, and we would argue very strongly that our members should have the opportunity to contribute to that costing so that we know that, whenever any new commitment is made, we can afford it. Our nervousness is that, fantastic though all those recommendations are, we simply do not think they are affordable in the current envelope. Again, we need some clarity here about how much each of them will cost, when they are expected to be introduced and where the funding is coming from.

Julie Wood: Our members are fully committed to delivering parity of esteem through funding for mental health services. I would agree with the view about the fog. We need to be clear about what is in CCG allocations and what is already assumed to be in the baselines because that does not help CCGs when they are trying to deliver all of that. Normally, we would not be supportive of ring-fencing particular pots of money, believing very strongly that it is for local commissioners to decide how much resource they need to invest in different services, but I make one exception, and that is in relation to charging and people's mental health where, because of where it is starting from—very much a Cinderella service—we would absolutely support the ring-fencing of that funding such that we can guarantee that it is going to go to and be targeted at the right place to deliver the improved services that are so desperately needed.

There may be different views across the panel. Chris and I may have different views about whether CCGs have delivered their commitment in terms of mental health funding, so I am going to get in first this time, Chris, in that the figures we have seen from NHS England, which has pulled together all the spending plans from CCGs, suggest that by far the vast majority of CCGs have increased their investment in mental health by at least the

level of growth that they have received. That is in 2015-16. Clearly, they are in the middle of negotiating 2016-17, and some have gone beyond that. We have examples of where that has happened. If you think about moving forward into 2016-17, because of this fog, it is difficult for CCGs to be able to demonstrate again that they are putting in place the increase in funding that is equivalent at least to their share of growth because growth is being counted at least three times. There are a lot of things that are already pre-committed. A CCG with average growth of 3.4% may find that it has not got as free growth to invest in mental health services or other ways because it is pre-committed to things like GP IT and doing things in terms of tariff, and actually its level of growth is closer to zero. It is going to be hard, but, in 2015-16, by far the vast majority of CCGs have increased their spending on mental health to help deliver parity of esteem.

Chris Hopson: The fact that we are having an argument about it, and that our members feel strongly they have not seen that increase, suggests that there is an issue to be resolved about how we are measuring and making this transparent. NHS England has said that, but none of us on our side has seen the workings. Our members are saying to us that there are some very interesting calculations going on, such as—again, you might argue about whether this is legitimate or not—increased prescribing of antipsychotic drugs being counted as part of an increased commitment to mental health funding, whereas our guys would say that volumes are going absolutely through the roof and we would therefore expect to see our contracts rise in an appropriate way to reflect that increased demand. There is a bit of a sense that CCGs are using some slightly weird and wonderful calculation methodology to prove they have delivered this increase, when our members are saying it is not coming to the front line where it really is needed.

Helen Whately: I know you want to respond on that, Julie, but before you do—

Dr Whitford: Professor Briggs sits back.

Professor Briggs: I am piggy in the middle.

Q144 Helen Whately: Chris, looking forwards, what would give you more confidence that the amount of money that is being given to mental health, the increase—and I know there may be some uncertainty about what that increase is, but whatever it is—will reach the front line?

Chris Hopson: There are three things. The first would be absolute clarity on how much extra money is going to be given to mental health to deliver priorities; secondly, a very clear instruction to CCGs, which again I think I know Julie might not like, about how much extra will be spent; thirdly, a completely transparent methodology so that we can see if, in the case of each individual CCG, that commitment has truly been met and where that extra money has been spent. Then our members can look at that detailed information and say, yes, they genuinely believe that that commitment has been met. Please let us not end on a provider-versus-CCG note. We have driven Tim out of the room now.

Julie Wood: Seeing the money go to the front line is not always about seeing the money go to provider trusts. This is about new models, not more of the same—so, community-based services, commissioning from community services, voluntary sector,

independent sector, where it is needed, and new partnerships with all providers. In 2014-15, £1.9 billion was spent on mental health outside mental health trusts, so it is not about “more of the same”.

Chris Hopson: I recognise that.

Q145 Chair: What do you think about FOIs used as a way of seeing whether the money has gone to mental health? Do you see, Julie, that there will be better transparent accounting, because wherever it is being commissioned from, including the voluntary sector, the public need to see it there transparently without having to put in FOIs?

Julie Wood: It is on NHS England’s website now. NHS England has published the financial plans of all CCGs, so you can look across at where all that investment has gone—trusts, community services and primary care, and I am not sure about medicines. You can certainly track it and it is on NHS England’s website now, so it does not require separate FOI requests.

Chair: Thank you very much and for bearing with us during the interruptions. Thank you.

Examination of Witnesses

Witnesses: **Michael Brodie**, Finance and Commercial Director, Public Health England, **Professor Ian R Cumming OBE**, Chief Executive, Health Education England, and **Christina McAnea**, Head of Health, UNISON, gave evidence.

Chair: Good afternoon. I am very sorry to have kept you waiting longer than everyone expected, and thank you for coming to this session examining the implications of the CSR. For those following from outside, could you introduce yourselves, perhaps starting with Ian Cumming?

Professor Cumming: Thank you. I am Ian Cumming, chief executive of Health Education England. We are the body responsible for educating, training and developing the future workforce in England for the NHS and other health carers.

Michael Brodie: Good afternoon and thank you for inviting us today. My name is Michael Brodie, and I am finance and commercial director for Public Health England.

Christina McAnea: I am Christina McAnea. I am head of health for the trade union UNISON, which is the largest health union in the UK.

Q146 Mr Bradshaw: Christina, you described in your evidence the Government’s CSR settlement for the NHS as relatively meagre. Is that not a bit grudging, given, as we heard in the earlier session, that it is one of the few areas of government not to suffer cuts and, compared with local government, where you also have a lot of members, it has been left relatively unscathed?

Christina McAnea: That is not how we would describe it. Our take on it is that it is seen in some quarters as a generous settlement because it has not been as drastic a cut as in

some other parts of the public sector, but it is still a cut, none the less, in that it is not keeping pace with either inflation within the NHS or increased demand on the NHS. I know that you have had previous sessions on this where people have given you all the statistics, but statistically, or traditionally, the NHS had between 4% and 5% per year to meet those expectations and the current settlement does not go anywhere near that. Between 2010 up to 2020, there will be an accumulation of a settlement that is less than is needed to keep pace with inflation and meet the demand. We do think it is meagre. It is having a massive impact on the lives of our members who are providing those services and we get that fed back to us all the time.

Q147 Mr Bradshaw: Can you say a little bit more about the impact?

Christina McAnea: The impact is on things like not only their pay and conditions—particularly, pay has a massive impact—but if pay had kept pace with inflation, either CPI or RPI, the staff in the NHS would be earning a lot more than they are currently earning from 2010 up to now. Between 2010 till now, if I use a nurse as an example, if it had kept pace with RPI, a nurse would be earning £4,700 more today than they currently earn, and that is with the 1% pay freeze for the next four years. The reduction in relative worth of their pay can only get worse.

Q148 Mr Bradshaw: Is there not an argument that public sector workers and health workers, in particular, did fairly well under the Labour Government years and they also have good pensions, and that some sort of readjustment was justified given the fiscal situation the Government found themselves in after the global financial crash?

Christina McAnea: You have to go beyond even the Labour Government then, because the Labour Government were investing in public services because they had been so severely run down through the previous Administration. That is certainly my union's perception of that, and, indeed, we would say there is evidence to support it. What the Labour Government did, I think, was invest in public services, and that meant bringing up the pay of groups like teachers and nurses, who had fallen quite significantly behind other groups—if you like, other comparable groups. There is not a strict comparison because most teachers, nurses and a lot of people who work in the public sector do jobs that are provided predominantly in the public sector, but if you compare them with what is happening to other graduate professions, they have fallen quite significantly behind. Since 2010, there has been much more stagnation. We would say that we still have good public sector pensions in this country and that was always the kind of quid pro quo for taking a job in the public sector. Nobody expected to get huge bonuses; nobody expected to become very rich if you took a job as a nurse or an occupational therapist; but you would have some security of employment and a decent pension at the end of it. That seems to be being eroded.

Q149 Mr Bradshaw: Is the situation you described having an impact on recruitment, retention and morale, and, if so, what?

Christina McAnea: There is an impact on recruitment and retention. The latest staff survey has just come out this week, or last week, and has shown that there are some particular areas where recruitment and retention is a problem. It is not endemic across the

whole of the NHS, but there are certain areas, both geographical areas and certain professional groups, where it is becoming an issue. Certainly, what we get fed back from our members, and again some of this is reflected in the staff survey, is that many of the staff feel they are having to go above and beyond. Something like 90% of them feel they do unpaid overtime. They come into work; they go above and beyond; they do not clock out as soon as their shift has finished. There is a lot of presenteeism—people turning up for work even when they are not feeling particularly well—and again that has come through in the staff survey. We have a nursing sector and healthcare assistant sector seminar in Cardiff next week, and I will be going down to that. When we go down and talk to them, the thing I notice most is that people say it is not as enjoyable to work in the NHS any more. People still love their job and like to work for the NHS, but that element of having time to talk to patients and interact more closely with them has gone from a lot of these jobs because there is such pressure on staffing levels. Particularly if you work in the acute sector and you are perhaps a nurse or a healthcare assistant, there is a lot of pressure on people to be there, do the job and get through the range of tasks that they have to do without having time perhaps to talk to and care for patients in the way they would like to.

Q150 Mr Bradshaw: Looking forward over the CSR period, what do you anticipate happening, both in terms of the service as a whole but also—if you want to answer this as well in your answer specifically—on public health and mental health, which has already been touched on in the earlier session?

Christina McAnea: I am sorry; can you repeat that?

Q151 Mr Bradshaw: What is your anticipation as to whether what the Government have promised in terms of resource will deliver what it is intended to deliver: seven-day service, improvement and so forth?

Christina McAnea: There is a lot of concern about what will happen to pay. We have had the 1% pay freeze announced for the next four years, but, on top of that, that 1% cap is expected to cover the cost of the introduction of the new minimum wage. This year—we have just had it announced this morning—it will be 1% across the board for everyone. That is because at the moment the NHS is higher than the basic; it is £2 an hour higher than the minimum wage. That might be the case the following year, but from 2017 onwards that is not expected to be the case. From 2017 onwards, that 1% that we would consider very meagre will not be able to be distributed in the form of a 1% across the board because, if it is having to cover, in England—this is only for England—the cost of paying the new minimum wage, it cannot be 1% across the board.

There are disparities now existing across the four countries, so we have the Welsh and Scottish Governments committed to the living wage, not the minimum wage, and England and Northern Ireland not committed to that; so we will start to see a difference there. We are under pressure to do things like look at restructuring and reforming the Agenda for Change contract, which I have to say we are happy to look at. Any agreement that is more than 10 years old should be looked at, should be refreshed and you should look to see whether it still meets the legal requirements and is still the right thing to have in the sector. We are happy to have that discussion, but, often, a restructuring or a reorganisation of a

pay structure will cost money, certainly in the short term. It may lead to longer-term savings, but it is very difficult to do these things without cutting if you are going to change them but still give an element of protection. That cannot be done within the 1% pay cap that has been announced.

Q152 Dr Whitford: Could I ask this particularly to Professor Cumming? The £8 billion settlement is predominantly within NHS England, and public health and health education do not fare quite so well. What do you feel is the likely impact of that on health education and training the workforce?

Professor Cumming: From Health Education England's perspective, in what was a generous settlement for the NHS in the context of what other Government Departments had, the settlement that we reached was flat cash. Effectively, that means that for every £100 we receive this year we will receive £100 in 2020, with the exception of £1.2 billion that perhaps I will come back to in a moment. In terms of that flat cash settlement, that means that we have to improve our efficiency by inflation on an annual basis to maintain our purchasing power, to continue to achieve what we are achieving in 2020 compared with now. That leaves us with a substantial sum of money, £3.8 billion, give or take, to invest in the current and future workforce. A decision was made in the spending review that the money that we currently spend on commissioning predominantly undergraduate but some postgraduate programmes from universities would be taken to the Student Loans Company in a different funding route, and the money that we currently spend on bursaries, in particular for nurses and allied health professions, would also transfer to the Student Loans Company from 2017. That accounts for about £1.2 billion. The impact on our budget is that as we cease to have that expenditure, because it is transferred to the Student Loans Company, it will be taken out of us, so in financial terms there will not be an impact on that as a result of the policy decision because we will lose it in accordance with the expenditure moving.

Q153 Dr Whitford: Do you feel you will be able to meet that efficiency and deliver the health education and training, particularly as the Government are talking about 5,000 extra GPs? That is a lot more people to be trained and more nurses to be trained.

Professor Cumming: It is a lot and it will always be a challenge for us to constantly improve our efficiency, but, at the moment, on the levels of commissions that we are making, there will be a net available additional 25,000 to 80,000 members of clinical staff that the NHS could employ by 2020. We are anticipating, as I think the Committee has heard me say before, by 2019, that we will be back into supply and demand with regard to nurses, but we are anticipating over that next four-year period, for example, that there will be a net additional 11,000 doctors who are already in training at the moment. Almost everybody who will be a member of clinical staff available to the NHS by 2020 is already in training, so we can be reasonably sure about these numbers. There are perhaps a few who may enter in 2017 on nursing programmes or AHP programmes that would add to that, but almost everybody who we will use as a clinical member of staff is now in training, so I can give you the actual figures. Assuming that the turnover—the loss of people from our NHS—remains the same, we will have quite significant growth in the workforce available for the NHS to employ.

Q154 Dr Whitford: During that time, you will be starting to train the people who are for 2020 to 2025, so are you confident that you can make these efficiency targets and keep this flow of people into medical and nursing training?

Professor Cumming: If we leave medical—we will come back to it in a moment—all the nursing and allied health profession commissions that will be made by HEE have now been made, because any made in the future will be made on the basis of the Student Loans Company arrangement. The last big numbers of HEE commissions will start in September of this year, 2016; there will be some small numbers starting next March, but, beyond that, it is a transfer to the new system. With regard to doctors, we will continue to provide the training at postgraduate level for doctors and we are not factoring in any reduction in the number of doctors. We might make some changes between specialties, but we are not factoring in any reduction in post-graduate training for doctors.

Q155 Dr Whitford: What do you think the effect will be of the removal of the nursing bursary?

Professor Cumming: If I may, I will answer that in terms of the bursary and the fees because I think you have to consider them together. There are opportunities and disadvantages in both the current system and the new system. The current system is cash constrained. We can only commission the number of places that we can afford in terms of the level of resource that we have, and we know that on an annual basis there are roughly three applicants for every place at nursing school, so there are many more people who want to train as nurses than we are currently able to make available training places for. Clearly, a shift to the new system will result in individuals incurring debt through the student loan system, but if people are willing to incur that debt, then there will definitely be more opportunities. I am talking to universities at the moment that are intending increasing the intake on nursing, physiotherapy and various other programmes, utilising what they expect to see as an increasing number of students coming through and accessing the student loan.

On the bursary component, of course, at the moment there are two parts to it. There is the means-tested component that is dependent on family income, and there is the non-means-tested component that everybody receives. Again, this will transfer to the loans system, where everybody will be able to access more as a right. As to the non-means-tested part of it, if people wish to borrow a greater sum of money to see them through their course, they would be able to do so. There is a greater access to resource but people will have to start repaying this once they hit that £21,000 of income.

Q156 Dr Whitford: What is your estimate of the debt that a nurse is likely to incur in training?

Professor Cumming: It depends on how much of the bursary component they draw down, but the student loan will be £9,000 times three years—that is, £27,000—and, in theory, you could see a similar amount of money being drawn down through the maintenance grant mechanism.

Q157 Dr Whitford: Do you not think that that will put off some people who do not have financial backing behind them to take this up as a career?

Professor Cumming: We have looked at the impact of the introduction of the previous student loan system and it did not seem to have a huge impact on the number of students applying in those days. That being said, we have to remember that quite a large number of people applying for nursing degrees in particular are mature entrants, and there is certainly some concern about whether people who may have family commitments or who may have mortgage commitments will be less likely to want to take out a student loan than somebody who is 18 coming straight out of school, which is why in our organisation we are looking at alternative routes to degree-level nursing. We are out to consultation at the moment on the nurse associate role, which is an intermediate role that sits between healthcare support worker and degree-level registered nurse, where people could earn and learn at the same time and progress, while delivering care to patients through to the nursing associate level, and progress from the nursing associate level through to the degree-level registered nurse without having to go through the student loan system and the full-time degree system.

Q158 Dr Whitford: That is going back towards the enrolled nurse that we used to have as a stepping stone to eventually getting to a degree.

Professor Cumming: It is a different role. We are out to consultation at the moment, but we are seeking to define what the roles and responsibilities of that individual are. It came out of Lord Willis's report that he did for us, "Shape of Caring", looking at the needs of the nursing profession. He clearly defined a role for us that sits between the degree-level registered nurse and the healthcare support worker that can be used as a progression route. That is something that we are keen to do. We are seeking to have 1,000 people enter training this calendar year and then grow that number over the next few years into that first nursing associate role, and then have a pathway through to degree-level registered nurse.

Q159 Dr Whitford: Can I ask you to come in on that, Christina, because a concern I have is the fact that it is an older age group with other commitments, and this will put people off at exactly the time we want more people in?

Christina McAnea: We are hugely concerned about this. Our strong argument is that we think the Government are rushing this through without enough research to back it up. Ian has already alluded to some of the things about the research that was done when you look at when they moved to a loan system last time and when they increased it. It does not include healthcare students because they were not affected by that last time round. Particularly for the nursing students, the demographics of that group are very different from the demographics—and Ian has already said that—of your normal university intake. The average age is 28; 50% of them have child care or caring responsibilities; they are more likely to come from a poorer background; they are much more likely to be women; they are more likely to be BME students; a significant number will have had a previous degree and then will have to take on this additional debt. Our estimates are that it is about £51,000-worth of debt that people will be coming out with in 2020. If we are assuming a 1% increase over the next four years, pay will be just over £22,000, starting salary, so

most of them will immediately go on to having to repay their student loan, which will mean £900 in their first year. In effect, you are talking about a £900 pay cut for someone who goes through this, takes out the money, the loans, et cetera, and then in their first year they will be paying back £900. We think that is very significant.

I want to comment as well on the figures around the numbers of students who apply and then do not get accepted. Again, there is a lack of information and data here about why and at what stage in the application people are being rejected. If you are a nurse or a healthcare professional student, in most cases you will go through a far more rigorous application and can be rejected for a number of reasons, so the fact that it is not just—

Q160 Dr Whitford: Do we have any evidence on whether it is about not meeting the standards or just numbers?

Christina McAnea: I do not know if Ian has it, but we have been trying to get that information and it has been incredibly difficult to get it other than just picking out bits and pieces from different bits of information. It is not easy to get the hard data, but we know they do go through a much more rigorous process, particularly post-Francis where all institutions are having to assess the suitability of the candidates for these particular training courses.

Q161 Dr Whitford: We do not have the tuition fees in Scotland anyway, but what would be the one ask—I do not know whether it might be for all students or particularly the mature students—from your union such that, if the Government could just change this, it would have a lesser effect?

Christina McAnea: To be honest, you would have to reverse this decision, and I know that is going to be incredibly difficult, or at least you would have to put in some system where you were giving students something to compensate them for the periods during which they are doing clinical placements. That could be a way of overcoming some of that if—we do not want to call it paying them—you actually recognise the fact that they have to put in substantial amounts of time in clinical placements. It means they work shifts and weekends. I have to say that a bit of me feels that, instead of taking away the bursary, you ought to be paying them a salary as a healthcare student. If we could get something in as a recognition of that, it would make a significant difference. When they are doing the placements, it makes it more difficult for them to take part-time work as well to help them supplement their income.

Q162 Chair: Thank you. Before we move on to the next question, Ian, have you seen an impact on the number of F2 doctors who are moving into the next stage of their training? Have you seen a fall-off in the numbers?

Professor Cumming: We have not, as those figures have not closed yet. The applications are still open, so we will not know until that round closes.

Q163 Chair: When will we have that data?

Professor Cumming: We will have an indication towards the end of March in terms of the F2. The F1 round has closed and the analysis has just been done on that, so that is entry

from medical school into F1. The F2 into specialty training is the end of March—the 22nd, from memory.

Q164 Chair: Would it be possible for you to write to the Committee in time for that data to appear in our report?

Professor Cumming: Yes, it would be a pleasure.

Chair: That would be very helpful.

Q165 Dr Davies: Professor Cumming, what are the main features of your workforce strategy for the NHS during the comprehensive spending review period?

Professor Cumming: The clear No. 1 overarching objective that we have had over the last few years is to make sure that we produce the number of nurses that the NHS, but also the social care environment, needs in this country. I will not repeat what I said last time I talked to the Committee, but the expansion in the number of qualified nursing posts of 24,000 is absolutely unprecedented over a two to three-year period. We only train about 20,000 nurses a year, so we are very much playing catch-up in terms of trying to produce the number of nurses to meet this demand. Roughly speaking, at the moment, about 7.5% of all clinical posts across England are vacant, but that hides a number of issues. In parts of London, that figure is 15%, and in parts of the north-west that figure is 3.5%, so it is very variable. Our No. 1 issue has been getting the balance right in terms of overall number but also geographical number. The next area we have been taking forward, and this links back to some earlier questioning from the panel, is making sure that we protect the parity of esteem professions to ensure we have the continuing supply of workforce through into mental health, and that we meet the Government objectives around primary care—Dr Wollaston has already mentioned the 5,000 additional doctors working in general practice—to make sure that we have that workforce coming through. I suppose the final key area of responsibility in terms of the new workforce is focusing on where we need to do things differently, where we need to deliver change. Physicians associates would be a good example of that.

The separate strand of work is around the current workforce. If we are looking at transforming our NHS in accordance with the Five Year Forward View, the future workforce are important, but the future workforce are not going to deliver the Five Year Forward View for us because the Five Year Forward View is now going to happen in the next four years. Therefore, what do we do to transform the current workforce to make sure we deal with their education and training requirements to help people think about the sorts of issues that you heard about in the previous evidence session—best practice in orthopaedics, for example? That is about educating and training the current workforce, not the new.

Q166 Dr Davies: What elements of the strategy that you have are you most concerned about not being able to deliver?

Professor Cumming: The level of expenditure, the flat-cash settlement that we have received, has allowed us in 2016-17 to commission adequate workforce across every

heading to meet this range of 25,000 to 80,000 people that we believe we need for the future, which also picks up the seven-day issue, as we understand it, again going back to the earlier aspects. The area where money is going to be tight for us will be around some of the resource that we traditionally have helped NHS Employers with to run courses and programmes for their existing workforce. Effectively, we have focused on our core statutory responsibilities to deliver the future workforce and we may have to cut back a little on the amount that we spend on the continuing professional development life-long learning activities.

Q167 Dr Davies: It is expected that money is going to be tighter in the later years of the CSR. Does that pose you any specific concerns?

Professor Cumming: In parallel with the flat-cash settlement, we are looking at how we improve the efficiency of our own organisation. Along with many other arm's length bodies, we are looking at how we take 30% out of our running costs over the next three years. That is resource that we would then look at recycling back into being able to fund the continuing professional development and life-long learning aspects and some of the other programmes there—particularly postgraduate medical programmes—that we fund. It is going to be difficult, but with a 1.5% to 2% efficiency ask on our organisation on an annual basis, our board believes that that is deliverable.

Q168 Dr Whitford: To follow on what we have been talking about, particularly developing the current workforce to meet the Five Year Forward View, what do you think the impact is of the current dispute with junior doctors and, in essence, the bit of that that is a breakdown of relationship as opposed to the nuts and bolts of money or contracts?

Professor Cumming: Clearly, it has had an impact on morale and motivation of our junior medical workforce, who are absolutely fundamental to delivering the quality of care. Certainly, we are working through our postgraduate deans and various programme directors and leaders to make sure the educational component remains robust and that those individuals can not only deliver the day-to-day service but also receive the training that they need to allow them to progress.

Q169 Dr Whitford: I got a letter from a junior doctor whose rota is meant to have 13 doctors but only has seven on it, and they do not get to engage in any training at all. They are totally working lots of overtime, firefighting, and feel that the job that is coming to the end in the summer has not delivered the skills that are necessary.

Professor Cumming: If that is in England, if you would like to pass that through to me, we will certainly take a look at it, because, from our perspective, part of our responsibility is to make sure that the amount of money that we fund to employers for junior doctors is used for training purposes. So 50% of the basic salary of most junior doctors is funded by HEE and that is training time. The balance is funded by employers and that is service time. We recognise training places on a regular basis with colleagues from the GMC to make sure that everybody is gaining training in that environment as well as delivering the service. They are equally important. If there is no training going on, we would want to know about and be looking into that.

Q170 Chair: Could I bring Michael Brodie in next, to ask your view about whether or not there is enough allocation from the CSR to fund the improvements we need to bring in the Five Year Forward View public health commitments?

Michael Brodie: It is interesting because we have been talking all day, have we not, about the finance gap, which was one of the three gaps in the Five Year Forward View, and actually the wellbeing gap is as important? From our perspective of the CSR, there is a mixed impact. There are some things that we welcome, some that are a challenge and some, I think, that present an opportunity. We welcome the additional funding in the context, as Ian said before, of everything else, of the funding that has gone into the NHS; that is very welcome. Healthcare of itself is not enough, but it is certainly a good start, and a confident NHS is important. We welcome the continued funding of our leading screening and immunisation programmes and the additional programmes that will join that this year through the public health funding that the NHS continues to hold. We welcome the investment in public health science that Public Health England will receive over the next period as well. But there are definitely challenges. We are on record as saying that no cut in the public health grant is a good cut and there are challenges around the local government public health settlement. In context, it is probably worth being aware that we can have this conversation now because up until the reforms nobody knew and nobody talked about how much was spent on public health; it is transparent now—and it is transparent across a range of categories—that local government needs to spend across, and that is really important.

It is probably worth reflecting that, had public health stayed within the NHS in the current financial climate, there is a fair chance that public health budgets would have suffered equally as well. It is also important not just to focus on the quantum—the level of the grant. It is about how well and wisely it is spent. You have heard from DPHs over the last week or so about how local government has had to develop really strong skills in commissioning and procurement and how it is spending that money more wisely.

The final thing is that, if all we focus on is the level of the public health grant, we have somewhat missed the point of why public health has transferred into local government, and it is about not just the £3 billion but the entirety of the £100 billion that local government has to spend. It is probably more than that; it is around a place. We have talked a lot about place-based planning, and there is something as well about how we move towards place-based financing so we are not thinking about the institutions and the organisations and the statutory bodies but about the people that we serve and the places that they live in. I can give a good example of that. If you think about the fire service, which 20 years ago made that transformation from dealing with issues to prevention, they are welcomed into 750,000 homes every single year and they do—

Q171 Chair: We heard about that extensively last week from Michael Marmot, but the bigger question is: do you feel there is sufficient money within the settlement to allow the prevention arm that was part of the Five Year Forward View? The whole point about the Five Year Forward View is that closing the gap was dependent on delivering prevention. Do you think there is enough money there to deliver on that prevention?

Michael Brodie: We would rather not have seen the cut, but the real opportunity is moving towards place-based planning so we have the sustainability transformation plan.

Q172 Chair: That was not quite my question. Do you think there is enough within the settlement to achieve the aims within the Five Year Forward View?

Michael Brodie: There is enough within the system, so there is £100 billion of NHS spend and £100 billion of local government spend. If used appropriately, then there is, yes.

Q173 Chair: The local government settlement was also very challenging. There are two parts of the system, as you were saying, that need to work together, both of which have had quite a significant cut.

Michael Brodie: Yes, and that makes it all the more important that we think about the Devon pound, the Newcastle pound or the Leeds pound, rather than the statutory bodies from which they come. In its totality, yes, we should focus on the assets that we have and we think there is enough, but it needs to be spent wisely.

Q174 Chair: What we heard from the three think-tanks—the Nuffield Trust, the Health Foundation and the King’s Fund—was that they did not feel there was £8 billion extra going into the system. They felt it was more likely to be £4.5 billion if you looked at the way the baseline had changed, so that the increase in £8 billion was going to NHS England rather than the NHS as an entirety, and it is public health that has suffered in that change in the way that the baselines have moved. You have said very clearly you think there is enough there if we look at the whole system, but what do you think might suffer as a result of that? Which areas are you concerned about? Are you concerned about, for example, public mental health? Which parts of the system are you going to be watching most closely to check that we see progress?

Michael Brodie: Fundamentally, it is down to local areas to decide what their priorities are. They do their JSNAs and they have their local health and wellbeing strategy, so it is important that it is a locally led system and they decide, but we will obviously monitor the range of indicators in their public health outcomes framework; 75% of those are still heading in the right direction, so we will continue to track that. Inevitably, there will be a shift away from the biomedical model to looking at more about the social determinants of health, because, if there is not, then what was the point of the transfer? The risk will be in areas more around tobacco control and potentially sexual health as well, just as local government looks to new and different ways of commissioning services, so perhaps not commissioning based just on morbidity or an area but on the concept of wellbeing hubs. When somebody comes in, they are not just looked at for whether they smoke, but it is around issues of obesity, whether they smoke, is there an alcohol problem as well, and we treat the whole person rather than individual ailments.

Q175 Chair: Within the system, what would be your role, Michael, in seeing what is delivered?

Michael Brodie: We have probably five roles. Again, it is a locally led system, but the first thing we do is provide the transparency, so we provide the data and the information

on which everything is produced. We have the public health outcomes framework and we have produced products like “Longer Lives”, and we have a spend and outcomes tool that allows local government to assess how it is doing compared with like authorities. So we have the transparency and that is really important. We provide the evidence to support what works and what is best practice, and we know there is more we can do here, particularly around return on investment, so we provide the evidence base. Then, if we think that a particular authority is struggling in a particular area or outcomes are not good, we use our relationships. We are not an inspectorate or a regulator, but we provide expert advice so that we can provide that support. If that does not work, or if there is a particular issue across a theme, then we can do a thematic review, just as we did a year and a half ago around drugs and alcohol. We supported the 40 local authorities that were finding the biggest challenge in drug re-admissions. So we can provide thematic support that way. Ultimately, if there is an issue beyond that, we will support the sector-led improvement process and help local government to support itself.

Q176 Chair: Thank you. Can I ask a similar question, Christina, to you about social care? Do you want to comment at all on the effect of the precept for social care and whether that will have an effect?

Christina McAnea: Yes. I saw that you have already had some evidence on that and I would say we fall squarely in the camp of saying that we do not think it is going to have a significant impact. In fact, all the evidence says that the precept will just make the disadvantaged local authorities even worse off because those that can raise the least from council tax are those that spend the most, usually, on social care. The big issue for us is around what has been happening to local authority funding. I know this was a big element of the earlier session—that link between what happens in the acute sector and what happens in the community sector and social care sector.

We had a new survey come out last week—I do not know if it has been shared, but, if not, I can happily send it to the Committee—where we had a new look at what is happening in social care. Something like two thirds of our members are still saying they have been asked to do 15-minute visits. Of the local authorities that replied to the survey, over 70% are still basing their service on 15-minute visits, despite the NICE guidance that has come out. A huge percentage of our members do not feel they have enough time to give dignified care to people in their own homes, so there is still a massive gap in what is happening in the social care settings. We can certainly see a close connection between that and what happens in both the acute sector and the ambulance sector, their response times and the waiting times they have at hospitals; there is an absolute link between all those things.

Q177 Chair: You do not have much confidence in the precept to do this.

Christina McAnea: No

Q178 Chair: What is your view on the Better Care Fund?

Christina McAnea: We would like to see more of that money being delivered up front to local authorities and being given the money sooner rather than the way it is going to be

spread out. There is still a lack of clarity over how much of that is new money and how much is coming from the existing funding that is going into the NHS and the money that is coming from local authorities, but it is not enough to make a difference, given the level of cuts that local government has seen. We are talking about a minimum of 40%, but for some local authorities it is as much as 56% to 60% cuts. Although most local authorities have tried to protect their social care funding, I think the Association of Directors of Adult Social Services still estimate that, roughly, 25% cut across the board in social services, so the Better Care Fund does not go anywhere near making up for that, and certainly the money that can be raised in the 2% precept does not go anywhere close enough.

Q179 Helen Whately: I am going to bring us to the question of efficiency and build on the conversation we had with the previous panel, and particularly ask you, Christina, whether you agree with what we heard—that there is room for improvement in efficiency in the NHS. What is your view on that, and how do you think the NHS could make savings?

Christina McAnea: You would like to think there is always room for improvement—always room for things to be done better. On the grand scale of things, the level of savings that is expected to be made, we would share the scepticism that many of the think-tanks have: that £22 billion is not achievable. Even when you look in detail at some of the stuff that came through Lord Carter’s review—and I echo some of the points made in the earlier session—obviously, where you have big differences, when you compare the differences between trusts, there is work to be done. I was a bit disappointed in that some of the solutions that came through from Lord Carter seemed to be—instead of being what we had heard was going to be a more nuanced approach, about working with individual trusts to make things better—more in favour of that top-down approach: “Here is a target; you have to reach it.” If you look at what has been said around admin costs and corporate costs, so the move to get down to 7% and then 6%, when you have some trusts whose costs are currently 10% and 11%, just setting a hard target like that will be incredibly difficult for them. It is easy to fall into the trap of thinking that any money that is spent on admin or corporate costs is wasted money in the health service when clearly it is not.

Q180 Helen Whately: I can agree with you that in fact money on management and admin is important, and we all know how unhelpful it is when, for instance, clinical staff are given admin roles because of short-term saving cuts to get rid of ward clerks, for instance, so I completely understand what you mean there. I would particularly like to understand, although you might not be entirely happy with some of the details in the Carter report, what you see as the opportunities. You might not agree that there is a £22 billion opportunity, but, from your perspective, representing your members, what do you see are the opportunities, because there is not an infinite pot of money?

Christina McAnea: There is lots to be done in terms of looking at the equipment that is used. As to some of what Lord Carter said about the type of equipment that is used in certain operations—if you look at hip replacements, he talked about people using different products for some of these things and the difference in cost, differences in the cost of pharmaceuticals and even basic things like the procurement of certain products or services that are used in different trusts—I am sure there is work that can be done, but our view is that that is something that is best done with individual trusts and being pushed in the right

direction rather than being told, “This is an absolute target.” Yes, we would completely agree with that. One way we would also say—

Q181 Helen Whately: It sounds like you would support what I have heard is the feedback on the Carter report, that there was a huge amount of engagement around that and many trusts have been very supportive and found it very helpful. You are very much wanting an engagement, not a top-down approach, and you are agreeing there are opportunities.

Christina McAnea: I am sure in any organisation there are opportunities to save money and be more effective, but we are very much against this hard and fast, “This is what you will have to do to make those savings,” because you would have to recognise the differences between trusts. If you are a large trust, like Northumbria, that is trying to cover Northumbria and Cumbria, you have various centres to cover and you are running clinics across a large geographical area, so the chances are you may well employ more admin staff to be the people who are dealing with patients as they come in than perhaps another trust; so your percentage, of course, will be higher.

Q182 Helen Whately: I do not know that it is very helpful to start trying to unpick the details of the Carter report in here, but I take some reassurance that you say there is an opportunity. I want to pick up something that was in your written submission that talked about the UK falling behind other countries on healthcare spend as a share of GDP and specifically referenced Finland, Iceland and, I think, Slovenia. The latest OECD figures that I have seen on those countries, which are from 2013, showed that their publicly funded healthcare share of GDP was lower and they only came over the UK through the private funding of healthcare. Given that you particularly referenced those countries in the UNISON submission, is that a model that you think needs to be considered?

Christina McAnea: No, it is not, but we are looking at overall spending within economies—how much money is going into the health service. We would certainly share the view that a lot of health economists have, which is that health economies such as the United States, which spend a much higher proportion of their GDP on healthcare—but in the United States that almost predominantly comes from private spending—are not necessarily efficient or effective and do not necessarily get better outcomes. It is worth looking at what we as a nation spend on GDP, and I think it is a fair comparison to look at the amount that has gone in in any of these countries, whether it is coming from a public or a private source. The reason it is coming from a private source in those countries is because the public spending is so low and so people are paying an insurance premium into health.

Q183 Helen Whately: Something I have heard generally in some of your responses is that you are pushing for more money to be spent. If we look back over the last few years, we know the NHS has been given £10 billion, which is a bit more than the £8 billion that it asked for, and, as at the last election, there was not another major party in fact proposing to put more money into the NHS. Do you have a worry about the difference in what the workforce is calling for and what people involved in the health service are calling for, in terms of money and what the public is willing to spend? Is there something out of step there between what the NHS itself wants and what the public is willing to pay for?

Christina McAnea: Yes, possibly. There have been some studies done, have there not, that show that, if you ask the public if they would be prepared to put more money in if it was going specifically to the health service, a high percentage come back and say yes, they would? I do not have the figures to hand—I am sorry—so I do not have a specific figure on that. I think there should be a more honest debate about how we fund the NHS and what happens to the money that goes into it. It does feel that it is a political football, and it would be good if that was not necessarily the case and we could have an honest debate about people's expectations about the NHS. But that goes equally for Governments; I do not mean this specifically about the Conservative Government but any Government. If you look, for example, at the seven-day services commitment, that has been a good example of where a Government make a commitment to do something but do not necessarily want to put the money in to make it happen, but you have already built up an expectation with the public now because you have said that you want to extend seven-day services. People think, "What does that mean? Does that mean I should have access to anything over seven days or should I only be able to access emergencies over seven days?" The way that has been presented has perhaps been unfortunate because we have built up public expectation, but there is no money in the system to expand in the way that has been suggested.

Q184 Helen Whately: So it is important to have some clarity between what is being offered and what can be afforded. A final area to ask you about is the question of the agency pay rates, the cap to agency costs and whether you have a view that the cap that is being introduced will resolve that problem of higher agency pay and those high staff costs that are affecting provider deficits.

Christina McAnea: There are a number of reasons why staff go and work for an agency. In terms of an individual's choice to go and work for an agency, part of that is because of the pay rates that they get—so they get extra money—but a big part is also about flexibility and they feel they have more control over the hours they are having to work by choosing to work for an agency. We had mixed views about the effectiveness of the cap, as in whether all this will do is just restrict the pay that people can earn in an agency. In actual fact, would it not be better to restrict the profits that people can make from agencies? I know there was an element of that because it is about the charges that companies can impose for agencies. Again, and I know this has not been published, I understand there is some information that is going to come out on whether it has been effective or not. Anecdotally, we get told that a growing number of trusts are seeking to get an exemption from applying them, so they are putting forward the arguments they have to put forward to be exempt from the agency cap. I am sure that a number of trusts have tried very hard to keep within that. I understand the Government are collecting that information, but I do not think they have published it yet.

Q185 Helen Whately: Can I ask you how you think the NHS could reduce its spend on agency staff or—

Christina McAnea: Yes. One would be if we had decent pay rates for some of the staff. The average pay of a nurse in the NHS outside London is £31,500. About £4,000 of that is the money they get from unsocial hours and overtime payments, so if you take that away you are talking of about £27,000. That is not a particularly high salary. When you look at

things like leavers rates, the biggest group of nurses who leave are those who leave before retirement, so it is not just those who are retiring or getting over a certain age. There is a reason why people are leaving the profession.

Q186 Helen Whately: Earlier on, I think you said about nurses that the work is no longer enjoyable, part of it being not having the same amount of time to spend with patients. Is that not a significant factor rather than pay?

Christina McAnea: It is a mixture. Pay is not always the first reason people give for leaving the NHS, as I am sure you know, and that even includes people who are paramedics, who leave regularly. Pay is not always the top reason, but it is one of the reasons that they give for it, and it is that whole package of decent pay, more flexible working and the feeling of being valued and rewarded. That is the feedback that we get from our members—that it is not pay by itself, but the fact that there is a pay freeze and the fact that things are getting more difficult for them makes them feel that they are not valued in the NHS. That is also exacerbated by not having enough time to interact with patients, et cetera.

Q187 Helen Whately: That is a very important point—I have heard that a lot—not feeling valued being a significant reason for staff being unhappy and, ultimately, leaving. Professor Cumming, I saw you nodding. I do not know whether you had anything in particular to add to that.

Professor Cumming: Yes. There is variation between employers as well. I would certainly agree with Christina that pay is one factor, but it is the atmosphere, the environment, the morale, the motivation in the team, good leadership and good management in an organisation. We know that there is variation in sickness absence rates between organisations. We know there is variation in turnover between organisations. We have to look at what the very best organisations are doing to keep their staff motivated, because there is also a correlation between low turnover rates and the quality of clinical outcomes and the satisfaction of patients. If we identify what is happening in those best-run organisations, best led, and I do not mean just the chief executive but the whole culture of the organisation, and then look at what is happening in those organisations where they are struggling to recruit and they have very high turnover, they are also the organisations that have very high agency usage, et cetera. I completely agree with Christina that pay is a factor, but I do not think it is the main factor.

Q188 Dr Whitford: Do you not think that the actual nursing ratio is the factor—and that is everywhere because of the increased demand and nurses are hugely under pressure—in that when I speak to nurses a lot of it is this feeling that they do not have time to care? There are marked differences in the nurse-to-population ratios between Scotland and England. There is also the fact that NICE looking at it was kind of shelved, which makes people feel that what impinges on their daily job has just been put back on the shelf. Do you not feel it is about the quality of your day? You went into nursing not to be paid huge bonuses but to carry the bonus home with you of the experience with the patient.

Christina McAnea: Yes, absolutely, and that comes across very strongly when we talk to our members, particularly the nursing members, but not exclusively. They are worried

about safe staffing levels; we get a lot of comments especially from people who work nights and weekends about the levels of staffing at those times, and they are concerned about that. Again, it is hugely variable and some places are much better at managing that, but not all of them. That is the key—that there is huge variability across the sector.

Q189 Dr Whitford: In response to Francis, trusts took on extra staff, and to do it quickly it was agency staff; and that is now not allowed. As was mentioned, it takes quite a lot of time to bring on new staff. Are we not a little bit in danger of getting right back round the track to Mid Staffordshire or places running really close to the wind?

Christina McAnea: We still do surveys of our members and ask them things like, “Do you think something like Mid Staffordshire could happen in your area?” More people say yes than say no to that question, which is quite worrying.

Professor Cumming: If I may come in on that: the increased demand we have seen in nurses over the last three years, the 24,000 extra posts that have been created, have been created for by and large the same number of beds. Those 24,000 nurses were supposed to be going into the system to improve the quality, to put more nurses per patient in there. Of those 24,000 jobs, about half are substantively filled, so about 12,000 of those nursing posts have people in them. The balance of the 12,000 are filled by a mixture of bank, agency and overtime working. It is those posts we are seeking to fill through the increases in the commissions that we are making from universities. But it is important to remember that we do have 24,000 more nurses than we had three years ago for, broadly speaking, the same number of patients.

Q190 Dr Whitford: What do you think your nursing ratio now is after injecting 24,000 nurses?

Professor Cumming: From my perspective, the ratio is quite a blunt instrument in terms of how we look at this because we need to consider this in the round. For example, if you have a ward that is caring for people with stroke or dementia rehabilitation where they have occupational therapists, physiotherapists and nurses on the ward, where they have a good level of healthcare support staff backing them up, that will be a very different environment than, say, in intensive care. From my personal perspective, it needs to be a lot more sophisticated than a simple ratio in each area, but those 24,000 extra nurses are, as we hear from the CQC and other places, already having an impact on the quality of care that is being delivered, but we are only halfway there to filling all those jobs substantively. When we get that second tranche of 12,000 in, we will be in a very different place.

Q191 Dr Whitford: But there has been talk about headcount reductions. Do you think those posts will get filled or that some organisations, as they have to save money, will not fill jobs that were meant to be filled?

Professor Cumming: These are posts at the moment being filled by bank, agency and overtime. The NHS expenditure on agencies, as we have discussed, is high, and the employers are telling us at the moment that they really want the additional workforce that we are producing so that they can appoint substantive people into those posts rather than rely on the agency workforce, because the agency workforce is fine for particular times

when you have flexibility needs or you have particular issues or challenges, but it is not the right workforce for the long-term staffing of our clinical environment.

Q192 Chair: Can I ask, Ian, in otherwise comparable systems, are there some key things that you have noticed, trends in making some more effective at retaining staff in substantive posts? Are there others that you are starting to see emerging?

Professor Cumming: If I take junior doctors as an example, we talk to junior doctors up and down the country all the time. Some will say to us that in the organisation they are working in they do not know who the chief executive is and they do not know who the medical director is; that they basically come in, do their job and get their training. They know their immediate clinical team but do not feel part of the organisation. They feel they rotate through and move on to their next job, whereas they would describe other organisations that they start work in as part of their rotation where the chief executive is there to say hello to them on the first day, the medical director meets with them and says, “Here is my email address. If you have any issues, please be in touch.” They know who the local directorate manager is, they know who their clinical director is, and they are involved in some of the social activities and are made to feel part of a team. It has an impact on where people want to work after they have trained. If people have a bad experience in training, they do not want to go back there under any circumstances. That applies both to specialties as well as to individual organisations. We see that with junior doctors, but we also see it with other people on training placements. It almost becomes a self-fulfilling prophecy. If people have a bad experience in training, they do not want to go back to that organisation so apply somewhere else, which means that the organisation ends up having a high reliance on agency usage, and agency staff tend not to be as active and involved in training as substantive staff, and therefore the problem becomes worse over time. How we stop and reverse that is one of the challenges.

Q193 Chair: You say the same applies for nursing staff as well.

Professor Cumming: Yes.

Chair: Thank you very much. Thank you all for coming this afternoon. We appreciate your time and evidence. Thank you.