HOUSE OF LORDS

Select Committee on the Long-term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 12 July 2016

10.10 am

Watch the meeting

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 1 Heard in Public Questions 1 - 21

Witnesses

I: Andrew Baigent, Director of Finance, Department of Health, Dr Edward Scully, Deputy Director, Integrated Care, Department of Health, Gavin Larner, Director of Workforce, Department of Health, Tim Donohoe, Director, Informatics Delivery Management, Department of Health, Mark Davies, Director, Health and Wellbeing, Department of Health, and Graham Duncan, Deputy Director for Care and Reform, Department for Communities and Local Government.

Examination of witnesses

Andrew Baigent, Dr Edward Scully, Gavin Larner, Tim Donohoe, Mark Davies and Graham Duncan

Q1 **The Chairman**: Good morning. Thank you for coming to give evidence today at our first session. Before we start, may I say that this session is being broadcast and recorded? Whatever you say will be recorded, but it will also be broadcast. Therefore, it is important for both Committee members and you to know that any private conversation that you have will be picked up, because the microphones are rather sensitive. It will also be recorded and heard on the broadcast media, including the web. I see that there is one seat empty.

Andrew Baigent: Ed has gone for a quick comfort break. I am sure he will be with us in a few seconds.

The Chairman: Okay. Would you like to introduce yourselves? You may start, Mr Baigent.

Andrew Baigent: Of course. I am Andrew Baigent. I am the director of finance at the Department of Health.

Gavin Larner: I am Gavin Larner. I have been the director of workforce at the Department of Health for four weeks.

The Chairman: Mr Scully, do you want to introduce yourself?

Dr Edward Scully: I am Edward Scully. I am the deputy director at the Department of Health, responsible for the integration of health and social care.

Tim Donohoe: I am Tim Donohoe. I am the director of informatics delivery management, responsible for overseeing or deployment of technology and the programme portfolio, delivering that technology into health and social care.

Mark Davies: I am Mark Davies. I am the director of population health at the Department of Health, covering the public health system, healthy behaviours and prevention.

Graham Duncan: I am Graham Duncan. I am from the Department for Communities and Local Government. I am the deputy director for care and reform, which means that I am responsible for DCLG's interests in adult social care and public health, in particular, and in health and social care integration.

The Chairman: Thank you very much. I assume one of you will make sure that the right person answers the question.

Andrew Baigent: It will be down to me to do that.

The Chairman: Okay. Do you have an opening statement to make?

Andrew Baigent: I thought that I would make a few remarks, just to open up.

The Chairman: Before you do that, I will reiterate some information that we have given you. Remember that this inquiry is about long-term sustainability. We are looking at how the health service, including social care and prevention, could be sustainable after 2025, to 2030 and beyond.

Andrew Baigent: I am glad you have said that, because that is exactly what I hope I will do in the next couple of minutes.

I want to open by saying briefly that the department's role changed in 2013. We devolved a lot of the operational delivery of the health service to our arm's-length bodies—NHS England, Public Health England and others. To some extent, that has freed us up to look at some of the longer-term issues within the department. However, as you would expect, quite a lot of the work we do is focused on the short term and the medium term. In the short term, we focus on managing the arm's-length bodies and holding them to account for delivery of performance in the NHS and the broader health and social care system, and on making sure that we can do that within the funding that we have. We will not talk too much about that today, and I will not dwell on it. In the medium term, the NHS came up with a five-year forward view, which the Government have fully funded. A lot of our efforts in the department are in holding the ALBs accountable for delivering that forward view.

However, today we are talking about the longer-term stuff. My colleagues have already introduced themselves. Gavin can take us through some of the issues around workforce strategy and the long-term nature of that. Tim Donohoe can talk about how we are trying to advance our infrastructure and IT infrastructure base, to get IT fully integrated with the delivery of health and social care. I can talk a little about shorter-term efficiency and how we are setting up that basis. I suspect that we will not dwell too much on that, as we are looking over the longer term. Mark will be able to talk about population health and some of the prevention work that we are doing. Ed and Graham will be able to talk about social care. However, you know that already.

Q2 **The Chairman**: The key questions have been submitted to you. No doubt Committee members will have lots of supplementary questions. Might I make a start? You said that you are involved in some long-term strategic thinking. Would you like to tell us what long-term thinking is taking place in government bodies on the sustainability of the NHS beyond the next 15 to 20 years?

Andrew Baigent: It is probably best to break it down into each of the areas we have talked about: workforce, IT and integration.

The Chairman: We have questions related to all those. Could you stick to finance first?

Andrew Baigent: I can talk briefly about finance. As always happens in these things, we have a five-year settlement in the spending review. The funding of the NHS is planned in the five-year forward view to meet that settlement. At the moment, most of our focus with the finances is on being able to deliver within that envelope and emerging at the end of it in a position to carry on, with roughly the same envelope.

The Government have been quite clear that they see spending as being taxpayer funded. At the moment, we are not exploring any particular avenues of longer-term thinking about charging. That is the policy Lord Prior has talked about in front of Members of the House of Lords at various points. To some extent, it is about looking at the underlying pressures in the system and how we can model those and approach the delivery of healthcare in a different way, building on the forward view. While the finance is a governing factor in being able to deliver the service, to some extent, it has to be completely responsive to the underlying pressures. As you will know, those pressures are the cost of the workforce, the cost of the drugs and how we do that, the cost of the infrastructure, the way in which we deliver services and the balance between primary care, secondary care and emergency non-elective care, when that comes through the door into the acute sector.

The Chairman: You said that, in your thinking, you have come to the conclusion that in the long term you will still be looking at a taxpayer-funded NHS. Have you ruled out the possibility of any charges? Do you think that a service free at the point of need is sustainable?

Andrew Baigent: That is current policy, and that is the way we are thinking. As you know, we have done some work around eligibility. Migrant access charges and charging for overseas visitors are coming in, so there is some charging. There are always considerations around prescription charging and how that is taken forward, but those are all issues of what we should charge for services that are being charged for at the moment. We have done no thinking beyond that about charging, under current policy.

Q3 **Lord Willis of Knaresborough**: Thank you for that. I find it somewhat incredible, given that, with every modern healthcare system, we are facing issues of long-term sustainability, and given that you have to integrate health and social care into a single package, that you are doing absolutely no thinking about whether there are any items in both health and social care that we could remove from being free at the point of delivery and put on to a pay list. Is none of that thinking going on? If not, could we have your personal view as to whether we should be doing it?

Andrew Baigent: On the broader strategic issue of whether there are large clumps of things where we are looking at charging and different charging mechanisms, there is no thinking going on that has gone beyond very early thoughts. As a Civil Service, clearly we think about some of these things, in case Ministers wish to take them forward, but at the moment that is not there.

NHS England is looking at low-value procedures. There is some work going on around whether there are certain low-value procedures that should be taken out. That is a matter on which I need to defer to NHS England, because it is doing the thinking. Personally, I would think of that not as strategic thinking but as short-term tactical thinking that will make a difference around the margins. If you look at the figures that NHS England has provided in the past around the five year forward view and the efficiency challenge—the £22 billion, which you will be aware of there—an element of that is about not offering certain low-value procedures.

Lord Willis of Knaresborough: So we have nothing beyond five years. Mr Duncan, I wonder whether you could comment here. You have the issue of large swathes of social care and, indeed, public health that are now involved with local government. Surely you are doing this work, looking ahead and saying, "Come on. Are there areas that could be taken off 'free at the point of delivery', to release funds for greater integrated care?" Are you not doing that either?

Graham Duncan: Our main interest is in how you shift money from one part of the system to the other. The long-term strategic story is about shifting from a system that targeted disease in hospitals to one that looks at long-term conditions—particularly for older people, but also for people with learning disabilities. Over the last decades, we have gradually been on a journey to make that shift. Community care is a good example from 20 to 30 years ago, but it is a long-term journey. We need to go further on that. Our focus and interest are in how you shift activity and resources from acute to community settings.

Lord Willis of Knaresborough: Whether they are in acute or in the community, they still need paying for. How do we release more resource to pay for the whole package unless you look at the core issue of what is free at the point of delivery?

Graham Duncan: All I would say is that that is not our focus. Our focus is on how you make the money that will be in the system work. In the end, Governments will have to make a decision about how much they put into the system. What we need to think about is how you best use the resources that are likely to be available to get better outcomes for the people for the same amount.

Lord Mawhinney: We were set up to look at the long-term sustainability of the NHS. You are doing no thinking about the long-term sustainability of the NHS. How would you want to convince us that you are fit for purpose?

Andrew Baigent: The question was very directly against the finances. As colleagues and I have said, we are working within an envelope that the Government have decided and within a set of instructions around how that will be funded.

Lord Mawhinney: I understand all that, as do my colleagues. My

question is an entirely different one. We are supposed to be looking at sustainability. You have told us that you are not doing any work on sustainability. Why should we conclude in our report that you are fit for purpose?

Andrew Baigent: On sustainability, we are looking at each of the cost drivers—the demand for the service, for treatment and for social care. We are looking at how we will have the right workforce to deliver. That work is fairly long-term and goes 15 or 20 years into the future. That is important as well. We are looking at how we get efficiencies out of the service. Those will continue, of course. If we get them in place in the next two, three or four years, they will underlie the operation of the health and care service going forward. We need to look for as many opportunities as we can to do that, within the envelope that we have been given.

Lord Mawhinney: Forgive me, but some of us have been listening to this for 30 years. We have listened to people saying, "We will improve the efficiency, Minister. We are looking at how we can constrain demand". Demand is increasing all the time. Efficiencies, such as they are, are not remotely staying in line with demand. Sustainability will be even worse in the future than it is now, according to what you have just told us, because you cannot control the demand. I ask you for the third time, if you cannot control the demand, sustainability is going to get worse and you are not doing any thinking about sustainability, can you understand why we, as a Select Committee that is looking at sustainability, might come to the conclusion that you are not fit for purpose?

Andrew Baigent: I certainly understand where you are coming from on that; you make it very clear. I come back to the point that you have just made on demand. We have not yet explored the work that is being done on demand. Of course, you will also talk to NHS England about that, as the inquiry continues. Demand for the services that are offered currently is increasing. How we deliver those services—whether we can do them in a more efficient way, closer to home, in different care settings—is very much the focus of what we are doing within the department and with colleagues in CLG. That is the plan—to work out how we can deliver that. You used the term "efficiency". That is right, but it is also about what we are delivering and how we are delivering it, to meet local demand.

The Chairman: Through your answers, you have excited so many different Committee members that we are stuck on the first set of questions. I will take a quick question from Lord Scriven, who will be followed by Baroness Blackstone, Baroness Redfern, Lord Turnberg, Lord Warner and the Bishop of Carlisle.

Q4 **Lord Scriven**: I get the message that you have been asked to work within a policy framework of "free at the point of use". You do not have operational responsibility, so you are forward planning. Based on projections that you have done about sustainability of the NHS free at the point of use, what are the implications for 10 or 15 years' time as regards demand, core service delivery, et cetera?

Andrew Baigent: As we look forward on demand, most of the modelling has been done for the five-year forward view. We are now turning our attention to looking beyond that. I cannot tell you today where that is in respect of modelling going forward. What I can do is talk briefly about the efficiency side of things, which we have looked at very carefully. The five year forward view talks about a two percent-year year-on-year efficiency—

Lord Scriven: May I stop you? Have you done nothing beyond five years? Is that what you are telling us? There is no work beyond five years about a service free at the point of use, as regards core provision and the implications, particularly given that planning in the NHS takes more than a couple of years to implement.

Gavin Larner: On workforce, we have a much longer-term timeframe. The bulk of health and care costs are tied up in the cost of employing people. There are two main strands of work. The first is by Health Education England, to inform its commissioning strategy, particularly for medicine. The timeframe for new consultants is 14 or 15 years ahead, so you need to imagine the world in 2030. Last year, it published an updated version of the 15-year strategy, which takes three key focuses. The first is global drivers of change in health and social care around population demographics, to do with the ageing population and the shape of the employable workforce—factors such as the attitudes of millennials and when people work past 60, for the supply side.

Lord Scriven: You say that it has done this work. What are the answers?

Gavin Larner: The key conclusion is that the thing you can predict most is that the future is quite unpredictable 15 or 20 years hence, as regards what skill sets you need. The kind of health professionals we need to start training now, particularly the higher-cost ones, are people who are not just specialist surgeons—I know that there are many around here—but who can flex quickly, adapt to meet new technologies and circumstances, and jump on new opportunities to make the service more sustainable. Some really important work needs to be done over the next few years, particularly in medicine, on how we can adapt. I am quite optimistic on that front. If you look at the way in which doctors and surgeons have adapted to new pharma and new technology over the past 15 or 20 years, you see that they have been pretty adaptable, flexible and agile. The challenges for the future are—

The Chairman: I am sorry to stop you, but time is important. I can summarise what you are saying. If I ask what workforce numbers planning has been done for 2025, there are thoughts given, but no answer.

Gavin Larner: There is a second piece of work, which we commissioned from the Centre for Workforce Intelligence, called *Horizon 2035*. It has been trying to extend the global factors I talked about, to see what the position will look like in the mid-2030s. A team of economists has been looking quite carefully at the evidence base. It concludes that, with the

ageing population and the further spread of chronic disease through all age groups—beyond just older age groups—an estimated 3 billion extra care hours will be needed by 2035 and demand for care could rise twice as fast as population by that time. Its conclusion based on that is that you will need a lot more capacity at bands 1 to 4 of agenda for change than we currently have, to cope with that non-specialist, caring social care-health care border, where you have a big population to look after.

Q5 **Baroness Blackstone**: Notwithstanding the very valid questions asked by Lord Mawhinney and other members of the Committee about long-term sustainability, I want to come back to the current position. As you all know, NHS providers had a deficit of nearly £2.5 billion last year. That is an enormous deficit. It is unclear—the NAO has commented on this—how you will close the gap between the resources available and patients' needs. Can you tell us a little about how far you think the current healthcare funding envelope is realistic? If you do not think that it is realistic, what are you going to do about it?

Andrew Baigent: I think that the current funding envelope for the period of the five year forward view is realistic, but it is challenging. I do not underestimate that challenge. Quite rightly, you said that the NHS will exit the year with a deficit of about £2.5 billion. Going into the new year, we have made available a considerable amount of additional money: £3.8 billion, against the £10 billion of the five year forward view, will come in year one. Of that, £1.8 billion will go into a sustainability and transformation fund, which is available principally to providers of emergency care. That will help to put in what Jim Mackey has described as a "firebreak" and give providers an opportunity to get themselves on to a more even keel. I understand that £1.8 billion is not £2.5 billion. We expect the NHS to come into balance in 2016-17—

Baroness Blackstone: May I interrupt? You say that you expect it to come into balance. Expectation is fine, but what will you do in reality to make that happen? What funding models are you considering that are different from what exists at the moment? There is no point in just giving us the figures. We need to have some understanding of what your underlying thinking is to create the balance that is obviously needed.

Andrew Baigent: In the short term—in 2016-17—it is a relatively crude fund to bring providers on to an even keel. The changes to the funding mechanism are around that. We will talk about that later in the week, with an announcement at that point.

Baroness Blackstone: You cannot tell us now.

Andrew Baigent: I cannot, I am afraid.

The Chairman: Could you send us the details, once it has been announced?

Andrew Baigent: Of course. That will be around what we think that we can achieve this year, through a combination of accelerating some of the Carter work that is going on, using the £1.8 million sustainability fund,

looking very carefully at the various investment plans and some detailed work around the level of cost increase within individual providers and the support that will be given to them. It is a detailed but very micro-level plan that I would not want to claim was strategic, in the sense of doing anything other than provide this firebreak.

Baroness Blackstone: May I ask one supplementary? I realise that, to some extent, this is a political question. Nevertheless, you must all have a view on it. Do you think that the NHS is sustainable with 9% of GDP going on healthcare, when the European average is 12%? That is a very big gap between us and the rest of Europe.

Andrew Baigent: I believe that I have the figures right when I say that, according to the OECD, we are at or about the European average. It re-did the figures fairly recently and included more of our private payment as part of GDP. When it comes to the European average, we are there or thereabouts. Do I believe that it is deliverable? Yes. The Commonwealth Fund has said that we have the No. 1 health service in the organisation—

The Chairman: That comment is often made. It is based on access and, maybe, even some comparable models in expenditure, but it is not based on outcomes. Are we sacrificing better outcomes for lower financing?

Andrew Baigent: I do not believe so.

The Chairman: But you would agree that the Commonwealth Fund puts us pretty low down—at the bottom—on outcomes.

Andrew Baigent: On population health, yes.

The Chairman: That is health outcomes—or are you trying to fudge the definition?

Andrew Baigent: No.

Lord Lipsey: The OECD league table shows a different picture, does it not?

The Chairman: Yes, silence is perhaps a good answer.

Q6 **Baroness Redfern**: You have spoken about the financial envelope. I have a local authority background. Mr Duncan, I would like to know a bit more about how you are bringing together health and social care in the very short term—how local authorities can work together very closely, as we link health and social care.

Graham Duncan: We work on this jointly with the Department of Health, NHS England, the Local Government Association and the Association of Directors of Adult Social Services. At national level, they feel like the right people to be involved. That cascades down to local level. I said earlier that we had been on a journey for quite a while. I am sure that you will have experienced this yourself with community care issues.

Baroness Redfern: We never seem to get to the end of it, though.

Graham Duncan: I know. I will say what I think is different now, because I agree with you. A couple of years ago, I was looking at some papers from my mother's trunks. She was a geriatric social worker in the late 1980s. The rhetoric around health and social care integration in the papers that I read there looked very similar to what we are saying now, so I accept the challenge. We have been trying to do this for a long time.

There are two things that are different now. We have never before had a Government who have tried to make this happen comprehensively across the country. The better care fund, which was introduced last year, is the first real attempt to do this across the system, in every area. It is not a perfect solution. However, if you look at what is happening in local areas, you will see that there have been real changes over the last couple of years already. All of a sudden, in every area—not just in those areas where there was already enthusiasm—there are conversations between health and social care professionals that did not happen in the past. In some areas, they definitely did; in others, they definitely did not. You get conversations between GPs about options that are not within their normal toolkit, because social care professionals can direct them towards those.

Baroness Redfern: That is fine. A conversation is a conversation. It is about action and really working together. Do you know what I mean?

The Chairman: Briefly.

Graham Duncan: I would challenge that slightly. Our work shows that relationships are critical to making this work. You can have systems, mechanisms, boards and structures, but if you do not have strong working relationships it will not work. Conversations are important.

The Chairman: I am managing this badly. We are still on the first question, and we have six more to get through. I ask you to make the answers succinct and my colleagues to do the same with questions. I have four more requests for supplementaries, from Lord Warner, Lord Turnberg, the Bishop of Carlisle and Lord Bradley.

Q7 **Lord Warner**: May I take you back to demand management and the five-year plan? The five year forward view, which will be two years old in October, was based on a set of assumptions. You would have to be a heroic optimist to believe that those assumptions are working in support of the five year forward view at the moment. There is also the issue that you sound a bit like someone who will be relieved, like a slightly beached whale, when you get to 2020, as it will all be done. What comes after the five year forward view? How will you reappraise the five year forward view if it is going off course? Do you have no contingency plans or mechanisms for dealing with that? If you do, please share them with us.

Andrew Baigent: If we look at the assumptions in the five year forward view and take the one for demand, we are not a million miles away from where the plan was. In the period so far, there has been weighted average cost growth of about 2%. We are keeping each of the elements

under very active review. There is a detailed plan that is monitoring each element of how we meet the £30 billion challenge of reducing the cost increase in the service and checking their progress as we go through. We have a plan that is monitoring each of those lines and items at a fairly granular level. As things go off track, we will take intervention—

Lord Warner: The other assumptions were that social care was properly funded and that there was a prevention strategy. Those are quite key to delivering the five year forward view. Where are you taking and evaluating that?

Andrew Baigent: I will defer to colleagues on those two points.

Mark Davies: On the prevention element of the five year forward view, we have a prevention board, which is chaired by Duncan Selbie, the chief executive of Public Health England, and brings together all the key players. It is looking at all the elements of prevention. Within the efficiency savings, £500 million is attributed to prevention. We are tracking that very closely. We will look closely at the sustainability of transformation plans when they come in to see how far they deliver those numbers on prevention. The majority of them—in fact, 43 out of 44—put prevention as one of their key priorities. They are still being worked on; they are not yet finalised. We think that the prevention elements of the five year forward view are in place. Of course, prevention goes much beyond the five years. Most of the key elements and key work that we are doing on prevention look beyond 2020 and into the next decade.

Lord Turnberg: You may have got the hint that the Committee is a little surprised that there is not a plan beyond five years. I wonder why that is the case. You are all intelligent civil servants, yet there has not been much thinking beyond that. It seems to me that it must be because you have been prevented from taking forward those sorts of ideas. Is it the Treasury? Are Ministers saying, "Do not think beyond five years"? You may wish to nod, if this is a politically loaded question.

Andrew Baigent: Colleagues will butt in. As I said, we are doing long-term thinking on each of the elements—on workforce, on the delivery of care, on how it is delivered and on integration. We are doing the work in those areas and are looking through them.

The Chairman: When can you send us the work that you are doing beyond the next 10 years?

Gavin Larner: I am happy to send you the two strategic reviews that we have done on workforce—

The Chairman: Are you able to write to us about this next week?

Gavin Larner: Yes. I can send them to you tomorrow.

The Chairman: So why can you not answer the question today, instead of just saying that you are doing some work?

Gavin Larner: I was speaking specifically about workforce needs and how we think those will look. We have done a quite thorough piece of work, which is ongoing. I can send you the two main reports we have got to on that. They are a good, thorough take, based on the evidence that we have, on what we think the workforce needs will be, in so far as we can predict them.

The Chairman: This is the report that you have produced entitled *Future demand for skills: Initial results*.

Gavin Larner: Yes.

Lord Turnberg: Have you costed that?

Gavin Larner: No.

Bishop of Carlisle: I go back to the initial question about the sustainability of the NHS over the next 15 years. You made it clear at the beginning that you have handed over a certain amount of the operational work to people like NHS England, so that you can do more thinking yourselves. As we have heard, you are not thinking much beyond five years, except in those areas that you have mentioned. Do you know whether anybody, apart from us, is doing that thinking?

The Chairman: Silence is another answer, I guess.

Lord Bradley: I want briefly to pick up two issues that have been raised. First, on the relationship between finance and quality outcomes, control totals are now set for provider organisations. Are you able to explain to me how those control totals are calculated for 2016-17? Secondly, within the five year forward view, there is another dynamic, under the broad banner of parity of esteem between physical and mental health—the requirement to invest more in mental health, away from the current balance of 87% for physical and 13% for mental. Do you think that you can achieve that within the five-year plan? If not, what are your longer-term plans for the sustainability of mental and physical health services going forward?

Andrew Baigent: I can answer the first question, on the details of the calculation. The calculation is done by NHS Improvement. I cannot answer on the precise methodology on a case-by-case basis. What I can say—

Lord Bradley: Can you provide me with it?

Andrew Baigent: I am sure that we can. I believe that you will see NHS Improvement next week, so I can give you an outline.

Lord Bradley: It would be very helpful to have that.

Andrew Baigent: In effect, it is based partly on outturn from previous years and partly on looking at some of the fundamental cost increases, the demand increases that they have had over the last year and their

projections going forward. It looks particularly at labour costs and how they have moved.

Lord Bradley: What about the second part?

Andrew Baigent: Your question was about mental health. Mental health funding has gone into the mandate, as part of the written side of that. It includes parity of esteem. That is probably a question of detail that is best directed to NHS England when you see it next week.

The Chairman: Baroness Blackstone, you have covered question 2, but you may have a supplementary.

Q8 **Baroness Blackstone**: I want to pick up something about switching funding from one area to another. You are concerned about social care, but how will the rest of the NHS survive if you topslice it to provide social care funding—which, of course, is desperately needed—when NHS providers are already running a big deficit? Surely there has to be some other way through this. That is why we need some other models for how this relationship will work and how, over a rather shorter timescale of five to 10 years, you will have a system that does not run into these huge deficits every year. Surely that in itself is unsustainable.

Graham Duncan: I will answer that from the social care point of view. This is already happening in areas. If you can spend money on care at home, rather than in hospital or even in residential care, that is not just cheaper but—assuming that the circumstances are right—better for the person involved. There is a win-win here. It is not easy, but it is happening in areas right now. It is not just an aspiration. The challenge is to make it happen more widely.

The Chairman: What are the challenges?

Graham Duncan: There is a challenge in taking someone out of a hospital bed and putting them at home. That is great for the person, but a hospital bed is still there, so you do not make a full cost saving. People often have a binary conversation about this, which goes, "The hospital is still there, so you have not saved the money". Actually, there is something about what you are spending in relation to that bed and whether you can shut down a ward for a while. I am straying slightly far from my territory here, but there are things that you can do to mitigate those challenges. There is a danger of being too defeatist about it.

The Chairman: You did not answer the question, but I dropped you in that. Baroness Redfern, do you have a supplementary to question 2?

Baroness Redfern: Yes. It is directed to Mark Davies and is particularly about funding for mental health. I wonder whether you have looked into that, to see where you can target some extra financial support.

Mark Davies: Mental health is not part of my remit. I am not sure whether there is anyone here today who can answer that.

Baroness Redfern: I read in the brief that you had been involved with that.

Mark Davies: Previously, but not at the moment.

Baroness Redfern: You have moved on.

Lord Mawhinney: What is the budget for the NHS for 2016-17? What would that budget need to be if the NHS and social care were fully integrated?

Dr Edward Scully: You could fully integrate them and have the same budget. Are you talking about changing access and entitlements to social care—

Lord Mawhinney: I am talking about getting rid of a government department and going back to where we were 25 or 30 years ago, with one organisation responsible for healthcare and all social care. What would the budget be in 2016-17? Remind us what it is for health and tell us what it would be if you integrated the whole lot.

Andrew Baigent: The budget for health in 2016-17 is £115,611,000,000. I cannot answer the second part of the question.

Graham Duncan: For social care, it is about £15 billion this year. There is one department responsible for health policy and adult social care policy. That is the Department of Health.

Baroness Blackstone: May I ask a very simple question? Will next year's budget for the NHS deal with the predicted funding gap or not?

Andrew Baigent: I believe that it will.

Baroness Blackstone: What about the year after and the year after that?

Andrew Baigent: I believe that, as a whole, we will balance in 2016-17.

Baroness Blackstone: You believe that, but you are not sure.

Andrew Baigent: No, I am confident.

The Chairman: Lord Warner, can we move on to the next question?

Q9 **Lord Warner**: Can I move away from the big picture to a bit more detail about how people get paid in this great and glorious system? What work and analysis have the Government done on different pricing structures and financial payment systems to help to improve how money is spent?

Andrew Baigent: I return to the five year forward view. We have been looking at different models of delivering healthcare. MCPs—multi-specialty community providers—and the primary and acute care systems or PACS are looking at different ways of funding healthcare, based on a whole local health economy. We believe that that is a good way to do some pilots, to see whether it works and is more effective. While that is

evaluated, we will be able to see whether it works going forward and whether it is a better way of funding.

Lord Warner: How quickly will that happen? For most of the five year forward view, will you just stick with payment by results and local commissioning?

Andrew Baigent: Those areas are being implemented now. As we go through, it will happen fairly quickly and we will evaluate it and take it forward. At the moment, we are sticking with payment by results for the majority of the NHS, but that is not written in stone. It continues to be looked at from year to year.

Lord Warner: Most of your deficits are in acute hospitals. Many outside experts would say that what you have is supplier-induced demand. What are you doing about that? Supplier-induced demand could blow the five year forward view out of the water. What are you doing in the here and now to change the system rapidly? I do not get a sense of urgency about any of this.

Andrew Baigent: NHS England is looking at the local sustainability and transformation plans, which are regionally based. We are quite far on in the process of those initial plans coming in. They look at the local health economy as a whole. I do not have the detail, because that work is being led by NHS England.

Lord Warner: At the end of the day, it will be your political boss who takes the rap for the budget being out of control. I know that, because I had the painful experience of having to deal with it. The Department of Health cannot say that this is all down to NHS England. We as a Committee need to know what the Health Secretary's department is doing about improving the payment systems. Where are you? Personally, I would like a report—with some timescales in it—showing what you are doing over the next two or three years to change those systems.

Andrew Baigent: I come back to the work that is being done on the local sustainability and transformation plans and how they will be funded. We have asked NHS England to lead on that. Ministers and officials are working with NHS England to deliver it. At the moment, it is too early to talk to the Committee about the outcomes of that work.

Lord Warner: We are not asking for the outcomes. I am asking about payment systems. Payment systems are separate from those plans. As I understand your answer, you are relying on payment by results and local commissioning, a system that has led you to the deficits that you have now. What is going to change, in significant terms, to make sure that there is some lasting sustainability in these arrangements?

Andrew Baigent: As you say, at the moment we are relying on those mechanisms.

Dr Edward Scully: There is exploratory work being done around capitated budgets. Monitor, working with the Department of Health,

instigated work on a possible shift. As you probably know, the rules allow areas to shift on to capitated budgets and off payment by results. One area in the vanguard is Stockport, which is using weighted capitated budgets. You have seen examples internationally such as Valencia, where they have gone to capitated budgets and think that they have made 30% reductions around emergency admissions. There is some developmental work going on between the department and what is now NHS Improvement around what that would be. However, as Andrew said, it is early days. There is concern that there may be some inherent risks around using capitated budgets, so there is a desire to trial them slowly.

Lord Warner: Let us have some more information about how many trials there are, how many parts of the country have moved away from the present system, what the success is and how fast you are going to change. Personally, I cannot see how you can deliver the five-year view and produce a sustainable NHS, in funding terms, when you are carrying on using the system that has got you into a mess in the first place.

Dr Edward Scully: We can provide information about the areas that are doing it and the timescales for the project.

The Chairman: We would be grateful if we could have that information. Lord Ribeiro, you have some questions on workforce. We have heard about the plan, but you have some supplementaries.

Q10 **Lord Ribeiro**: You have already told us something about the workforce issues. In 2001, the Wanless report identified that there would need to be skill mixtures and changes in the workforce in time to come. Currently, some two-thirds of the health service budget goes on salaries and wages for staff. We also have an issue on the question of international migration and the fact that some 10% of our doctors and 4% of nurses currently come from the EU. What modelling or planning has been done? You have talked about what the Centre for Workforce Intelligence has done up to 2035. How much of that was done against the background that there may well be a change to staffing coming in from the EU and of our commitment to reduce poaching, if you like that word—taking nurses and doctors from low-income countries?

Gavin Larner: I will need to check in what detail *Horizon 2035* looked at future migration patterns. The Health Education England annual planning process for commissioning not just medical training, but nursing and allied health professional training, tries to take account of who will fall out of the domestic population and what the scope for international recruitment is to fill those gaps. As you say, currently about 5% of NHS staff are EU nationals. The figure is higher in places like London. Across social care, it is slightly higher still, at about 6%. We will continue to need international recruitment for some time, even if we increase domestic supply to try to become less dependent on that.

Lord Ribeiro: In the modelling that has been done—in the Centre for Workforce Intelligence work, we are talking about 2035—how much of the proportion of migrant staff has been modelled to tell us how many of

our own staff need to be recruited to overcome that? If we stick with a policy of not recruiting from low-income countries—and we made that decision as a policy decision—how do we fill the gap?

Gavin Larner: I will need to check the report and write to the Chair on that. I am sorry.

Baroness Blackstone: I want to ask you about the present skills mix and how far you think that is appropriate for the next five to 10 years. Does it need to be changed? Are there ways of changing it that would help us to reduce costs and to deal with the deficit we talked about earlier?

Gavin Larner: With the introduction of new roles, such as 1,000 nursing associates and 1,000 physician associates by the end of this Parliament, we are starting to look at how adding less costly roles into the mix can start to free up time for the costlier ones to focus on the things that they do best. A thousand of each is a start. The longer-term picture is that we will continue to need more in the 1 to 4 roles, as there is more chronic disease and long-term conditions around. It is about other, costlier roles, such as senior nurses and doctors, being able to flex more readily and to adapt to changing circumstances.

Baroness Blackstone: How will you bring that about and get this more flexible mix? Which areas in the higher-level skills groups do you see being reduced, possibly, as a result of bringing in more people with lower-level skills to work in the NHS?

Gavin Larner: At the moment, we are not talking about reducing any levels. Overall, the current plan is for the workforce to stay relatively stable in size over the next five years, but with an increase of 6,000 extra consultants, 5,000 extra doctors in primary care and another 5,000 staff in primary care. There will be more support grades, such as the counsellors for mental health, as part of the IAPT scheme. Overall, HEE is planning to continue to increase medicine each year and to increase nursing by about 260 places a year, which will give us another 20,000 by 2020. For the moment, the workforce is relatively stable in its composition, but it will need to become more dependent on assistants and lower grades as demand increases.

Baroness Blackstone: There seems to be a bit of a contradiction in what you are saying. On the one hand, you are saying that you need more lower-level skills in the NHS, to take some of the work away from people with higher-level skills. However, at the same time, you are saying that you also need more nurses and that you are not changing the medical manpower numbers. What you seem to be saying is that NHS manpower will simply go on growing. If that is true, what impact does it have on the current cost problems?

Gavin Larner: How it grows after 2020-21 depends on the resources that are put into the system and what we can afford. What I am saying is that, for now, the pattern in the five year forward view is for the overall

workforce to stay fairly stable in size, but for there to be an increase in the number of nurses, the number of consultants and the number of doctors in general practice. Beyond that, the planning-out work that I mentioned earlier—the 15-year forward view and the 2035 forward view—needs to inform HEE commissioning over the next two, three or four years, to grow the numbers that we need for the 2020s and the 2030s. At the same time, there is a piece of work about continuing professional development of the existing stock of people we have and how we adapt them to the new challenges that we face.

Q11 **Lord Willis of Knaresborough**: I have been quite impressed—I am not always negative—by what HEE is attempting to do, in looking forward to 2035. I declare an interest here, having produced the work on nursing assistants. It is the devil's job to get any change at all within the silo-laden protectionism of the professional groups within the NHS. It was absolutely horrendous simply to get in that one change and to classify it not as lower-cost staff but as staff doing a more appropriate job. First, what you are going to do to attack the real challenges within junior doctors and the consultant workforce, for example, of having greater generic specialisms, rather than simply more and more of the same? Secondly, what are you doing about the huge issue of attrition? We lose about 25% of our nurses during their training and another 25% in their first three years on the wards. We cannot afford to do that. What plans are in place to deal with those two massive workforce issues?

Gavin Larner: On the last point, NHS Improvement is currently reviewing turnover, retention and attrition. NHS Employers is also working on that. We are hoping for the outcome of that in the autumn, to give a sense of what short-term things you can practically do.

Lord Willis of Knaresborough: Could we have that? I think that it is important.

Gavin Larner: I can certainly give you an update on where they have got to so far.

The first question was about the slow nature of the change in the skill mix. I agree that there are strong culturally conservative parts of our healthcare system, where the different professional tribes see particular ways of delivering services. That is not necessarily always a self-regarding thing—it can be a genuine concern about what they feel is the best place to deliver the safest care. There is a lot of work to be done, partly on new models of care, in some of the vanguard stuff that is going on in the five year forward view, to put in charge the leadership that can build trust with clinicians—particularly senior doctors, who are often the enabler, the "vetoer" or the enthusiast for change—so that they really give these things a go. Alongside the technical, technocratic stuff of commissioning numbers of places and designing new roles, there is a leadership and culture shift piece that is probably more difficult. We need to talk about that a lot more and to support leaders in pushing it. It is particularly powerful when professionals themselves step out of their

particular cultural places in the name of the higher calling of patient care to do new and interesting things.

The Chairman: So there is a lot of thinking but no action as yet.

Gavin Larner: There is quite a lot of work going on in Health Education England about the roles themselves and commissioning new roles and a new skill mix. What is difficult is for leaders and staff who are dealing with the pressure of how to create the headroom to do the change that will help us to move forward on this.

Q12 **Lord Warner**: May I come back to the issue of the capability of the system to deliver what you may want? I appreciate that you have been here for only four weeks, so I will be very gentle about this. Somewhere in the system—whether it is by you, Health Education England or whoever—presumably some work must be being done on whether there will be the capacity in the training schools, the educational institutions and the practice placements to deliver more people. It is no good saying, "We need X thousand more nurses", or whatever. What work is being done on the capacity of the system to deliver that?

Gavin Larner: I will need to check back on medicine, because I have not delved into that area yet. With the current work to reform the funding of nursing education and allied health professional education, we are talking to Universities UK and HEFCE about how we can get the high-quality placements that we need to allow expansion of 10,000 places by the end of the Parliament. All that I can say at the moment is that those discussions are going on. We will publish proposals in the autumn about how we think that will work.

Lord Warner: Is there a financial risk problem associated with that? Who takes the risk?

Gavin Larner: There is a discussion about how that is shared across the system.

Baroness Blackstone: Following up what Lord Warner and Lord Willis have just asked you about, is anybody thinking more radically about existing roles and whether they are all fit for purpose? About half of our medical workforce are GPs. It is not clear to me whether, in the longer term, the current role of GPs will be the right one for the kind of system that we need. Who is thinking about that? If you are not doing it in the Department of Health, who is doing it elsewhere? Can you tell the Committee a bit about that?

Gavin Larner: There has been a bit of thinking in think tank-land. The Health Foundation, the Nuffield Trust and the King's Fund have all touched on this area. In the past, the Royal College of Physicians' future hospital report looked at it a bit, as did Greenaway.

The Chairman: They are think tanks. They are not official government bodies. Baroness Blackstone is asking who is doing the thinking.

Gavin Larner: Strategically, within the system, it would sit with Health Education England to do that thinking. However, it is legitimate to say that there needs to be a conversation around the system, in the light of the 15-year strategy and the 2035 strategy that I keep mentioning, about what that means for medicine and whether we can start to think a bit harder about what we recommission.

Lord Mawhinney: You have been extremely gracious in saying, when you did not know the answer, that you would write to us briefly. In the next week or 10 days, would you write to us with the names of three or four people in the department—or in government—who are thinking about this, so that we can see what they are thinking?

Gavin Larner: Certainly.

The Chairman: We could get evidence from them.

Dr Edward Scully: In one niche area, Ministers in the department have commissioned Health Education England and Skills for Care to go away and do a strategic piece of work, to think about the workforce requirements for a better-integrated system. There are three areas they have focused on, in talking to me. The first is capacity and numbers, particularly around those groups that straddle both health and social care. I am thinking particularly about OTs and care workers. The second area is what we call co-ordination. You have touched on new roles. They have been commissioned to look at what new roles may be required. I am thinking particularly about new emergency roles—care co-ordinators, care navigators and the various different names that we have seen emerge in pioneers and vanguards. The third area is culture. They have been asked to go away and think about what the different issues are if you have two systems that have existed in very separate places—Lord Willis touched on the fact that you have a lot of professional silos—and what is required with regard to leadership and culture to start to get the two to operate in a proper multidisciplinary fashion.

The Chairman: I will take a quick question from Lord Ribeiro and then move on to Lord Lipsey.

Lord Ribeiro: You have talked a lot about roles, et cetera, but there is the question of the gender and feminisation of the workforce. Not only is there a demand for work/life balance, which affects males as well as females, but it is quite clear that there will be far more job sharing and part-time working. That will have an implication for staffing costs. Is there any long-term modelling on that?

Gavin Larner: I will need to check back.

The Chairman: That is another one you will have to write to us about.

Gavin Larner: I am sorry.

Q13 **Lord Lipsey**: We have not been able to resist touching on social care and health integration already, slightly ahead of the agenda, but I would like

to ask two specific questions. As soon as you start thinking about this subject, it is pretty obvious that integrating the two is very difficult unless you have integrated budgets. I first wrote that in 1999, in the minority report of the Royal Commission on Long-Term Care. Could you tell us where we are now on integrating local authority and health inputs into budgets?

Dr Edward Scully: Yes, of course. As Graham touched on before, the better care fund was initiated last year. That was the first national step to try to bring them together formally. The initial pooling amount was £3.8 billion for 2015-16, but local areas went above and beyond that, to £5.3 billion, which showed that there was appetite for it. In the next week or two, we will announce that we believe that the amount for the better care fund and pooled budgets will go up to £6 billion this year. We think it has been shown that there is some appetite for that.

As you know, the Government are trying to bring together a number of different pieces of advice on health and social care integration. As I see it, there are three different layers and three different ways of integrating. You can integrate at the person level, at the commissioning level and at the provider level. The better care fund is geared to trying to integrate at the commissioner level, to try to bring about better strategic alignment. As Graham touched on before, it is about relationships, but it goes beyond that—it is about how you start to get people to walk in one another's shoes. Our early informal feedback on the better care fund was that, while some areas—particularly advanced ones—said that it had held them back a bit, because there was quite a bit of bureaucracy, there were a number of areas where the chief executives of the different organisations had never even spoken to each other. We found that the better care fund brought people together to start that strategic alignment.

On integrating at the provider level, I have mentioned the vanguards. My personal belief is that that is one of the most effective ways forward. Integrating the budgets and the commissioner level is a means to an end, because the way in which people experience better joined-up services is through joined-up services at the provider level.

I have two more points. Your question was specifically about budgets and commissioning. In the last six months, we have changed the regulations to enable GPs to access the better care fund from this year. We are also going to undertake further exploratory policy work and to consult on whether the secondary regulations that enable the better care fund and pooled budgets are still fit for purpose, because of feedback that we have had. Greater Manchester, for example, is using Section 75 for the Greater Manchester integration, but it was not designed for something on that scale. We think that we need to look at it again to see what changes we may need to make to enable integration on a greater scale.

Lord Lipsey: The second question that I want to ask is this. Better integration is used practically as the magic wand to solve the health service's sustainability problem. I was therefore very struck to read the

report by the National Audit Office, which casts grave doubts on whether you will be able to save a lot of money in that way. Do you have any comment to make on the NAO report, or do you accept its findings?

Dr Edward Scully: My own take is that the potential for savings through integration of health and social care is not what people have set out; it is more limited. It is not a utopia or a panacea for releasing savings. We have done some internal work and believe that it could release savings in the region of £300 million to £500 million a year.

Lord Turnberg: I wonder whether there has been any follow-up on the Dalton report, in which Sir David Dalton produced a summary of examples around the country where services have been integrated in different ways. He, of course, has done it quite successfully in Salford. Where has that movement got to now? Is it spreading? These are local initiatives.

Dr Edward Scully: They are spreading. That is part of the point of the five-year forward view vanguards, of which Salford is one. The difficulty with the vanguards is separating it out. Not all the vanguards cover integration of health and social care; only a much more limited subsection of the 50 do. For the primary and acute care system model, you have Salford. Northumberland is another good example. There is the Symphony project in South Somerset. Some of the multi-specialty community provider models also integrate: Stockport Together is one of them. There is spread.

My own take, from going around the country and visiting areas such as Cornwall, Greenwich and South Warwickshire, is that it is happening, but it is incredibly dependent on local leadership. Wherever I see a big, successful project that is well done, I encounter dynamic leaders who are almost social entrepreneurs—who spot where the gaps are and how they can improve things. That is my take. It is spreading, and the vanguard and pioneers programmes are there to drive it. We are also trying to drive it through the better care fund. It is spreading, but there is still a fair way to go.

Lord Turnberg: It is local leadership that we need.

Dr Edward Scully: It is local leadership. There are a number of factors. I do not know whether you want me to go into them, as I know that this is question 5 and I may be going off the point. There is a paradoxical factor around organisations. It is stating the obvious, but you have completely different organisational structures and different access and entitlements. There is a lack of coterminosity. On the one hand, we see that the structural issues are really important. On the other, we are being told by areas, "Please do not reorganise again, whatever you do". It is about taking on board and understanding that, although it is difficult because of the structural issues, from the bottom up we are hearing, "Do not reorganise".

One thing that is worth dropping in here is the sustainability and transformation plan process, which is a genuine attempt to go for place-based commissioning. That is why it is trying to involve the local NHS plus social care plus public health, to bring them all together to plan on a five-year, more strategic basis.

Q14 **Lord Bradley**: I have two questions. One is on the short term. Do you think that, through those initiatives—the better care fund and the transformation fund—enough money is being put in to allow that change to take place in a timely way, sometimes with double running of services, so that an alternative, community-based service that the public will have confidence in is in place before a service is shifted out of the acute sector? Do you not see a continued tension between the acute sector not wanting to give up some of its financial control over local health economies and shifting that money into the community? To extend that further, while we have been slightly depressed by the short-term thinking of the Department of Health, where you do think you want to get to? What is the strategic planning for the balance between hospital-based and community-based care over the next 15 to 20 years?

The Chairman: The emphasis being on the next 15 to 20 years.

Dr Edward Scully: On the transformation of funding, I know that some areas have managed to do a bit of double running. In an ideal world, you would double-run when trying to change the configuration of provision of services in local areas. It is always a challenge for areas. You have touched on the transformation of funding for vanguard areas. One of them, in Manchester, got £450 million over the period to help with that.

Lord Bradley: Over the five years?

Dr Edward Scully: Over the five years. That is obviously a massive help. In an ideal world, you would want that.

Your third question was about the longer-term plan. Last year, the spending review set out a commitment to drive better health and social integration and for areas to have plans in 2017 for how they will integrate more fully by 2020. It is still the Government's intention to fulfil that SR commitment. There is a lot of work going on at the moment between departments—DCLG, the Treasury and the Department of Health, working with NHS England—on how that is done. That is still in policy development. Unfortunately, I cannot talk too much about it, because it is still being worked up. We are consulting the Local Government Association, ADASS and NHS colleagues on making that a reality.

Could you remind me of your second question?

The Chairman: I think you have covered part of it.

Q15 **Baroness Redfern**: I have a very quick question. You have talked about pooled budgets, working with partners, et cetera. How far have we come with sharing data? There has always been a nervousness about confidentiality and sharing data. I wonder whether you can give us some

evidence on how we can integrate and share data.

Dr Edward Scully: Tim is the expert, so I will hand over to him on this.

Tim Donohoe: This has long been recognised as one of the areas in which we need to make progress. Our national data guardian, Dame Fiona Caldicott, reported a few days ago. What she has proposed is intended to help people across the system understand what their responsibilities are to protect information and to make it much simpler for people to share information for legitimate purposes, when necessary. That will be one of the key underpinning changes. A period of consultation has now started on that, to give people a chance to comment on the opt-out model that is being proposed. That will form the basis on which we then test a model that is acceptable and simple enough for people to understand, so that people can feel that their data are being used for what they see as legitimate purposes and they are not surprised to find their data being used in a particular way.

Dame Fiona's report shows that, by and large, people have confidence in the NHS to protect their data. Data breaches, when they occur, are seen as undermining that trust. The other angle of what Dame Fiona is proposing is very much to make this a leadership issue. This is something that leaders of organisations have to take as seriously as they take financial accountability and accountability for outcomes. It should become part of the CQC inspection regime going forward. That is slightly the negative side of it. The key point is the potential to use the data to improve outcomes at individual patient level and to integrate services. The data in and of themselves are not of use—it is about what you do with it to plan service and population health. That is what we hope Dame Fiona's report will unlock.

Lord Mawhinney: Dr Scully, you have told us about plans better to integrate health and social care and that by 2020 they ought to be reasonably well integrated. I think that that is a fair reflection of what you said.

Dr Edward Scully: Yes.

Lord Mawhinney: Although it is only for the next five years, of course. We are constantly bombarded with anecdotal and factual evidence that—if they are lucky—frail, elderly people at home may get two visits a day, each of 25 minutes, from a care worker. In 2020, with this newly integrated health and social care system, how many visits can frail, elderly people at home expect to receive, and of what length?

Dr Edward Scully: It is impossible to specify how many there will be and of what length. You hear stories where an NHS person goes in to treat one part of a person and someone from social care also goes in to see them. The belief is that, if you bring the two systems together, you can release some allocative and technical efficiencies. By doing that, hopefully you should be able to invest more time in people. That is the thinking behind this.

Lord Mawhinney: If you will forgive me for saying so, that is just not acceptable. It is absolutely not impressive. One of the things that has characterised the last hour and a half has been that you are very good at plans, reviews and thinking—though not at strategy—and the patients are not getting a mention. When I ask about a patient, there are blank looks. Your body language is quite clear. Just as the deputy director for care in the Department for Communities and Local Government thought that I did not know that health was responsible for absolutely everything, you think that it is unreasonable of me to ask, from a patient point of view, what the advantage will be of this integrated system, which goes only up to 2020.

Dr Edward Scully: I do not think it is at all unreasonable for you to say—

Lord Mawhinney: When will you be able to answer it?

Dr Edward Scully: There are two points. First, it is not unreasonable. The whole point of the integrated care agenda is to improve care for people, so that they do not go from pillar to post in different parts of the system and they get a proper, decent service, co-ordinated care and a proper care plan. That is the whole point of it, and that is what we have worked for. For the last two years, I have been doing that. It is not at all unreasonable of you, but I can guarantee that that is our whole focus. If anything, my experience of working on the integrated care agenda for two years has made me believe—the evidence shows this—that better integrated care, when you start to make one service, will lead to a much better patient experience and much better outcomes, but not necessarily to massive efficiencies. You will get some technical and allocative efficiencies, but not massive ones.

I did not think that it was unreasonable. All that I was trying to get across was that it is quite hard to specify the exact implication in five years' time of different resource levels. That is partly because, at the moment, social care is run by local government. There is a single set of eligibility criteria, but there is still some difference between how services are provided by different local authorities. I do not want to give you an answer that will not be true and that I do not think I can give.

Lord Mawhinney: The Department of Health is responsible for everything in this area. I think that I am right in saying that I was the Minister—or one of the Ministers—responsible for the introduction of community care 25 years ago. Mr Duncan tells us that it is still on a journey and has not yet got to the end of that, so we do not know what the outcome is going to be. Is your integrated care on a 30-year journey? If it is, you need to be careful, otherwise you will have to do some long-term thinking.

Dr Edward Scully: I can assure you that we have done some long-term thinking around the integrated care agenda. That is why we have done the basis of whether we think that we have released enough efficiencies.

Baroness Redfern: It worked well when public health came into local authorities. That was really good and that was moved on very quickly.

Dr Edward Scully: I totally agree with that.

Q16 **Lord Scriven**: May I ask about disruptive technology, digitisation and data, which are affecting every industry and how humans work with organisations? Where is the NHS with digitisation? Could you give me a percentage of services, rather than just what is happening? Where are we with integration of data, either around personalisation within health or—one question has already been asked about this—across different organisations? What percentage is really integrated? What are the issues?

Tim Donohoe: We think about it in this way. First and foremost, are the technologies in place at individual organisational level? Beyond that, are they being used to deliver services? Beyond that, the third level is whether those services are integrated and the technology is serving that integration. When you look across health and social care, you see a mixed picture. For example, something in excess of 98% of GP practices use an electronic system for patient records and in the administration of their practice. You can look at some of the national services—things like the summary care record. A very high percentage of patients now have a record. Those are starting to become available across different care settings. Forgive me, as I do not have all the percentages in front of me. However, I can certainly let you have the current figures.

The area where there is much to be done is in the digital maturity of the provider sector—the extent to which systems are in place and are being used within individual organisations—and in integration at local level, so that local care teams have a single view of a patient and know what is happening across all the different organisations involved in that patient's treatment. Over time, we have seen a swing in policy. At one time, we saw a drive to centralisation, which was seen as a top-down attempt to impose standards and technologies on the system. We have seen very local initiatives. The downside of the very local is that they do not tend to spread beyond the areas in which they are initiated. Where we are now is that the department has taken a slightly different view of how this will—

The Chairman: Mr Donohoe, answer the question that Lord Scriven asked. You are not answering. You are giving us what the thinking is, as all of you have done for most of the morning. Can you say where you wish to be in, say, 2025? Where do you expect to be? What are the steps from now until then that you can take to achieve that?

Tim Donohoe: There is a whole programme in place. With respect, I am trying to answer the question. I am trying to set out everything that is currently in train as a result of what we have learned over the past decade about what works and what does not work. The department has created a National Information Board, which brings together stakeholders from across the system. That group has taken some of the challenges set out in the five year forward view and tried to look at the technologies that will permit a different approach to service delivery.

In the question, you asked about disruption. Technology can disrupt in two ways. It can disrupt in an adverse way—we have seen lots of that in the past—and it can disrupt in a very positive way, because of the transformation that it makes possible.

Lord Scriven: Yes, but in the NHS it tends to be disruptive technology, because of lack of planning from the centre. What I am trying to get at is this. Clearly, this will be a huge step change in the way in which health and social care are provided, because it is happening across cultures. I am not clear about what the plan is over the next 10 to 15 years to implement this successfully. What is in place? What planning is there? You keep coming back to local leadership, so it is not just about what you do at national level. What is there to increase capacity down at local level to implement this in a way that is clever and smart, as well as integrated?

Tim Donohoe: You are absolutely right to emphasise the local aspect. In the National Information Board, we have tried to bring local stakeholders and people who are succeeding at local level in integrating information and services right into the heart of what we are trying to do over the next decade. Right now, there is a programme of investment that leads to 2020. That will put in place the ability for the system to become much more digitally mature in general. Within that set of initiatives, there are specific things around integration of social care, for example, which we have discussed already. There are things about making sure that local leadership teams are sufficiently skilled and sufficiently aware of what technology can do, so that they see technologies not just as projects for implementing technology, but as change processes, and have a clear view of the outcomes we are trying to get to.

Lord Scriven: You have raised a really important issue—that it is not just about the technology. What incentives or changes in payments are being put in place to encourage this kind of working?

Tim Donohoe: Right now, the focus is on making sure that the technologies are in place and helping to make funding available to local organisations, so that they can select and choose the technologies. Each local area has been asked to put together a digital road map, which essentially sets out—

Lord Scriven: Can I ask the question again? What planning is going on to incentivise the use of this type of work that proves to be successful, at scale?

Tim Donohoe: I cannot answer specifically around incentivisation.

Dr Edward Scully: I do not believe that there is specific incentivisation of ways—

Lord Scriven: So good practice could happen, but there is no incentive for it to be taken at scale across the NHS. Is that what you saying?

Dr Edward Scully: It will try to drive the spread of good practice in other ways, but not necessarily through incentivisation. With the new care models, I know that there is a National Information Board team whose specific role is to go out to local areas to try to spread best practice.

Lord Scriven: What percentage of services are digitised now? In forward planning for 2020 and 2020-plus, what assumptions are there? What will need to be put in place to do that?

Tim Donohoe: It is very hard to give an answer on a service-by-service level. There are services that are offered. We can be very clear about the extent to which those services are being taken up. There are the things that I have mentioned, such as the summary care record. At local level, we do not have a clear picture. NHS England has done the first iteration of something called the digital maturity index, which sampled acute providers and asked them to self-assess the extent to which their services were being offered and technology was being utilised in the delivery of those services. Again, that showed a very mixed picture. The results were published on the "My NHS" website a few weeks ago. If it would be helpful, we could try to summarise those and give you a written response.

Lord Warner: Who is in charge of all this? I have heard many of the same answers that you have given from NHS England staff. Do we have two lines of command and control?

Tim Donohoe: No, absolutely not.

Lord Warner: Explain the difference.

Tim Donohoe: The department's role here is to steward the system. In this context, that means that we have within NHS England a recently appointed CCIO, Professor Keith McNeil, who will be responsible, on behalf of the whole health and social care system, for commissioning the technologies, the services and the enablers that we believe the system needs. Most of that will be delivered by what was formerly known as the Health and Social Care Information Centre and is now called NHS Digital. The department's role is a strategic one. It is overseeing that and assuring the delivery, to make sure that the things that are being funded are being delivered.

Lord Warner: Can I stop you? I have heard some of these people. They are rather impressive. Why do we need you?

Tim Donohoe: The system that we have designed needs someone to oversee it. It needs to be clear. If things are not working in the system for any reason, which we have seen in the past, part of the function of the department will be to look at those arrangements over time, to make sure that they are working. When it comes to hands-on delivery, we are trying to make sure that the people who are best able to do that are

given every chance to succeed and to deliver what we think will help the system.

Lord Scriven: *Making IT Work* is a report that was meant to be published in June 2016. That is when it was meant to be published.

Tim Donohoe: Yes—Professor Wachter's review.

Lord Scriven: Where are we with that? That is exactly the work that you should be doing, which is about the first base—getting the right IT in place. Why has it not been published yet? What are the issues?

Tim Donohoe: My understanding is that Professor Wachter's report will be published in September.

Lord Scriven: So it is late.

Tim Donohoe: Yes—partly because of the referendum, but partly because there was a need to do some further work in a couple of areas.

The Chairman: So, hopefully, by September we will get a report from you on that. We have been informed of how important disease-based informatics will be to getting better outcomes for the patient, reducing cost in health and social care and increasing productivity in both health and social care. Will NHS Digital be responsible for driving that informatics?

Tim Donohoe: NHS Digital is essentially responsible for delivery. That may mean that, on occasion, it will directly build and supply technologies, but it also means that it will procure technologies on behalf of the system, where necessary, or administer the funding that has been put out to the system to enable it to supply its own technology.

The Chairman: My question is about long-term thinking. Is that being done now? Will it be done—or may it be done?

Tim Donohoe: We have done some initial work within the department on the period beyond 2025. As Professor McNeil has taken up the post—

The Chairman: Why is it that, when the evidence has been available for several years on how such information can improve outcomes, reduce costs and increase productivity, you are just beginning to think about doing some thinking?

Tim Donohoe: That is a rather unfair characterisation, if I may say so. The thinking has been going on. Over the last year or so, the effort has gone into the immediate pressures of responding to the five year forward view, building on some of the technologies that we could see working and making a difference out in the service, and trying to plan that at national level, to ensure that we have a coherent delivery that is not another major IT programme, but a series of targeted interventions that are specifically grouped around some of the transformations that we need to see in the system. Many of these technologies will remain and have a

long-term relevance. On population health, integrated datasets will permit the kind of analysis you are referring to. That is what we are trying to achieve with this.

Q17 **Lord Turnberg**: Everyone agrees that public health and prevention are very important. It is one of the most difficult areas in which to work and to demonstrate that we are doing anything good, apart from in a few small areas. The question is: what is the long-term strategy for public health and prevention, particularly given that it is so dependent on the public themselves? How do we get them engaged in the long term? Have Ministers asked you to develop a long-term strategy?

Mark Davies: As a director of population health, I will answer that. Our long-term strategy has three elements to it. You are seeing some of them being implemented as we speak. Baroness Redfern referred to the move of public health into local government. That has happened. It is still in transition, but, by and large, it is seen as a positive move. It gives leadership to local government and allows it to work across all responsibilities and to look at health in all policies. At the same time, we have developed Public Health England as the delivery vehicle that provides the evidence and supports local government. We have also given NHS England a key role, through Section 7A of the legislation, which allows us to commission it to do really important work on immunisation, vaccination and screening. That seems to be working very well at the moment.

The third element is what we are doing about particular issues and looking forward at some of the biggest killers across the health and care system. We are quite proud as a nation that, effectively, we lead the world on smoking and tobacco control. We have done an enormous amount of work there. All this is subject to political considerations, but we are planning to do a further tobacco control plan, which will push beyond the work that we have done on plain packaging, smoking in cars and those sorts of things. We have got the level of smoking down to 18% of the population, which is one of the best in the world, but we still have 8 million people smoking. We think that that leads to about 80,000 deaths per year. There is a huge opportunity to address that and that is what we are planning to do.

The other area—the second biggest cause of death—is obesity, which is a developing problem. We have been working for many months on a childhood obesity strategy. There is a lot of anticipation about that piece of work. We have one prepared. It has been announced that it will be launched in the summer, but we are still waiting to press the button on it. If and when it is published, we hope that it will be a really cross-sectoral look at all aspects of childhood obesity and all the things that drive it, including behaviour, family attitude, promotion, reformulation of food and what happens in school. We are working on a comprehensive strategy. It is a long-term strategy. If we get it right, it will have intergenerational impact and will stretch way beyond the next five or 10 years.

As part of the five year forward view, NHS England has done an important piece of work on diabetes prevention, looking at the needs of adults at risk of diabetes. That programme is starting to roll out. I see it as a long-term programme. What we do now will impact on adults' need for services in 15, 20 or 30 years' time.

There are three elements: shifting responsibility to different parts of the system and making it clearer; putting the national organisations in the lead of various elements of it; and thinking about the biggest killers. That is our long-term strategy.

Lord Turnberg: It sounds as if we are just carrying on with what we know now. Has there been any thinking about looking at how we might begin screening populations? As we develop genetic tests, might detecting genetic predispositions to diseases come into your planning for the future, along with how we detect disease early, before it is symptomatic, and how we prevent it? Will you ever take folic acid supplementation of the diet on to your agenda? There are big issues of dementia and early detection. There are all sorts of techniques coming along. How far are you taking those into account in your planning for the future, quite apart from the ones we know about?

Mark Davies: The good thing about the public health world is that we are blessed with good evidence and people doing a lot of thinking about this work. We have our vaccination and immunisation programme. We should be proud as a nation that that is informed by the best evidence from the Joint Committee on Vaccination and Immunisation. Genomics England is doing the work on sequencing the human genome. That is slightly out of my knowledge area.

Lord Turnberg: It is the sort of thing it is doing that you might take into account in developing a plan for the future.

Mark Davies: Of course. In a sense, that is why one of the key functions of Public Health England is to bring together that evidence and to be objective about the way in which it is presented. We look to Public Health England to advise both us and NHS England on exactly that. I am confident that that work is taking place within Public Health England.

Dementia is a relatively rapidly developing area of knowledge. We know that we are starting to find ways of addressing and preventing dementia, but that is all in development. We need to find a way—that is what we ask Public Health England to do—of putting it into the mainstream, so that we can apply it nationally and across all areas.

The Chairman: I am well aware that we have gone slightly over time, but we started slightly late. I see that there is still passion to ask you some very relevant questions, because we will not get you again.

Q18 **Bishop of Carlisle**: On the question of prevention, can I take you back to what you said earlier about workforce? If we are going to take prevention much more seriously, are there any implications for the make-

up of the workforce—for instance, the employment of health visitors, whom you have not mentioned thus far?

The Chairman: Please keep the answers short—yes, no, maybe or absolutely.

Mark Davies: I am sure that the answer is yes, but that is probably not enough. It is more about what the workforce does. In deploying the workforce to help people to make beneficial changes to their behaviour, the form of words that we use is "making every contact count". That is about the workforce being more adept at spotting the opportunities to intervene. For example, the health check that all people over a certain age are invited to do now includes an alcohol element because, opportunistically, you can ask questions about people's alcohol consumption, which has an important impact on their future. It is a workforce issue, but it is not about the type of workforce—it is about what the workforce does.

Lord Scriven: In answer to Lord Warner's question earlier, you said that your role was to oversee the system when it was not working well. There is a real example of where the system is not working at the moment. That is on PrEP for HIV, where different parts of the system are arguing. I do not want you to take PrEP, because I understand there are legal issues involved, but I want to use it as an example. Given that people in the system are arguing about who is responsible for PrEP and we want to move to prevention, what work will you do in the long term to make sure that we do not get another PrEP situation, so that we are working together for prevention, rather than arguing about who will pay for it?

Mark Davies: I believe that the PrEP issue will be resolved—

Lord Scriven: I want to use that as an example of the wider system.

Mark Davies: I am relatively new to this area of the system, but I have not observed many cases where we dispute who is responsible. NHS England has taken a particular view on PrEP, which has been challenged. Mostly, these things are resolved. It is not really an issue. This one is a particular issue. I am quite new to it, but I assume that it will be resolved in the courts tomorrow.

Lord Scriven: So everybody at local level is working towards prevention.

Mark Davies: I cannot say that everyone at local level is doing that. From the way in which the national organisations work and the way in which we get intelligence from the local level, I think that there is a good focus on prevention. We are still looking at, and kicking the tyres on, the sustainability and transformation plans. However, as I mentioned earlier, they seem to be showing that most areas—43 out of 44—have prevention as one of their highest priorities. That suggests to me that, locally, people are really starting to think about this.

Lord Bradley: I am disappointed that, in your list of initiatives, not one related to mental health. The five year forward view estimated that that

costs £100 billion a year as the cost to the whole of the NHS. Comment.

Mark Davies: We have focused mostly on physical health, so that is fair comment. We know less about the behaviours that cause subsequent mental health problems. As was observed previously, I used to be responsible for mental health policy. I helped to implement the IAPT programme and the former National Service Framework for Mental Health. It is less clear what we can do to intervene early to prevent mental health problems. That is an important area for research and investigation. We follow the evidence. The evidence shows that, if you tackle smoking and obesity, you will tackle a significant amount of future disease.

Lord Bradley: So you are arguing for further investment in research into mental health.

Mark Davies: I think that you have identified a gap, Lord Bradley. That is all that I would say.

Q19 **Baroness Blackstone**: I want to come back to obesity. I think I am right in saying that the UK has one of the worst records on grossly obese people. We are close to the top of the league table for the number of people who are hugely overweight. You have not said anything about the food industry. For a very long time, the Government refused to move, but recently they have made some move towards the taxation of food companies that provide food, or particularly drink, that is hugely over-sugared. Do you think that the Government have gone far enough in that respect and that what they have done so far will have any impact?

Mark Davies: We have not published our strategy yet. As the director responsible for the development of the strategy—

The Chairman: When will that strategy appear?

Mark Davies: I do not know. We were planning it, but obviously there have been some changes.

The Chairman: You have been promising this strategy for a long time.

Mark Davies: It was delayed by the referendum, as many things were. That is the case. It is ready. We are hoping to publish it—

The Chairman: What does the referendum have to do with a national strategy on obesity?

Mark Davies: There are European elements to it. Some of the nutrition legislation is founded on European legislation. These are the rules that we have to follow as government officials, I am afraid. We do not make them—we just slavishly observe them. It is up to the politicians to decide when to publish the childhood obesity strategy.

Baroness Blackstone: It is not just up to the politicians. It is also up to the NHS and the Department of Health, which has politicians in it, to reach agreement with their colleagues in other departments.

Mark Davies: Of course.

Baroness Blackstone: It is also up to you and NHS England to have a tougher strategy on the sale of some of these products all over the NHS. You can see them all over our hospitals.

Mark Davies: Indeed. You will find that Simon Stevens has made a commitment to remove unhealthy foods from hospitals. That is something that we want NHS England to pursue rigorously.

You mentioned the food industry. The Chancellor has announced what is known as the soft drinks industry levy—the sugar tax—which will be introduced from 2018. We hope to consult on how that will work very soon. It is a good sign of the importance that the Government place on the need to address unnecessary sugar in food. The childhood obesity strategy, should it be published, addresses the whole range of issues relating to food and the food industry.

Lord Ribeiro: Aside from the fact that we are spending nearly £13 billion on obesity, smoking, inactivity and alcohol, what are you doing to shine a mirror on patients and to ask them who is responsible for their health?

Mark Davies: That is always a challenging one, is it not? We are very clear about our position on smoking. We tax it. We seem to be allowed to tax tobacco as much as we like. We are very clear about regulating things such as where people smoke and how they buy cigarettes. We could not be clearer on tobacco in society.

Alcohol is slightly more difficult, but some really positive work is being done by alcohol-funded initiatives such as Drinkaware, which is very clear about safe drinking. The Chief Medical Officer's guidelines on alcohol are changing as well. We are about to publish the follow-up to the consultation on that, we hope. The guidelines are influential as regards how people perceive their own drinking. Again, we are doing quite a lot on that.

The inactivity issue is more of a challenge, because this is how people live their lives. There is a limit to how far the Government can—

Lord Ribeiro: It is about taking responsibility and making sure that they are aware that they have a responsibility.

Mark Davies: It is, yes. We have made lots of improvements in the way we address alcohol, through the Chief Medical Officer and the messages that the industry puts out, and people's alcohol use, through things like the health checks. The other thing that you may have noticed, which launched earlier this year, is a programme run by Public Health England called One You. It is aimed at unfortunate people like me who have hit middle years, do not do enough exercise and probably have a slightly unhealthy lifestyle.

Q20 **Lord Warner**: Can I bring you back to the money? I have quite good contacts in public health. All the messages that I have been picking up

from Public Health England and from the public health people in local government are that, when budgets are tight and there is overspending in prospect, people come calling and cut their budgets. Do we need to be a bit more rigorous about protecting public health budgets nationally and locally?

Mark Davies: The public health budget to local authorities is ring-fenced. Although it has reduced slightly over the last few years, the evidence that we have is that this year local authorities are planning to spend slightly more than the grant, by a small amount. The grant for local authorities is £3.4 billion this year. The plans that we have seen for 2016-17 show planned spending of £3.5 billion, which is a small increase. It is tough, but I do not think that the evidence shows that people are necessarily going straight for public health as the soft option. Only a very small number of local authorities are reducing their spend this year over last. The majority are either keeping it level or increasing it. The evidence is still emerging. It is quite a new set of responsibilities, but I do not get the feeling that this is the place where people are going first.

Lord Warner: Public Health England had £200 million taken out of its budget.

Mark Davies: Indeed. That was a one-off. It will not be repeated, as far as we know. Actually, local authorities seem to have coped with that. I have every admiration for local government in the way it copes with spending.

Baroness Redfern: It has given local authorities more flexibility to use that budget. On mental health, we are doing different things, such as walking. That does not cost a lot of money, but it helps to focus on new ideas and where we can work collaboratively with health.

Q21 **The Chairman**: As I said at the outset, the focus of the inquiry is long-term sustainability, which requires thinking to be done in the long term, as well as looking at the evidence of what developments in healthcare may be coming down the line and how they will impact on delivery and cost, and how you can make the whole system work in the most cost-effective way, based on cost-benefit analysis. From what you have told us today, it appears that there is not such thinking being done in the long term. Do you look at other health systems and how they do their long-term thinking? Is there learning from there?

Dr Edward Scully: From an integration point of view, we do.

The Chairman: Which countries?

Dr Edward Scully: We look at Spain and the United States. We look close to home as well. We have looked at Scotland. We have done visits in Scotland.

The Chairman: So you have some evidence of what you looked at and what you gained or did not gain from that. Have you come to some judgments?

Dr Edward Scully: Yes.

The Chairman: Are you able to send us that evidence?

Dr Edward Scully: I would be happy to. Some of the key bits around that are probably the various different meta-analyses of the evidence and the systematic reviews of both its effectiveness and what it does on outcomes.

The Chairman: No—I am talking about long-term thinking. Have you looked at other health systems and how they do long-term thinking about their healthcare, social care and preventive care systems?

Dr Edward Scully: We have not.

The Chairman: You have not.

Dr Edward Scully: We have looked at how they do it, all the things that they have done and how they have planned for it. However, we do not have access to their internal long-term planning, so I do not think that that is possible for the specific question of integration.

The Chairman: Surely how they do it cannot be a secret.

Dr Edward Scully: No, it is not a secret how they do it. We have their short-term and medium-term policy frameworks and their example. We do not have the work that they will have done internally about where they see themselves 20 years down the line. We just do not have that.

Mark Davies: On prevention, yes, indeed we do. We talk to other countries all the time and learn from them. On things like smoking, we are probably the leading country in the world, but we still learn from Australia, which was the first to do plain packaging, for example. On the sugary drinks tax, we have looked at what Mexico has done and we look at what France is planning. We are learning from all those countries.

The Chairman: You go on about that, but there are other areas. I explored one with you—informatics. You did not give me the confidence that you were looking at it.

Tim Donohoe: We are certainly talking to other countries. We have done a lot of work with the US on its future thinking around this area. The Wachter review is partly a result of that. I think that there is much more to be done. There is a huge opportunity here, but one of the things we have focused on this morning is slightly beyond the horizon we have been working in.

The Chairman: Thank you very much for coming today. We will send you the transcript of today's session very soon—not for you to change it, but so that you can let us know if there is any misinformation. I know that it has not been easy for you, but we are really trying to find out—to help you for the future—how we can have a system in place that can look at the long-term sustainability of the NHS.