HOUSE OF LORDS

Select Committee on the Long-term Sustainability of the NHS

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

Tuesday 19 July 2016

10.10 am

Watch the meeting

Members present: Lord Patel (Chairman); Lord Bradley; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 2 Heard in Public Questions 22 - 31

Witnesses

I: Nigel Edwards, Chief Executive, Nuffield Trust, Richard Murray, Director of Policy, The King's Fund, and Dr Jennifer Dixon, Chief Executive, The Health Foundation.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Nigel Edwards, Richard Murray and Dr Jennifer Dixon

Q22 **The Chairman**: Good morning to you all. Welcome. Thank you for coming to help us today with the inquiry that we are doing on NHS sustainability. I have two points. First, we are being broadcast. Any conversation that you may have in private—this applies to all of us—may well be picked up, so be careful what you say. The best thing is to avoid having private conversations. I will let you know when we are off the air. Secondly, a photographer is going around taking photographs of various Committees, so somebody may appear to take your picture. Please ignore him or her. They will go away pretty quickly.

Before we start, if you wish to introduce yourself or to make a statement, please do so. The procedure will be that each of us, in turn, will ask you questions that we have. We want to cover the full gamut of questions that we have for you, so I ask both the Committee and our panel of witnesses to be as short and clear as they possibly can. Who would like to start?

Nigel Edwards: I am Nigel Edwards. I am the chief executive of the Nuffield Trust, which is a health services research and policy think tank.

Richard Murray: I am Richard Murray. I am director of policy at the King's Fund. We are a think tank working in health and social care.

Dr Jennifer Dixon: Hello. I am Jennifer Dixon. I am the chief executive of the Health Foundation, which is an endowed foundation doing policy analysis and giving funds out to the service for quality improvement.

Q23 **The Chairman**: Thank you very much. Do any of you wish to make a statement? If not, that is good.

The first question is from me. We have statements on what the funding requirements for healthcare will be in the future. The OBR predicts that the figure will go from 6.2% of GDP to 8% in the mid-2060s. On the other hand, we have OECD projections that are quite different. What do you think needs to happen for the health system to be sustainable? I emphasise that this inquiry is interested only in a health system that is sustainable beyond 2025 and further into the future. We do not want to focus on the current issues in the health service. What do you feel needs to happen to make it sustainable in the long term?

Richard Murray: First, particularly over the longer term, with the ageing population and the demographic pressures we are under, you need to think about health and social care. It is already difficult to separate out the health service. It is no longer an island that stands alone from what is going on around social care. As the years go by—particularly as you throw out to those years into the future—you need to think about both at the same time.

Secondly, within the question there is a slightly unspoken assumption, which is that we mean a health service that looks something like the

health service of today—a comprehensive health service that is free at the point of use and in which people have confidence. In a very narrow way, you could make the health service sustainable simply by cutting the offer over time—by rolling it back and looking towards alternative sources of funding, such as charging. However, we rather assume that you do not mean that.

If you are thinking about the long term, there are not many alternatives to paying, over time, to raise the share of GDP that goes on health and social care in the light of demographic change. As you look over long periods of time across the OECD and, of course, within the United Kingdom, that is exactly what you see. There may be an ability to bring about reductions in health spending in the short term. If you look over longer periods, you find that those do not survive and do not work. We have seen experience in places such as Canada. Sweden brought down healthcare's share of GDP for a while, but, as the years go by, they go back to trend. If you are thinking about the very long term, in particular, there are not many alternatives but to pay. The question is: who pays? Is it the public sector, or is it private pay?

Nigel Edwards: There is the effect of ageing. Proximity to death is also a major predictor of health spending. We have been fortunate, in many ways, over the last four decades in that the death rate has been falling. It is now about to start rising inexorably, for the next 40 to 50 years, as the baby boomers come through. That means that, in addition to ageing, there will be complexity, because of the number of patients with comorbid conditions. That is a big driver.

Historically, new medicines and technologies have also been a significant driver. Healthcare is unusual in that the application of technology seems to increase costs. In most other sectors of the economy, technology reduces costs. Unfortunately—or fortunately, in many ways—the technology in healthcare has been additive. There is a big pipeline of very expensive biologicals and other treatments coming down the track. Historically, it has been very hard for policymakers, Governments and, indeed, insurers—in insurance-based systems—to say no to that pressure. If you add together the increasing complexity of the patients, the growth in the number of people who will die over the next five decades, the changes in the age structure and the increasing demands that will be made just because things are available, it will be very difficult to hold the line much below the historic trend, which has been about 4% growth in the UK. There may even be pressure to drive it above that.

Dr Jennifer Dixon: Funding is the big issue. Over the last 20 years, healthcare costs across OECD countries have outstripped GDP growth. Funding over that period—not just for health and social care, which Richard pointed to, but also for welfare spending—very much influences healthcare costs. There is a recent RAND study you may want to take a look at. It looked at 30 countries in the past, to see whether there is an association between social spending, health outcomes and health

spending. It found that there is, particularly in countries where there are greater inequalities in welfare and income distribution.

If you do not want to ration, very big changes in productivity are needed. We have a whole range of intelligent policies to this end at the moment, but they need to be seriously stepped up. That is one thing the Committee could really look at. It is an issue not just for the NHS in the UK but for health systems across the developed world. Everybody is chasing the same solutions. There is no one big-ticket item to increase productivity I can see across the OECD that we are not doing and others are.

The Chairman: To pick up the point about efficiency and productivity, is there any evidence that a different kind of funding system—social insurance, charging or whatever—improves efficiency in healthcare? Secondly, how do you increase productivity?

Nigel Edwards: I am not aware of any studies showing differences between funding systems. It is noticeable that Bismarck systems seem to have produced more doctors, because their finance ministries have been less keen on restraining the supply side. They tend to pay their doctors more. However, often, as in Germany, they have had quite long lengths of stay and relatively low admission thresholds. There is no immediate link between how you collect money and how efficiently it is disbursed. Because some social insurance systems have more supply, they are able to have more competitive environments. There is some evidence that competition in some bits of the system improves provider efficiency, but there are also dead-weight costs to having competition. It works quite well in certain sectors of the health system, such as diagnostics and elective surgery.

The technique that most systems have used to improve efficiency is payment systems that try to pay providers prospectively, generally using some sort of diagnosis-related group pricing system. We are probably reaching the limits of the ability of that type of system, on its own, to improve efficiency. That is partly because, generally, healthcare systems have been very slow to adopt the redesign and re-engineering approaches that we have seen in other industries. The job of health service administration and management has often stopped short of the clinical processes. It has managed the support services—the porters and the administration—and has helped the clinicians to do their jobs better, but it has not really applied the same sort of rigour to saying, "Could these processes and systems be done better?". That is partly because you probably need to have a very strong clinical background to be able to do that effectively. You almost need two sets of skills, which is quite rare. I think that we have missed a trick. You can send a pricing signal to the hospitals to say, "Please become more efficient", and set a price that says, "We need better efficiency". The missing bit of the equation is the hospital's own knowledge and ability to do the change to get the

efficiency improvement to meet the pricing signals that it has been receiving.

Richard Murray: I absolutely agree that, if you do not engage the workforce with a message that it understands and accepts, you will not get traditional efficiency measures to work. If we think of your timeframe, the challenge will be how to do high-quality care appropriately and efficiently with larger numbers of very old people who are frail and have multiple comorbidities. That is partly about what we have traditionally done, which is to lean on the hospital sector. That is what most countries have done, because it is the biggest cost centre. Twenty or 30 years into the future, you may end up with a system that is still overwhelmingly hospital-based, but that will be very expensive to run. At the moment, efficiency measures have tended to focus on the acute sector. As we look out over the next 20 to 30 years, we will want ways to try to bind together an integrated approach, to provide efficient care that crosses both primary care—general practice, services in the community and social care—and the acute sector. We should not try to compartmentalise the system into small buckets, because that is not the population group we will be dealing with.

The Chairman: I will take Lord Warner and Lord Lipsey. Then I will move on to the next question.

Lord Willis of Knaresborough: Chairman, would it be possible to hear what Dr Dixon has to say on this, given that she introduced the idea of efficiency? Do you have any ideas, Dr Dixon?

Dr Jennifer Dixon: I am mindful of the fact that there is a very good study by Mark Pearson, from the OECD, that clumped health systems into different archetypes: market-based systems, national health systems, Bismarckian systems and heterogeneous systems. When he looked at the performance of those systems, including efficiency measures, he found that no one archetype outperformed another and that there was more variation within archetypes than across them. His conclusion was that a health system that is seriously trying to improve performance should not necessarily look to any other system but should work with what it has. That was quite an interesting message.

Secondly, like Nigel and Richard, in my job I go around the world and see interesting examples—as you may do, too. There are some really excellent examples of technical efficiency in hospitals. A lot of those are in high performing providers in the US, where they have had massive engagement of clinicians in quality improvement techniques. They also have huge amounts of data, banks of analysts and leaders who have been in place for 12 to 20 years. Those examples do not easily translate here.

I go back to my point: I do not think there is one quick thing that we can do to raise productivity. Everyone knows that. The approach should be gradual but robust progress using a more comprehensive set of approaches than we have at the moment.

Lord Warner: Can we go back to the issue of payment systems? Let us assume that you cannot easily increase the total quantum and that you have to work harder at making the quantum deliver what you want. What thinking is coming out of the think tanks about payment systems, particularly to providers, and dealing with the issue of provider-induced demand? What payment systems should we be trying to move our health and social care system to in order to get a better bang for our buck?

Nigel Edwards: Jamie Robinson, the health economist from UC Berkeley, says that the three worst ways of paying healthcare providers are capitation, fee for service and salary. In other words, every single payment method has some form of downside. Up to now, in common with the US and, more recently, Canada and Australia, as well as quite a lot of continental Europe, we have used a modified diagnosis-related group payment to hospitals for the activity that they do. Largely, we have paid general practitioners on a capitation basis, with some quality incentives and a very small number of items as service payments.

The downside of paying hospitals for volume is that there is quite a lot of what they do where you do not want more, particularly in emergency admissions. We see a shift to trying to get hospitals to take some capitation. The result of that is that the commissioners in our system have held much of the risk for volume. The move that we see in this country and, to some extent, in the US is an attempt to get hospitals and other providers to take the shared risk for a capitated population. You retain the episodic payment model, using DRGs, largely for elective surgery, diagnostics and things where you may want to incentivise volume. Even there, you may want to set limits to try to control volume. The overall movement is to shift the risk that you hold as an insurer to increase volume to the providers. They are better able, it is thought, to design a system to make the decisions that mean that you can have some control over a phenomenon many of you will be familiar with—the fact that if you increase supply the level of demand seems to go up. You sometimes hear people say, "If you build it, they will come". That seems to be the movement.

The downside of capitation, particularly in our system, is potentially the creation of unchallenged local monopolies. Capitation encourages slacking, in that you have received a set sum of money. Unless you get very good at measuring the outcomes for your population, you are at risk from capitation models as well, in that, potentially, you introduce a different type of inefficiency into your system—an allocative inefficiency. You spend money on the wrong things, or your providers do not do the things that they should be doing. It is fair to say that the art of measuring outcomes at a population level, by commissioners or others, is still in its infancy. We have to be able to do better than HbA1C for diabetes, which is the standard example that is always trotted out. That sort of precision of measurement is one of the problems that is holding back the payment system at the moment from a more full-blooded move to a capitated model.

Lord Lipsey: Mr Murray, you said that it would be vital to increase the share of GDP going to healthcare, but is there not a prior point, which is that it all depends on how fast GDP is growing in the first place? When GDP was growing merrily in the early 2000s, at 3% a year, we did not have much trouble financing health. Since it stopped growing, we have had ghastly problems. Of course, the growth rate is not a matter wholly for the health system, but health priorities can affect growth rates. For example, the more prevention you do so that people can go on working during their working lifetime, the better. I am afraid that end-of-life care, important though it is, does not contribute a penny to growth. Is it not necessary to put growth at the centre of your models when looking at how we fund healthcare?

Richard Murray: Yes, I agree. The slower the growth of the economy, the harder it will be to finance health and social care as you go forward—absolutely. I said that it was inevitable that spending would have to go up, but there is a prior assumption in there about what kind of service you would hope for—if you want it to look comprehensive and free at the point of use, and if we are talking about public spending.

Over the next 20 to 30 years, there are things that the health service may be able to do to support the growth rate. We are a high-tech industry, so it feeds in both ways. It is quite difficult for the health service to do that if it is very short of staff, time and money. If you have a set of priorities in front of clinicians and they have long lists of patients waiting at the front door, it is not easy to divert them into GDP-growing research.

I want to say a bit about the incentive issue. I agree with everything that Nigel has said. I would add only that we should think more often about pathways that try to unite elements of care, so that people do not fall between gaps as they move between different providers, and that we must be able to do better on outcomes than we do at the moment. That is the key problem around capitation and the incentives that it gives.

My final point is that we spend a lot of time fiddling around with payment systems, but if your providers are all bust anyway it does not make a lot of difference. You are pouring water into a paper bag, and the paper bag has a great big hole near the bottom. There is a lot of very fine-tuning that goes on, but I am not sure what benefit it has. Fundamentally, trying to have clarity on what you want the system to deliver, and making sure that clinicians are on board and enabled to do the things that patients want them to do, will probably help a lot more on efficiency going forward.

The Chairman: On resources, the next issue is the big issue of the workforce, of course. Just now there does not seem to be much of a solution there. Again, I want you to think ahead, to 2025, 2030 and beyond.

Q24 **Lord Ribeiro**: We have had paper bags filling up with water. Workforce seems to be one of the Achilles heels of planning that we do not seem to get right. As far as consultant staff are concerned, the pipeline is

anything from 10 to 15 years before you get the product. Thinking long term, what are the main challenges affecting workforce planning? What will the requirements for the workforce be? What will it do?

Richard Murray: We are struggling at the moment with the difference in workforce planning between models that build up from population need, which tell you that you will need an awful lot of people going forward, and models that build up from what NHS employers will actually be able to pay for—what size of pay bill is affordable. Part of the problem we have at the moment is that we have a workforce that was designed to be affordable. It has turned out to be too small, so we have turned to more expensive staff. That is the failure of planning. There is a fundamental difference around these approaches. Do you base it on what you think you will need if you are to meet all the needs of the population, or do you base it on how much pay you are willing to give out?

As we look over multiple years, we have to get workforce planning better than it is now. Everybody knows that. As we were standing outside, I said that we always think that planning is terrible, but the huge waiting lists that the NHS had inherited by 2000 were removed. That was done by a huge expansion in the workforce, which was designed to link to the growth in activity. It may have been messy, and it was not always perfect, but planning is not always a failure. Sometimes it has scored some major successes.

The challenges as you look out into the future, alongside the demand and affordability piece, are particularly around new roles. We have an old model of consultants, nurses and more junior staff. As you look out—particularly reflecting the changing demographic needs of the population—is that appropriate? It is very difficult for a planner to know now, as some of the roles are nascent roles that are not with us yet. Hopefully, they can begin to reduce some of the problems about the length of planning that you need to do, not just for the consultant workforce but for the nursing workforce. There is no element of the workforce in healthcare that is easy to push up. It is expensive to reduce it, too.

Lord Ribeiro: On the nursing side—this is something that you may want to pick up, Jennifer, as it appears in your paper—one thing seems to be how different countries have determined how they will recruit and retain nurses. In the table that you show, there is a very dramatic figure. In the UK, 12.7% of nurses are foreign trained. In the USA, the figure is 6%. In Denmark, it is 0.7%. Somewhere along the line, these countries are taking a view on how they will grow their own workforce and how much they will recruit from outside. What is our problem?

Dr Jennifer Dixon: Thank you for referring to our report. We have produced two reports in the last few months. One looks at the architecture of workforce planning bodies and professional groups that help to define roles, et cetera. It shows that the architecture is quite byzantine; a very complex set of bodies is involved. Secondly, there is the report you have referred to, which looks at numbers—in, out,

planning over a certain period, and so on. Some figures are very stark, as you say—not just the proportion of nurses trained overseas but that of doctors. One-third of our doctors are now trained overseas. Did we plan that? Do we want that? Half of new registrants to the nursing register last year were from the EU, for example.

Lord Ribeiro: Presumably it will get more acute if we come out of the EU in two years' time. That will be a major problem.

Dr Jennifer Dixon: Indeed. Whatever has happened with bottom-up planning of staff numbers, which has been restricted by the overall envelope of funding, is not producing the trained staff the NHS needs. As David Metcalf said on the Migration Advisory Committee, the "get-out-of-jail-free card" for planning which is suboptimal is the use of overseas recruitment. At ward level, it means that you have people from different countries, with different skill sets. If you are trying to make improvements over time, but you have a churn of people with different skill sets and experience, it is like running in sand. The churn and the heterogeneity of training levels of different staff groups will multiply the challenges you face, if you are trying to make a sustained progress towards more efficiency.

The Chairman: Mr Edwards, do you have a comment?

Nigel Edwards: No, I have nothing to add to that. I agree with both of you.

Q25 **Lord Willis of Knaresborough**: I have a question specifically on this issue. I declare an interest. At the moment, I am doing work for HEE on planning the workforce. The thing that I found, which I could not believe, was the level of attrition in training, particularly of nurses. On average, roughly 24% of starts leave, which is an incredible cost. In addition, many of those people do not come into the system. There is also massive attrition in the first two to three years when a registered nurse actually starts work. If we could do just a little to improve that, we would suddenly reduce the number of people we have to recruit from abroad, and yet there does not seem to be any real drive to change the culture that is driving people out of the system. Does anybody do that better? Are we aware of that?

Dr Jennifer Dixon: You have to look at overall HR practices in the National Health Service—for all staff groups, not just nurses—to know whether there is more that could be done. Our work has shown that there are a lot of things that could be done locally to improve retention—not just for nursing staff but for others. HR management is a pretty underpowered profession. We just do not devote enough thinking in national or local policy to the wellbeing and motivation of staff, even though they are our biggest asset. Overall, if you look at the figures for staff joining and leaving the NHS, in some years the percentage joining and leaving is more or less the same, so you have a big leaky bucket. This is a big area the Committee could focus on very usefully.

If I am allowed, I would like to go back to Norman's point, because we got through it rather quickly. Could I say something on the financial incentives? At the moment, the biggest stimulus in the health sector, on money, is the fact that there is a global budget and it is very tight. Underneath that, on payment, there are two issues. One is the level of the price of payments. The other, which you were alluding to, is the payment currency. The evidence I have seen shows that relying on one system of payment or currency has obvious disadvantages and that constructing a blend reduced those disadvantages. However, the overall point that I would like to make is that our capacity in this country to work out optimal price and currency blend of payments is very limited. There are just a handful of economists outside the NHS, mostly located in York, who do this type of analysis. There are relatively few inside the NHS. We are largely flying blind as to the impact of changes in payments.

The other obvious point to make, which is a long-standing one, is that a lot of big cost centres, such as hospitals, do not know what their costs truly are. Progress on that, which links through to another of your interests—progress on informatics—is also a critical point going into the longer term.

The Chairman: I now seek quick-fire questions and quick-fire responses.

Baroness Redfern: Before I ask my supplementary, I declare that I was chair of specialist healthcare on the council back home. My question is about whether changing the skill mix of the workforce is a cost-effective option. Could you give any examples of that?

Nigel Edwards: Yes; we can send you some. There are a lot of very good examples already. Because we are short of doctors and tend to rely on trainees, we have seen a large expansion in the role of nurses, who have taken on specialist duties that we would traditionally have expected junior doctors to do. They do them very effectively. It is a bit more cost-effective. There is a price difference between a nurse and a junior doctor, but the nurses tend to take a little longer, so it is quite finely balanced. There are plenty of opportunities to use physiotherapists and occupational therapists in better ways. In Scotland, there is a tendency increasingly to refer all musculoskeletal conditions straight to a physiotherapist, without patients seeing a GP. That is some 20% of the general practice workload, so there are interesting examples there.

The bit of the skill mix that has remained largely untouched is the senior medical skill mix. We have a system in this country where everyone is a consultant. There is no hierarchy within that. That is slightly unusual compared with other countries, where you would expect to see a bit more differentiation between different types of doctors. We had—they are still around—a staff grade of associate specialist doctors. It was always said that, if you were having your hip replaced, you would be better off having it done by one of them, because they did them a lot—and did them very effectively. However, they have been phased out, to some extent. There is still a lot more that we could do with the skill mix, but it needs to be done with care and with careful planning. One of the risks that we have

seen is the multiplication of slightly different types of role that are not very comparable. Then people cannot move about, because they do not have portable qualifications. There is also a lagging regulatory system, which means that you have people who are quite capable of prescribing from a limited formulary, for example, but who are not allowed to do so because of the legislative framework.

Baroness Redfern: If I may, I will point my question to GPs, as well, because GPs can help with skill mixing. Health and social care, in particular, will be a big player. I wonder whether there is a huge opportunity there. I know that there may be in the acute sector, but I am looking at the primary sector.

Nigel Edwards: In general practice, there are some very interesting models in the US, where the ratio of GPs to patients is different. There you have one GP and a large multidisciplinary team supporting them. The GP focuses on the things where their particular expertise is valuable—complex cases, difficult diagnoses and the co-ordination of care with specialties. I think that we will see more of that. However, to make it work, you need general practice to be at a larger scale than it currently is. It needs back-up and support, with telephone centres and a variety of other bits of infrastructure. We have now started to see that change happen very quickly, below the radar. GPs are already starting to scale up. They are not yet ready to start doing that, but I would predict—

Baroness Redfern: There seems to be some mileage in that area.

Nigel Edwards: Yes. We will see that.

The Chairman: Once, when I tried to raise the issue that not everybody needs to be a consultant and there might be other grades, the whole wrath of the medical profession fell on me.

Nigel Edwards: Yes. I said that being close to the door.

The Chairman: I tried it, and look what happened to me.

Lord Scriven: Have you come across any models that link future planning to productivity gains? In a number of reports, you refer to productivity. How do you use planning to get the most productive workforce for the future? Have you come across that anywhere?

Nigel Edwards: Getting the numbers right is difficult enough. I am not sure that I have come across any examples of that internationally. Some countries only plan doctors, because doctors are expensive to produce. If you have too many, there is a danger that, because doctors like doing things and working, you will end up with a supply-induced demand problem. Most countries try to regulate the number of doctors, but even a few of those have stopped. A number of other countries tend to leave production more to the market, rather than try to plan the numbers exquisitely. I have not seen any examples in a modern system, as opposed to the former Soviet Union.

Lord Scriven: As complex as it may be, do you think that it is something that would be useful?

Dr Jennifer Dixon: There is so much variation, if you look at trust-level productivity in England, for example. That is the first place to look. Why are some trusts more productive than others? Is it something to do with how they have planned their workforce, or is it something entirely different—the structures that they have inherited or the processes of care that they do, outwith any staffing numbers? I would have thought that that was the place to start. We should look at Scotland and Wales, too.

Nigel Edwards: One issue is that the speed with which some of the technology and treatments in medicine change makes that quite hard. We should train people so that there is more opportunity for them to be flexible and to acquire new skills and competences. Again, this is sensitive territory; something called the shape of training review tried to look at it. That will allow them to adapt their skills as technology changes. The answer is probably to train people to be flexible, so that they can use and find knowledge, and to be able to retrain them quickly as technology changes, so that when someone comes up with a new treatment and the thing that they have spent the last 10 years learning suddenly becomes obsolete—which will happen increasingly—they are able to adapt to that quickly. Your question is interesting, but I do not think that there are any international examples.

Lord McColl of Dulwich: Looking at wastage, do you have any data on why large numbers of GPs, nurses and practice nurses are leaving? What is destroying the morale? I know quite a bit about general practice, and I know why many of them are leaving. I wondered whether you had any data.

Richard Murray: Recently the fund published on general practice. That involved a series of discussions with trainees, those who are GPs now and the people who work around them. We have done the same with district and community nurses, who are also suffering very heavily from people leaving the profession. That will be published quite soon. If I were to summarise, what comes across quite a lot is burnout—the fact that they are tired and stressed. We have had examples of district nurses, in particular, saying that they are leaving because they no longer think that their care is safe and they no longer have enough time to do the job. Those are the things that are coming across. Pay does not seem to come up very often—it is about the nature of the job. When some younger people, in particular—those who are joining the professions now—look at it, their answer is instead to look for a portfolio career. They say, "I will be only a part-time GP. I will not be a part-time member of the NHS workforce—I shall do something else as well—but I will not do that job full time". We have an imbalance between the asks on staff and what they feel capable of doing.

Lord McColl of Dulwich: The CQC has been acknowledged to be a disaster in general practice. It is demoralising GPs. Its staff, who are often unqualified and do not know what they are talking about, go in and

nitpick. I will give just one example. When they went into a very good general practice, the chap in charge was someone of 25, covered with acne, which is not a very good thing to have in general practice. All that they discovered was that one ampule in the refrigerator was a month out of date. That was a very serious complaint and was put in the report. Surely these people should know that any doctor or nurse checks an ampule to see whether it is in date and what it is. Two people check it. That is the sort of thing that is demoralising health.

The Chairman: We will take that as a comment. I move on to Lord Warner.

Q26 **Lord Warner**: Can I move us on to integration? Underpinning the five year forward view is a very considerable emphasis on integration, particularly in social care. You know that things are starting to change when the chief executive of NHS England starts saying that if you have any spare cash in the NHS you ought to give it to social care. There is a movement, ideologically at least. What are the practical changes required to provide the population with an integrated national health and care service? In particular, what are the obstacles to that movement in the longer term that the Committee should be trying to remove?

Richard Murray: In the longer term, the Barker commission, which was supported by the King's Fund, identified as issues the separation of budgets between health and social care and the extent of means testing in social care, compared with care free at the point of use in the NHS. Looking into the years ahead, it is fundamental to think about having a single, ring-fenced budget for social care and one that tries progressively to be more generous on the social care side, to take away the extent of means testing that we have at the moment. Without that, there is a fundamental question about what integration looks like, as you look to the years ahead. Social care probably came through the spending review slightly better than many had feared that it would. That is not to say that it came through well—it is just that the fears were very great beforehand. It is one thing to integrate between two public payers. It is a very different thing for the health service to try to integrate with 200,000 private payers, because the extent of public financing retreats over time—certainly if it were to continue at the rate that we have seen more recently.

That is on the big-picture piece. There are things that get in the way of integration at local level. One is just how complicated it is. This is not something that you do quickly—it takes a lot of time to think through. You need to think about how patients and users move through the system and what they want from a more integrated system. There are two separate workforces here—in fact, more than two in the NHS—that have different cultures and ways of working. Bringing those together into a coherent whole is not the work of a short period of time. It is great that we are seeing lots of work going on in the vanguards and in other areas to try to knit these two different systems together. However, I do not think that we will ever end up with a single bullet that provides what you

want right from one end of the country to the other, no doubt because of the variation that you are seeing.

Dr Jennifer Dixon: I agree with all of that, plus the obvious points, which are about local leadership and stability of leadership. You can see some of the greater advances in areas where boards and senior staff have been in place for some time and have good, trusting relationships. We also need data on impact. A lot of places do not know what the impact of their efforts has been, so they may be discouraged if they do not see it, but in fact there is progress. We need time, as has been said, and rigorous, detailed planning and project management. Over and over again—I was involved in the integrated care pioneer programme, for example—that is what is needed. It is often in short supply.

The Chairman: Nigel, do you have a quick comment?

Nigel Edwards: I will not add anything to what has been said. That covers it.

Lord Bradley: Under the general umbrella of integration, you have health and social care, physical and mental health—around whole-person care—and the shift from hospital-based care to community-based care. Richard, earlier today you said that is still overwhelmingly hospital-based. What do you think the levers are over 15 or 20 years to get to a community-based, integrated service? We have touched on funding, workforce planning and other barriers to that change. Do you think that there is enough money in the transformation fund and the vanguards really to shift away from hospital-based service when there are so many incentives to retain patients in hospital?

Richard Murray: At the moment, no. Much of the transformation funding that is available will end up being directed at deficits in the acute sector, so it will not show up in mental health and out-of-hospital settings. There are some other things that you need to do to rebalance the imbalances that we have at the moment. Our understanding of outcomes is not great in the acute sector, but we have some understanding of outcomes. We do not in most out-of-hospital settings, so a lot of what goes on there is invisible. It is not easy to see and is the bit that tends to get cut. I echo what Jennifer has said about data. We do not really know what the workforce is doing in community settings. We think that it is going down, but it is very difficult to track. Even basics like that are not easy to see.

We have a system that is trying to deliver a set of targets for the acute sector. When the system comes under pressure, what it does—we have seen this—is move money bit by bit back into the acute sector, to try to maintain the targets that sit there. There is no visibility and no comparability counterweight, other than exhortation and hopefulness that commissioners may try to move the money in the other way. Thinking about the workforce, that is why, when NHS England asks employers in community settings and in mental health what they want for the future, their answer is, "Fewer staff", because they do not think that their

budgets will turn around and go back up. Until you overcome that fundamental problem, it is quite difficult to move things into the community. That is certainly not happening at the moment.

Lord Bradley: I should have declared my interests.

The Chairman: Just now we have compartmentalised thinking about workforce planning and funding—managing the money. Do you think that the separation is too great? Workforce is resources. Do you think that thinking should be done by NHS England—I know that we have a second session with NHS England—which is managing the money? Is this a problem of dichotomy of thinking—different organisations with different responsibilities?

Richard Murray: I think so. If you think back to when we were doing things like national service frameworks, which were trying to change how care was delivered, you tried to ensure that there was the money. However, because of everything that we have said about workforce, the money in the health service is not enough—you also need to know where you are going to get the staff, and on what timetable, to deliver that level of service. We can see the downside of not doing that. We have pushed acute hospitals on to a recruitment round for nurses. Those nurses did not exist. Consequently, they have been pushed into using agency staff as well. You want to try to make sure that your objectives around the health service and social care are matched with resources: do you have the money to do it, is there a system of data and outcomes that can try to track how performance is doing, and are there the staff to deliver it? They need to go together.

The Chairman: Dr Dixon, the Health Foundation had a comment on this.

Dr Jennifer Dixon: There is a wider point, which is about the national leadership for the ALBs how coordinated it is. You mentioned NHS England, but HEE and NHS Improvement are also in the picture. We have just produced a report on quality. An overarching strategy on quality is absent, in part because of a lack of coordinated leadership on that particular issue. There is a good start with the five year forward view, which is a great example of people coming together, but this needs to address the wider issue of quality of care and longer term than the next five years. The department of health has a role to help coordinate this, but much of the thinking should come from the arm's-length collection of so called'system stewards'.

Nigel Edwards: I wonder whether the sheer scale of the NHS makes investing that planning in one set of central bodies sensible. I am not aware of any successful health system that tries to do that on such a large scale that is so focused on national bodies, as opposed to the amalgamation of more regional authorities. Other NHS systems do not run the system nationally. Spain and Italy are perhaps not models that you would copy normally. However, if you look at other health systems, there is something about the scale of the NHS that, I suspect, means that the overall complexity is likely to overwhelm the people you have,

however smart they are. I may be remembering a golden age—I am probably being overly nostalgic—but we have stripped out the knowledge and planning abilities that may have been there. That local ability to plan, which you might have been able to amalgamate up, has gone. There is a very serious question to be asked about whether, however good you get the stewardship bits at the top, 53 million people is too large a unit to do things with.

Dr Jennifer Dixon: I agree with that. There is planning, but there is also the separate issue of a coherent strategy overall. That is the point that I was trying to make.

Lord Bradley: To declare my interest, do you think that the devolution deal for Greater Manchester, for example, is an opportunity to test out what you have just described?

Nigel Edwards: It would be if it were devolution, as opposed to delegation.

Lord Scriven: Mr Edwards has more or less answered part of my next question. Going back to international comparisons, are there any international comparators that get integration between different parts of the health service or between health and social care better than the UK? What are the key components that you think are missing that could be transferred into the British system?

Nigel Edwards: Even the Scandinavian countries have struggled with disputes. In Sweden, the municipalities run social care and the counties run hospital care. One thing that is worth pointing out here—it is one of the reasons why this takes time—is that the mental models, value system and approach to the problem of social work staff are very different from those of medical staff. There is a good reason why they are different, and there is value in both. However, it means that when they come together it is not just a straightforward thing of putting everybody in the same building, under the same management, and telling them to integrate.

Lord Scriven: What about integration between healthcare providers—not just between trusts, but between primary, community and acute providers?

Nigel Edwards: You are asking for an international example. No—

Richard Murray: There are individual examples. You would struggle to say that an entire system had managed to do it. Indeed, surprising as it may seem, on some international comparisons—for example, by the Commonwealth Fund—England tends to do relatively better, partly because we have GPs who at least form a bedrock for the population. You find individual examples in many countries that have got further down that road, but you can also find ones in England that have got further down the road of integrating health and social care.

Lord Scriven: Do you see any commonality on which are the key issues?

Richard Murray: It goes back to some of the things that Jennifer said about strong local leadership and stability in the leadership team. They need to have a clear vision and to go through the quite long slog of thinking through the plan, adjusting as they go through and recognising the very cultural differences that Nigel has noted. It is harder if you just think that merging organisations will bring about integrated care. It does not. You can go to acute hospitals that are not a real hospital, but separate fiefdoms all around the building. Just merging organisations does not do that. There needs to be a recognition of the complexity of the staff and just how important the task is. Many other countries are on the same demographic journey we are on. We were in a world where you could separate health and social care, to some extent. However, given the way in which the demographics have gone across the whole developed world, that is looking harder and harder. The integration agenda is one that many other countries understand. I do not think that anyone has found a magic bullet.

The Chairman: There is no evidence we can look at, in a whole system.

Dr Jennifer Dixon: Not in a whole system. Richard was absolutely right to say that there are individual examples. However, every health system is different, because the context is very different. It is very difficult to read across to the NHS, so you can only get glimpses of what we might try. The thing I am closest to—as I guess my colleagues are—is looking at the developing accountable care organisations in the United States. Generally, they do not include social care, but try to integrate across health care settings and shift care outside hospitals. They are absolutely rigorous in programme management to make that happen, as well as monitoring impact. Financial incentives and data are the two big levers that they have been using to help stimulate change. They are very well supported by the CMS Innovation Center: it has commissioned rapid cycle evaluation, which gives regular feedback to local ACOs to allow people trying things out at the front line to course-correct within weeks, instead of waiting a year for data. There are some examples of how it can work.

Q27 **Lord Kakkar**: I remind the Committee, particularly for this question, of my interest in UCLPartners. To what extent has digitisation of data and services taken place? Building on the comments that we have just heard, how important are data and informatics in driving forward changes? What evidence do we have that the appropriate collection of data and health informatics has resulted in improved efficiency and more effective use of funds?

Dr Jennifer Dixon: Personally, I think that we are in the foothills of what this asset can do for us in the National Health Service—that is the existing asset, let alone developing it. We have a ton of data, and it is not used enough. That is in part because of blockages in getting hold of data, particularly person-level data, to allow people to be tracked anonymously across the health system, so that we can spot who is at high risk, who might need greater support and which general practices and communities they are coming from. Some parts of the country can do that, but it is not

typical across the country as a whole. That is a very promising area work on, to try to improve efficiencies.

Without getting all technical, there is a whole set of data—routine administrative data—that you can use to track patients, because it is always collected automatically when they use the NHS. However, there is another separate set of information, which is clinical audit data. Only last week, I was seeing the most advanced collection of clinical data in the world on cancer, at the National Cancer Intelligence Network in Cambridge and its related bodies. I note that it has linked together multiple sources of data in hospitals, in a way no other country has done before. It has done so incrementally, slowly, over time, rigorously and carefully. The result is that we have more data about cancer care in this country, by cohorts of people, on everyone who has cancer or a suspected diagnosis than any other country in the world. Your question is, how do you translate that into productivity savings? That is where there is a gap. It is about sweating that asset and using it for benefit.

Lord Kakkar: How do we bridge that gap? How will we get there, so that we use this opportunity with regard to data and informatics to answer the sustainability question 20 years hence?

Dr Jennifer Dixon: A practical example is that we need to give those vanguard sites that are trying to shift care out into the community feedback of information on the quality and cost of the impact of their efforts in a rapid way. That means freeing up a lot more data than they have from national sources and docking it with audit data, to give them useable information about progress. At the moment, they cannot easily track progress of their efforts. That is avoidable with better access to data and analytical support. Data is a massive NHS asset that is underexploited.

Nigel Edwards: With the privacy restrictions and the fact that 1.5 million people have opted out of the hospital episode system for secondary use, there is a risk of our going backwards. We could be in the paradoxical situation where more data is available, but it is increasingly hard to get at and to use for research and improvement. Although you can opt out of having your clinical data shared between clinicians, hopefully we can at least get the improvement that clinical data will be available to treating clinicians, with the patient's permission. However, we lose the opportunity to improve both productivity and epidemiology-type research, because of restrictions that are increasingly being put on the availability of this sort of data for secondary use.

Richard Murray: The three of us have probably changed our tone on this point, because the issue of getting hold of data for secondary use is getting worse, not better. There is a real problem there. You talk about using the data, but you cannot even get hold of it. When it comes to data and linking that to direct patient care, a lot of it is now about delivery. Areas are putting together their digital road maps. I know that you will have NHS England and others here later. At local level, they are trying to come to agreements on how data moves across the system, to facilitate

direct patient care. There is a lot of optimism around that, but it is right at the critical point, as you begin to turn agreements into reality.

The other question is: is there evidence that sometimes data can really unlock change? I think that there is. There are many examples in the literature where being able to provide quicker, real-term or near-real-term feedback to staff makes an enormous difference. It can make a difference to managers and to everybody else. It becomes actionable—you can do things about it. We have just done something about getting feedback from users of maternity services. The staff react to it. There is a lot of granular evidence that it can work. What we probably have not done yet is manage to make it work at any kind of reasonable scale. There is major work under way, as we speak, to try to make that happen.

The Chairman: Who will be best placed—looking ahead to 2030 onwards, as Lord Kakkar said—on the use of appropriate data to improve productivity and the use of informatics to improve patient care, with the new science and the new means of diagnosis that will develop by 2030? Who should be in charge of doing that? Who will describe the road map for where we should be and how we get there?

Richard Murray: Some of the ACOs in the United States are at the cutting edge. They will be one place to look, to see what is potentially possible. As you do that, you will also want to think about some of the barriers. We have spoken about data sharing, but some of those issues also arise in the United States. The Americans spend an awful lot more money—vastly more money—on this.

The Chairman: Why do they spend more money on it?

Richard Murray: They spend about twice the share of GDP that we do on healthcare, anyway, so they are much better funded. Their costs are much higher than ours, so saving elements of care provides them with a much bigger bang than it does here. They have raised the money.

Lord Kakkar: Have they been able to demonstrate as a result that their system and the ACOs are more efficient and sustainable?

Dr Jennifer Dixon: Some have, yes, because they also have rigorous analysis of costs. They have had a fee-for-service system, so they rely on billing and have granular data on costing, whereas we do not. There are some examples within the UK that are more advanced, in Scotland and some parts of England.

The Chairman: I was hoping that you would say that.

Dr Jennifer Dixon: We can send you some information on those places. Nobody has joined up all the dots. There is no area where everything is singing, but there are a few areas you could look at that are vanguard areas on informatics. Bob Wachter is clearly focusing on this too.

Q28 **Baroness Redfern**: My question may have been asked previously. Are you saying that we have to get data sharing across the system right and

up to date before we can see any benefits?

Dr Jennifer Dixon: We are seeing some benefits already, but nowhere near as many as we could if we could unlock some of the data flows. As has been said, it is not just about the data—it is about having the analysts there who can help. Those are the very people who have been stripped out of the NHS because of administrative savings.

Lord Willis of Knaresborough: Is it not a folly sometimes to look too big? You are quite right—a mass of data is available. However, in trying to convince the public that sharing data is important, sometimes you have to have small successes. The Yorkshire CLAHRC, in which I declare an interest, produced a frailty index, using existing data, but 97% of GPs across England now use that to target the patients who require the greatest help. Examples like that eventually create scale, but they also bring buy-in from everyone. I wonder whether we are starting from the wrong end of the telescope.

Dr Jennifer Dixon: I chose the example of cancer care, where a tremendous database has been built up gradually over the last 10 years, without fuss and with the risks managed carefully. It all complies clearly with data protection. There is a lot that can be done locally. In certain parts of the country, the kind of datasets we are talking about have been linked up at person level. Nevertheless, there are some national issues, to do with governance, that need to be addressed to help.

Nigel Edwards: Particularly around data interoperability and data definitions, which need to be done nationally. There is a definite role for national bodies, but it is probably not in designing and implementing large systems.

Lord Kakkar: I want to deal with the second part of the question, beyond data—that is, the adoption of technology at scale and pace. We heard earlier that often, technological innovation is associated with an increase in cost. What are the barriers to adoption of technology in the medium term? In your view, how might that drive forward a more sustainable NHS?

Nigel Edwards: Do you mean digital technology specifically?

Lord Kakkar: Yes.

Nigel Edwards: One of the peculiar things Bob Wachter, who was referred to earlier, has written about is that the introduction of digital technology has often been associated with a drop in productivity in healthcare, rather than an increase. It is because we have often focused on the technology, rather than on redesigning the workflows and then fitting the technology to support the new workflow. It seems that a double loop of learning is required: you get the technology, you collect the data and then you are able to work out how your workflow needs to change. It is a more painful journey than people have tended to think. That is not uncommon in other industries. The productivity paradox—that you get an initial drop and then use the technology to get the data that

you need to do the learning to do the redesign—has been a feature there, too. The question is: how much are you investing? Never mind the fact that the US and its health system are richer—the investment is also much more significant as a proportion of turnover than it is here. A large health system in the US will probably invest 4% or 5% of its turnover in IT systems. I do not know what the comparable number is here, but I suspect that it is half of that, at best.

Dr Jennifer Dixon: There is new technology. Nobody really knows the potential benefits of that, but important to invest in. Every year, my organisation funds a lot of projects in the NHS to try to improve care, some of them using new technologies and some not. It is absolutely clear that, with or without new technologies, the skills and culture of the staff embedding those projects is almost more important than the technology itself. Some of our projects have shown the quite significant changes that can be made without any kind of technology, to do with learning a process of care, for example—creating more order where there has been quite a lot of disorder in the clinical pathway of care and reducing the time wasted on work-arounds on the ward because people waste time trying find things, do not know where things are or are trying to get hold of somebody. There is quite a lot that can be done, as we have shown, although what that would add up to across the NHS is another matter. We can give examples from our portfolio.

Q29 **Lord Turnberg**: My question is about public health and prevention. Before I ask it, can I follow up on the productivity question? It is very hard to demonstrate that the new technologies of all sorts, the new treatments and the biologicals, which are all very expensive, produce improved productivity. However, if you look more widely at society, there is quite a lot of evidence that, if you invest in research in cancer or heart disease, you gain productivity, with lower sickness rates, fewer sickness benefits and increased productivity by the workforce, as people get back to work because they have been treated. It depends on where you look at productivity. Is it the nation's productivity or the NHS's productivity? That is a problem for the NHS. Its gains are felt by the Treasury, but not within the Department of Health. Do you want to comment on that?

Nigel Edwards: There is a literature on this, although I am not an expert in it. When Marc Suhrcke, who was formerly at the University of East Anglia, did work on the Tallinn charter for the WHO about 10 years ago, he calculated a positive economic multiplier for spending on health—although, to be honest, it was not as good as the multiplier for spending on education, if I remember rightly. You may need a different witness, but my recollection of the literature on this is that there is definitely a case to be made. I suspect that even end-of-life care may be able to demonstrate that. At the very least, good end-of-life care probably reduces the burden on carers. It also tends to be cheaper than what we often do now.

Lord Turnberg: So there is good evidence in that research.

Nigel Edwards: There is.

Richard Murray: I completely agree. The evidence is good, if you look at health per se. It depends on whether or not you are in competition with education. However, you have to remember that, for chief executives of NHS trusts, this is unlikely to be what gets them—

Lord Turnberg: That is the problem.

Richard Murray: Busting the budget or missing your A&E target could end with your P45 being on your desk quite quickly. It is one thing to exhort the service to be more supportive of research and development agendas, but in the behaviours that the system actually adopts, it does not do that—it gives you a slap. You cannot trade the two. If you want to encourage more of it, the system needs to recognise it and to integrate it into the way in which it judges how well people have done.

The Chairman: Can I ask you to move on, Lord Turnberg?

Q30 **Lord Turnberg**: I am sorry, my Lord Chairman. I strayed a bit.

We have not yet spoken much about public health and prevention. We know all about the fact that we have managed to have some success on smoking reduction and modest success on alcohol reduction. We have not done so well on obesity reduction. We know that those are the issues. However, if we are looking forward some considerable time, we have to think about what more needs to be done in two areas. What research is being done on how one is able to influence public behaviour better in the future? We have a lot of rhetoric in this field, but not much action. The other thing is how we think about developments in areas other than the three that I have mentioned. How do we think about preventive measures for things like dementia, of which there are some? How do we begin to take advantage of all the novel developments in prediction of ill health, using genomics and like techniques, that we can use in preventive programmes? Is any work being done in that area?

Richard Murray: There is a lot of work on return on investment in prevention, often at more local levels, looking at what a local authority or the NHS might be able to do and where you get a bang for your buck. At the higher, national level, the clue is in some of the examples that you gave at the start. I will pick on smoking, in particular. That was a combined effort, involving the NHS, which provided stop smoking services, aggressive use of taxation levers, to make it expensive to smoke, and, increasingly, use of regulatory powers, to make it difficult to smoke. To some extent, alcohol has gone down the same path, although you could argue about quite how regulation has played its part on alcohol. Before looking for any radical, unknown lever, we want the system to rethink both what the NHS and local government can do and what you can do using the national levers of taxation and regulation to try to deal with the other public health issues. We have a set of tools that work pretty well on smoking and have had some successes in other areas, such as regulation on wearing a seatbelt. People tend to forget how powerful and successful a change that was. There is a set of traditional levers we are just not thinking about or using as we could. All

credit for the tax on sugary drinks, which begins to reopen the debate about using tax in a more imaginative way.

On dementia, you are absolutely right. It is partly about a change in mindset and seeing that elements of both dementia and mental health issues are preventable. We need to broaden out the conversation about what you can design and do around environments that help people with either dementia or mental health issues. A lot of this needs to be based on what people want. There is a lot of evidence on green space and the built environment. Local authorities have the powers to bring those about. Some of it is about a change in mindset and seeing that some of the things that we have tended to think are inevitable consequences of growing old are not and can be stopped.

The Chairman: Mr Edwards, do you have any comments?

Nigel Edwards: No, I have nothing to add.

The Chairman: Dr Dixon?

Dr Jennifer Dixon: I have nothing to add, except that, from our perspective, we know enough. It is far more about action, and managing that well. On teen pregnancies, there was a fantastic success story, through multisectoral action over a period of time, with a concentrated focus and management.

Lord Turnberg: Do you think that Public Health England is putting enough effort into these sorts of ideas?

Dr Jennifer Dixon: Maybe that is something you should ask it.

Richard Murray: It is tricky for Public Health England. It is part of the department, so some of the levers we spoke about around taxation and regulation are difficult for it. It puts them in a constitutionally awkward place.

Q31 **The Chairman**: We are continuously told, in report after report, that, for the long-term sustainability of both health and social care, we need to keep people well for a longer period of time and to make sure that people do what will reduce their chances of getting diseases. If you are going to do that, and that is going to keep the costs down and keep people healthy, we need to put bigger effort in. The question is right. Who is in charge just now? If it is Public Health England, is it doing enough, or should it be somebody else? Unless we give this a priority, we will not get to a health service where people are healthier for longer. Do you have a comment to make about that?

Richard Murray: I completely agree on the priority around public health—it is just not instantly straightforward to think of what the constitutional and governance arrangement would be that would make that happen. In some senses, Public Health England was created to do that. Clearly, it is doing a lot of good work with local authorities and the NHS. It does not seem to make quite the same amount of progress—

The Chairman: The Wanless report made some key points. One of them was that you had to get to a situation of being fully engaged. We have never got to that stage.

Nigel Edwards: For the reasons that Richard has explained, it is difficult to ask Public Health England to do all the heavy lifting on that. This is a cross-government problem. I seem to remember that Andrew Lansley's original conception was that his role would become much more that of the Minister for Public Health, working across government. Various things intervened to frustrate that, but the thinking behind it was that public health is cross-government. It is as important in education as it is in health. The ability of the health system to improve health is estimated at probably no better than 20% to 25%; the literature varies on this. Most of the rest is done in other bits of government, through the creative use of taxation, what local government does to create healthy environments, what we do in schools and, particularly, early years and support for new parents, and, increasingly—as Michael Marmot has pointed out—what we do on income inequality. None of those things is within the reach of Public Health England, except by very indirect influence. It is constrained in how it does that by where it sits.

Dr Jennifer Dixon: There is a question here about how changes in local government could be accelerated. Everybody knows what the things to do are—the question is, how can they be done faster? One aspect to consider here is how local authorities share good practice. When I was on the Audit Commission, there was a local government group called IDeA, which was a bit like a modernisation agency for local government. It helped to cross-fertilise ideas and gave people support to make the changes that they needed. If, as we all agree, we do not think that everything can be done nationally, we should look more carefully at the regional or local government level to see what extra support might help.

Lord Lipsey: Is there not a tendency to fall back on generalisations in the health prevention field? It would be terribly helpful if one had a table that said, "If you spend an extra £1 on stopping smoking, your return will be X", or, "If you spend £1 on obesity, your return will be Y". That is especially true because these calculations are not altogether simple; if you do not die of smoking, you will die of something else later on. I may be wrong—you may tell me that this exists—but I feel that there is a terrific lack of hard evidence in this area.

Dr Jennifer Dixon: I have not seen that it exists in England, but Wales has just produced the very document that you are describing. It shows what the ROI—the return on investment—is for a string of major public health interventions. It is worth having a look at. Dr Tracey Cooper has been behind that.

Richard Murray: It does exist. You have to have an understanding of what you have included and not included in your costs. A lot of them do not factor in the cost that, if they stop you dying of one thing, ultimately you will die of something else. There is a bit of methodological understanding about it. However, many of the things we are talking

about—whether it is dementia, obesity or the consequences of physical inactivity—make you ill a long time before you die, so they inflict both a lot of costs on the individual who has them, primarily, and a long period of ill health that the health and social care system needs to adopt. In many cases, it is not just about life expectancy.

Such documents do exist. They tend not to be of the nature that you would find in NICE. Generally, they are not randomised control trials—they tend to come from other sources. However, they do exist. They have proved to be quite influential with local government, when the information has been put in front of it, but they are not instantly accessible.

Dr Jennifer Dixon: I am sorry for banging on about data just one more time. As a country, we have greater opportunities to track cohorts of people from cradle to grave than any other country in the world. That would allow us to do cohort analyses, looking at the potential for secondary and primary prevention for people who ultimately become ill. That is not a population health issue—it is much more an issue of primary and secondary prevention at a person level. However, in thinking through to the future, that should be a priority.

Lord Warner: We took evidence from the Department of Health on this. I came away with a very strong impression of a deeply fragmented service area. I could not work out who was really in charge. If this is a national priority, can your three organisations, which are full of clever chaps and chapesses, produce some thoughts for us on what a coherent national priority set of strategies could look like and who would drive them? That would be extraordinarily helpful.

The Chairman: Is the answer yes?

Dr Jennifer Dixon: Yes, we could help.

Richard Murray: Absolutely. It is fascinating that you have just said that. We have been in conversation with some private companies and other charities working around the public health agenda that have begun to ask the same question.

Lord Bradley: As you have touched on this, would you ensure that downstream mental health elements of that co-ordination are included? They do tend to emphasise physical health interventions, rather than the interventions in mental health you have alluded to.

Richard Murray: Absolutely.

Dr Jennifer Dixon: We have already kicked off one or two pieces of work. This year we have done quite a lot of reconnaissance on exactly these opportunities for public health gains. We can share some material.

The Chairman: Thank you very much. Today is an evidence session, so it is all on record. However, we issued our call for evidence only yesterday. We have read various publications that your organisations

have produced, but we cannot have those as evidence. If, after today's discussion, there is any material that you feel would be beneficial relating to our call for evidence, we would welcome that. If you were able to distil your various reports into the themes that we have identified in our call for evidence and to submit that as evidence, it would be very useful. Any information that you could send us after today's session would also be useful.

Thank you for coming in. It has been most useful.