



Select Committee on the Long-term Sustainability of the NHS

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

Tuesday 19 July 2016

11.35 am

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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. 3

Heard in Public

Questions 32 - 48

Witnesses

I: Michael Macdonnell, Director of Strategy, NHS England, Sam Higginson, Director of Strategic Finance, NHS England, Caroline Corrigan, National Workforce Lead - New Care Models, NHS England, Richard Gleave, Deputy Chief Executive and Chief Operating Officer, Public Health England, and Bob Alexander, Executive Director of Resources and Deputy Chief Executive, NHS Improvement.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Michael Macdonnell, Sam Higginson, Caroline Corrigan, Richard Gleave and Bob Alexander

Q32 The Chairman: I welcome you all to this session. I know you were all listening to the last session, so obviously you are geared up and ready to fire at us. Thank you for coming. We realise that you are the current NHS, but our focus, as you have probably gathered, is on long-term sustainability, thinking about beyond 2025 and finding out from you what we need to have in place by 2025-30 in key areas to make the NHS sustainable in the long term, so that we do not end up with the problems that you and providers out there face today. That is our focus, not the current issues. I know that might be a bit difficult for you, but we hope you will focus on the long term, not the short term.

As I said earlier, we are being broadcast, so any conversations that you and Committee members have will be recorded and seen, and we should try to refrain from that. Committee members will declare interests if they are relevant to the questions they ask. Would you like quickly to introduce yourselves? We will then progress to questions, unless you have an opening statement to make. I encourage all of us—Committee members and you—to keep questions and answers brief to get through, in the time, the many questions we have.

Michael Macdonnell: I am Michael Macdonnell, director of the strategy group at NHS England.

Sam Higginson: I am Sam Higginson, the director of strategic finance at NHS England.

Caroline Corrigan: Hello. My name is Caroline Corrigan. I am the workforce lead for the new care model programme.

Richard Gleave: I am Richard Gleave, the deputy chief executive and chief operating officer at Public Health England.

Bob Alexander: Good morning. I am Bob Alexander, the deputy chief executive and director of resources at NHS Improvement, which is the umbrella organisation for Monitor, the regulator, and TDA, the oversight body for non-foundation trusts.

The Chairman: We welcome you too. I know you are not part of NHS England, but you are important. Does anyone want to make an opening statement?

Sam Higginson: We did not know whether it would be helpful for me to make a few comments about our medium to longer-term financial modelling, given your interest in 2025 and beyond.

The Chairman: There was an interesting letter from the chief executive in the *Daily Telegraph* today.

Sam Higginson: Indeed. Perhaps we could touch on capital later on, if that is of interest to the Committee. It might be helpful to talk a bit about the modelling that we did to support the five-year forward view, because, although it only goes to 2020, it informs our thinking about what might happen after that. Briefly, the forward view made three big arguments about sustainability: first, that we needed a radical upgrade in prevention and people taking control of their health; secondly, that we needed to move to new models of care and redesign how we deliver care; and, thirdly, that we needed to deliver a step change in efficiency, in part delivered through our transformation investment. When we did the modelling that underpinned the five-year forward view, we looked at demographic and non-demographic pressures, which we projected to 2020-21 and which gave us the £30 billion challenge that many of you are probably familiar with from the documents we published. We then looked at the level of efficiency that we thought the service could deliver over time, which is why we modelled a 2% per annum efficiency delivery, rising to 3% at the back end of the Parliament. We argued that the additional 1% could be delivered through improvements in demand management, whether improvements from investment in prevention, new models of care or other demand management initiatives. Then we made the argument about what we needed to close the gap, because, in effect, the 2% to 3% delivered about £22 billion in efficiencies—challenging but doable—and the argument that we made at the time of the spending review was that we needed the extra £8 billion, which would close the gap. The Government agreed that that was the best way forward in the spending settlement.

If we think about what that means after 2020-21, inevitably our modelling is much less developed, because the further out we go, the more variable it is and the more there is uncertainty. Our long-term trend modelling suggests that certainly the demographic and non-demographic pressures will continue. For us, from 2020-25 onwards, it is running at about 7.5% per annum, so we asked what level of efficiency we think the NHS might be able to continue to deliver year on year that far out, and we think it is reasonable to assume about 2% per annum as a long-run average, which gives a 5.5% gap. To try to articulate what that means, it would be the equivalent of funding the NHS in that period at about 3% real-terms growth, which is higher than we currently receive in this Parliament, but lower than the amount of funding we put into the NHS in the 2005-10 Parliament, for example. That is as far as we got in our longer-term view.

The Chairman: But the whole argument is dependent on efficiency savings. What would make you feel that in 2025-30 you could achieve those higher efficiency savings if you cannot achieve them now?

Sam Higginson: I am arguing that the level of efficiency we might achieve in that period is 2%.

The Chairman: Per annum.

Sam Higginson: Per annum. Work that has been done on long-run averages by York University suggests efficiencies running at about 1.4% per annum over time. Work we jointly did with NHS Improvement and Deloitte argued that we could deliver a secure 1.5% over time, and we could do better than that in getting some catch-up efficiency. Work done by the Health Foundation suggested lower, flatter efficiency over the last Parliament, but, in the year 2011-12, 3% efficiency was delivered. We do not think that 2% is unachievable.

Lord Warner: How much of that efficiency saving assumes pay restraint, and how much pay restraint?

Sam Higginson: Of the £22 billion that we modelled for 2015-20, between £6 billion and £7 billion is a combination of pay restraint and national actions, which leaves about £15 billion for the service. Within that £15 billion, we assumed about £4.5 billion for demand management savings that commissioners can make and about £11 billion that could be delivered by the provider sector in its entirety. Within that £11 billion, we assumed that about £2 billion can be delivered by primary care, which leaves about £9 billion to be delivered by the rest of the provider sector. In our modelling, we assumed that pay restraint continues up to 2019-20.

Lord Warner: Ten years of pay restraint.

Sam Higginson: Yes.

The Chairman: What effect does that have on workforce morale?

Michael Macdonnell: In the original discussions on the five-year forward view—

The Chairman: No, answer that question—not any other question. What effect does pay restraint for 10 years have on workforce morale, when workforce pressures, which we will come to, are horrendous now?

Michael Macdonnell: It will have long-term effects on workforce morale, so, for the reasons Sam outlined, we will have to think about new ways to capture efficiencies beyond this Parliament.

Q33 **Lord Mawhinney:** I want to ask you about this modelling that goes on year after year after year. I want to talk about today, Chairman, but only as a direction for the long term. Every year, we have modelling and we build in efficiencies and we wind up with a deficit at the end of the year. This past year was a real doolally; we had £2.5 billion of deficits. We have modelling and statements that it will be okay and that by the end of 2017 we will virtually be back to a level playing field, but I bet a fiver to a bent farthing that it will be serious again. This demonstrates year after year an inability to do what you claim to do, so why should we believe any of it when we are looking between 20 and 25 years down the path?

Sam Higginson: I think the deficits that you refer to are the deficits in the provider sector, so Bob might want to comment on some of those.

The modelling approach that we take looks at the NHS in the round, so we need to think about the number you refer to for this year in the context of the £600 million surplus that the commissioning sector delivered, the overall position for our capital spend and what happened with the department's budget. As you say, in the last couple of years, the provider sector has run a significant deficit, but over the medium term our strategy would be to bring that into balance.

Lord Mawhinney: Of course your strategy would be to bring it into balance, but we can look at the history, at the amount of money the Government keep having to pump in, because your strategy is, "If we could just have another £5 billion for this Parliament, we would break even", but before we blink an eye it is £8 billion to break even. I give you another fiver to a bent farthing that before we get to the end of this Parliament it will be a lot more than £8 billion to break even. Whether you do it just on providers or whether you do it in the round, why should we believe you?

Michael Macdonnell: Historically, we have not run consistent deficits in the provider sector and we have been able to manage within our limits. It is important to remind ourselves of that context. It is true that this year in particular and the coming years are incredibly tight. I would argue that we have to keep that in mind. The other thing I would argue is that at 9% GDP a year we are still a pretty cost-effective health system. We are undoubtedly constrained and we can see the effects, but there is room, should a choice be made, to fund it more.

Sam Higginson: Another point is that, as part of the spending review strategy, we argued that we needed the £8 billion front-loaded, so £3.8 billion of it comes this year, because we recognise that we need to address some of our current challenges and get on the right transformation trajectory to get back to a sustainable position.

Lord Mawhinney: You would have us believe that, before the election in 2020, you are not going to ask the Government to increase the £8 billion already set aside in this Parliament.

Sam Higginson: Yes, our current strategy is to bring the NHS—

Lord Mawhinney: I am not asking about your strategy; I am asking if that is a commitment.

Sam Higginson: Yes.

Lord Mawhinney: It is a commitment.

Michael Macdonnell: Parliament votes, and that is what we are getting on with.

The Chairman: Are you also saying that you have a coherent plan that will close the gap between resource need and patient need, looking ahead to 2025-30?

Sam Higginson: No, what we are talking about is a coherent strategy up to 2020, which is 2020-21.

The Chairman: But looking beyond.

Sam Higginson: Looking beyond that, I was talking about our long-term modelling. What we can do with the modelling we have currently—to 2020-21—is projected further.

The Chairman: You are saying that your current plan, looking to 2020, is the model you used, but you cannot be sure, looking at 2025-30, that the model is coherent enough, or that you are confident that it will close the gap between resource need and patient need by 2030.

Sam Higginson: What I outlined was that if we take the demographic and non-demographic trends to 2025-30, that is my 7.5% per annum pressure, and if we then assume that the NHS can deliver 2% efficiency year on year, it leaves me with my 5.5% gap, which is the equivalent of a 3% real-terms increase in funding year on year for the NHS.

The Chairman: If we come down to the real 3% increase per annum that you will require, how do you think we might meet that in resource terms? Is it by direct taxation and free at the point of need, or do you think that another model of funding needs to be looked at?

Sam Higginson: We would argue that 3% real-terms increase year on year is affordable within the current NHS model. I referred to 2005-10, when the average funding increase for the NHS was 4% in real terms, so 3% is not unreasonable.

Lord Lipsey: I am confused. Why is a 5.5% gap filled by a 3% real increase?

Sam Higginson: Because inflation is built in.

Lord Lipsey: The 7.5% figure includes inflation.

Sam Higginson: The 3% real is 3% plus inflation.

Lord Lipsey: The 7.5% is a cash figure.

Sam Higginson: Yes.

Lord Lipsey: How much of that is inflation?

Sam Higginson: About 2%.

Lord Kakkar: I declare my interests in general and as chairman of UCLPartners. To be clear, those assumptions take into account all the changing demographics and the increased burden of illness that the population will experience over that period.

Sam Higginson: Yes, we have built in a series of demographic pressures, which try to take into account the changing age profile and

health of the population, and non-demographic pressures, which try to measure things such as new drugs coming through the system. Inevitably, non-demographic pressures are more difficult to model; we can predict some types of drug coming through, but we cannot pick up all of them. To give a sense of that, in the modelling we assume that high-cost drugs increase by 10% year on year, so we have built in quite a large number. This year, for example, a new Hep C drug came through, and that sort of impact is difficult to model over a long period of time.

The Chairman: Is it available as a document or is it just thinking?

Sam Higginson: About six months ago, we provided the Select Committee on Health with the document I have here.

The Chairman: Will you be able to respond by submitting evidence to us today?

Sam Higginson: Yes, I am very happy to. This document is our detailed modelling up to 2020, which will give all the numbers I have been talking about.

Q34 **Lord Warner:** The five-year forward view and the NHS chief executive assumed adequate funding of social care to deliver it. What assumptions have you made for the period after 2020 about the funding of social care to live within the parameters you have just given?

Sam Higginson: You are absolutely right, Lord Warner. One of our key issues was that all our modelling for the five-year forward view assumed that the level of social care—the offer—was maintained. The modelling I have just been talking about is more indicative, so it does not assume anything about social care at the moment. I guess you would argue that the offer remains flat.

Michael Macdonnell: More generally, referring to the article that Simon Stevens put out today, our view would be that, if there was additional money, we would need to talk seriously about trying to get social care to a more sustainable place, not only because of the effects on the people we are caring for but because of the effects on the NHS.

Lord Warner: Can we be clear about what you are saying? You are assuming a real-terms flat increase, so you just cover inflation, for social care for the period up to 2020 and after. Is that the assumption?

Sam Higginson: The five-year forward view is for the NHS—a health model only—so it does not have social care in it, but as an input to the model we assumed that the current social care offer remained flat, because if it increased or decreased there would be an impact on pressures in the health service.

The Chairman: Lord Kakkar has a supplementary, and then we will move to the next question.

Lord Kakkar: Just to be clear, in this type of modelling, if the levels of

increase in funding between 2005 and 2010 were maintained beyond 2020, the view of NHS England would be that the NHS was sustainable.

Sam Higginson: Yes, but subject to Lord Warner's point; it is very health-centric. Obviously, we do not have a current view for 2020-25 about social care, but our principal argument would be that the offer needed to be maintained.

Lord Willis of Knaresborough: There is legislation that says that we will have integrated health and social care. There is legislation that says that you have to increase your offer on mental health. Those two huge things are not even included in your assumptions. I find that absolutely staggering.

Sam Higginson: Mental health spend is included in our assumptions, because—

Lord Willis of Knaresborough: At current levels.

Sam Higginson: Yes. The current commitment on parity of esteem is to continue to increase mental health spending in line with overall growth.

Michael Macdonnell: In fact, we published plans today that show that increase in mental health services year on year. We can provide them to the Committee.

Lord Scriven: If social service funding does not increase to your assumptions, what is the effect on the healthcare system? If there is a 1% or 2% reduction over the period after 2020, what is the implication?

Sam Higginson: I cannot give you a numerical answer, but the implication would be that demand for services from the NHS would increase.

Lord Scriven: Could you write to us with that? I think it is quite important, because it is the fundamental basis on which you have made the calculations for a sustainable healthcare system.

Michael Macdonnell: Additionally, in several of our hospitals, beds are being clogged up and people are being cared for in environments where they should not be, so we are seeing the real effects right now. That is why Simon Stevens set out that one of the tests of the five-year forward view would be an adequate social care funding settlement. Another test was that we would have an upgrade in prevention and public health. I think we would all agree that the jury is still out on that—I am sure we will come to that. We have to do more about it, not least on the national obesity strategy that we are still waiting for.

Q35 **Lord Bradley:** You said you would write to us about the rebalancing. Is the mental health addition a transfer from physical health money, or is it new money to mental health on a projection going forward from the 13% to a significant balancing, to parity of esteem?

Sam Higginson: There are two things going on. One is the parity of esteem commitment, which is that the mental health share of spend should grow in line with overall funding growth. That will mean that spending on mental health will go up over time. Secondly, there are some specific funding commitments—for example, on IAPT, which is additional funding that we are putting into mental health.

Michael Macdonnell: The plan published today shows that in the SR settlements we have additional funding in mental health rising to £1 billion a year by the end of the Parliament. It shows year by year how we are allocating that and stepping it up.

Lord Bradley: We will see the figures. I should have declared my interest.

Q36 **The Chairman:** The responses that you have given created a lot of excitement, but the fundamental question that I do not think you have answered is the question I asked initially: do you have a coherent plan now for the NHS, social care, mental health and the prevention strategy that will close the gap between resources and patient needs by 2025-30? The answer is either yes or no. If you have a plan and the answer is yes, would you please submit evidence to us?

Sam Higginson: The answer is no. We have a coherent plan up to 2020 and our key priorities for delivering it.

The Chairman: As I said at the beginning, our inquiry is looking at 2025 and beyond. The answer is no, you do not have a coherent plan.

Michael Macdonnell: May we explain a little bit about why we do not plan on that kind of basis, or would you like to move on? It is important to recognise that we get resource settlements every five years, so planning for that is very difficult. More importantly, the job right now is to do less strategising and more implementing. Our job has to be getting on with getting stuff done—what we have already committed to do.

The Chairman: The question I asked, and this is the final question before we move on, is: should somebody be doing that? It could be you, but, if it is not you, should somebody be doing it? You referred to it; you said that beyond 2021 you had looked at the demographic changes that might occur and you had looked at the kind of drugs that might come in and the costs that might have to be addressed. You have done some thinking, if not planning. Would it not be better that somebody does actual planning rather than just thinking?

Sam Higginson: It is important that it is done. The issue is partly, as Michael referred to, that a key element is to do with the decisions the Government make about long-term funding commitments. Obviously, we can project pressures and efficiency assumptions, but it is very difficult to come up with a coherent plan without longer-term funding commitments.

The Chairman: Lord Warner, do you have any more questions?

Lord Warner: Not on the quantum. Do you want to move to the next set of questions?

The Chairman: Yes.

Q37 **Lord Warner:** The next bit of the equation that we want to try to understand better is the whole issue of how you actually fund services, and how you can develop payment systems that are more likely to give the service delivery systems you want. I assume that, if you are going down the path of vanguards and STPs, some work has been done on the adaptation of payment systems to help you deliver what you say is the best way forward on service delivery systems. Can you tell us more about that, particularly what has happened to some of the work that Monitor did on different payment systems?

Sam Higginson: I am happy to start. Bob may want to come in. We are working with the vanguards to look at the most appropriate payment system to support their objectives on integration and changing models of care. In principle, we think that the best way to address their objectives is to move towards what we call a whole-population budget, or capitation-type system, for much of the care they deliver. That is currently possible in the existing tariff structure, so, although in the existing payment structure about £30 billion of activity is on payment by results—activity-based pricing—it is possible within the current structure for commissioners and providers to agree to opt out and move to an alternative structure. We aim to pilot the new whole-population budgets and capitation-type budgets from the beginning of the next financial year in a selection of the vanguards.

Lord Warner: Do you want to add anything, Mr Alexander?

Bob Alexander: Yes, of course. Sam is right. The thing that was most interesting when you spoke with the previous evidence-givers was that no one could say there was a single payment funding solution. As Sam said, we are looking at supporting the vanguard in coming up with whole-population budget payment flows, where they can evidence how that would work, and then we need to stay very close to make sure that we and especially NHSE understand what the outcomes of that payment funding give and what the risks are to the financials of the vanguard. That becomes very important.

We have to look at upgrading the HRG currency that we use in the traditional payment mechanism to make it at least fitter for purpose in the now to inform how we take that forward. As Sam said, we are keen to encourage local health systems to opt out and come up with local pricing mechanisms, as long as we understand the impact that has on both the quality of patient care and the financial positions of the health systems we are engaging with. We are of course looking at introducing mental health payment mechanisms. Again, we have to be really careful about the impact on the organisation and what it does to the quality of care. Underpinning that, and not really part of the payment mechanism but absolutely crucial in giving us confidence as to how we are moving

forward on payment flows, is doing a piece of work across the system to improve dramatically the quality of cost capture in NHS organisations, so that when we start promoting payment mechanisms we know that we are doing it on a better financial information basis than we might have done previously.

Lord Warner: To be clear, by the time we get to 2020 and we start the new decade, will we have got rid of payment by results, or will payment by results still be a major driver of costs in the NHS?

Sam Higginson: There are some services that we will always want on an activity basis; examples would be some specialised services where it might not be appropriate to use a small geography to run a whole-population budget. Similarly, there are probably some elective services where we would want particularly to maintain patient choice and an element of competition. By 2020, I think we will have a mixed economy where there will be some payment by result services but a much greater proportion of services will be on a whole-population budget or capitation-type approach.

Lord Warner: Can you send us a paper showing where you think you will be on payments systems by 2020? That is when you will be starting your forecasting for the next five to 20 years.

Sam Higginson: In the next couple of weeks, we will publish our tariff engagement document, which will set out our thinking on payment for the next couple of years. I am sure that in addition we could provide you with the thinking that went out a bit further.

Q38 **Baroness Redfern:** There is difficulty in measuring outcomes on capitation, so data sharing is critical. Could you elaborate on that?

Sam Higginson: Absolutely. You might be thinking: why move to whole-population budgets? The argument behind that is that we would help to facilitate integration and closer working of services. There are two challenges; I think you heard a bit about them from the previous evidence-givers. There is a big challenge about how to maintain patient choice. What happens if someone is not happy with the caregiver in the locality? How we do maintain the opportunity for them to opt out and go somewhere else? The second issue is that, with a whole-population budget, where you are giving a provider, albeit it an integrated provider, a total contract sum for the year, how does the commissioner track performance, particularly on outcomes?

Baroness Redfern: Precisely. You get efficiencies when you can do that.

Sam Higginson: We absolutely recognise that there is a lot more work to do in that area, hence we are planning to pilot it in a small number of places next year.

Michael Macdonnell: International evidence, especially in the US, showed that, when they could not work out where the costs truly lie, a lot

of providers lost their shirt. It is incredibly important to do that kind of groundwork, and it takes a bit of time.

The Chairman: Mr Alexander, did you want to come back?

Bob Alexander: No, thank you.

The Chairman: Lord Warner, have you finished?

Lord Warner: Yes.

The Chairman: We will move on to Lord Kakkar's questions.

Q39 **Lord Kakkar:** I want to turn to the question of workforce. To go back to earlier exchanges on that matter, how do you think the NHS can develop a strategy to ensure that we retain a well-trained and effective workforce who feel valued and committed to an entire career delivering healthcare for our fellow citizens?

Caroline Corrigan: First, we need a strategy. I do not believe there is a workforce strategy for the NHS at this moment. Parts of a strategy sit in individual arm's-length bodies. It joins up—for example, Health Education England, Lord Willis's point about attrition and how important the pipeline is. It goes through to who owns the student and who is trying to attract the student. I am thinking particularly of nurses. There is a need for a joined-up strategy to address recruitment and retention. It exists locally, in local organisations and in parts of us as arm's-length bodies. There is an opportunity to pull it together more coherently.

Lord Kakkar: In the last session, we heard that the size of the NHS makes it quite difficult to do that type of planning across the entire country and across the entire organisation. To achieve a strategy for a sustainable workforce to 2025 and beyond, what model of planning, based more regionally, might be adopted? How are you going to overcome that particular challenge?

Caroline Corrigan: As you probably heard earlier, the job of workforce planning sits with Health Education England, and I can talk to you about some its work and some of our experience of supporting the vanguard sites in their elements of workforce planning. I think that members of the previous panel talked about the complexity of the NHS and whether it was more effective to plan local to regional than to plan such a complex system continuing at national level. My personal view is that regional and local works.

Michael Macdonnell: To add to that, we are developing 44 sustainability and transformation plans around the country; they are not quite regional but some of the populations range between several hundred thousand and several million. One of the things we want to see through that process is whether those planning footprints are more effective ways of looking at workforce needs, given that they are closer to what they are trying to do on new care models or the retention problems they are having. We would like to see a subnational way of doing it emerge that

can connect with the national. Clearly we will need some sort of view nationally of the consequences, but that is one mechanism that might answer the question.

Lord Kakkar: Let us say that the STPs have a view about what the workforce needs are. What exists in the system at the moment, or in what way might we describe the medium-term needs, by way of capacity to develop the workforce?

Caroline Corrigan: To develop the workforce for—

Lord Kakkar: To address medium-term needs beyond 2025-30.

Caroline Corrigan: The aggregation of those plans through Health Education England and the forecast supply and demand pictures are all driven through Health Education England processes.

Lord Kakkar: Health Education England is now interacting with the STPs and starting to receive that information.

Caroline Corrigan: Yes. Colleagues in Health Education England talk about local workforce action boards that have been set up on each of the STP footprints, and natural flows of both labour market and students, and being able to look at the data of the workforce plan against the financial plan for the STP. Some of the work we are doing in the vanguards informs that planning process.

Lord Kakkar: Do you think the workforce planning and future longer-term workforce needs properly inform the financial plan? We heard earlier that the two are very distinct and that a 10-year effective pay freeze for the workforce will have a profound impact on morale? Do you think the two are properly joined up: the financial and the workforce assets?

Caroline Corrigan: Personally I believe that they are more joined up than they have been. It is the first time in some time that I have seen the financial and workforce templates go out together. Between us, as arm's-length bodies with Health Education, we are talking more about better data collection than potentially duplicative and fragmented data collection on the workforce.

Michael Macdonnell: Bob might want to come in on this. If we are being honest, one of the things we see at provider level is unrealistic staffing assumptions, including agency staff. I think there is still a job of work to look at what we can afford and what they think they want to bring on.

Lord Kakkar: I think Mr Alexander might have a view.

Bob Alexander: In no particular order of priority, if there is one area of medium-term, even short-term, planning the service could dramatically improve, it is the triangulation of workforce planning with financial planning. Where we are at the moment starts us on the aspirational journey to do that. In the past, it has been disappointing.

Lord Kakkar: Why has it not happened in the past? Why has it been disappointing?

Bob Alexander: Probably because it has been siloed—the purview of the finance director and the HR director. I am sure we are moving through that, but if you had asked me X years ago I would have said there was something in it. If even the timescales when people ask for a financial plan versus a workforce plan are not aligned, the likelihood is that there will be things that do not necessarily reconcile. We are in a completely different place now.

Specifically on medium-term strategies and what we can do, it strikes me that the strategy is best informed by understanding what is happening now, because then we know what we are trying to fix. A Commons Committee—the PAC—has already asked my organisation to do a piece of work on understanding the current key drivers of nursing turnover and the retention issues that need to be addressed. The result of that should be some time in the autumn. We are doing that piece of work with organisations; it is not just NHSI. I suspect that, having done it, we will try to move into the areas of medical turnover and medical retention. We hope that those pieces of work can directly inform medium workforce planning, let alone longer-term workforce planning, because it strikes me that that would be very beneficial.

The Chairman: Several people want to speak. Lord Willis first.

Q40 **Lord Willis of Knaresborough:** What is coming out of the STPs is very interesting, but what it tells us is that the current skills mix of staff is inappropriate for today's use, let alone in 10 years' time. In the past, the big failing in looking ahead 10 years was designing a future workforce based on the needs of today. We have to get away from that. What thinking is going on at strategic level to drive the changes that appeared in Greenaway's report and in my report, all of which get pushback from the professions themselves? They like silos.

Caroline Corrigan: I can talk about our experiences through the vanguard programme to tackle exactly that point—working with sites to say, "How would you redesign your workforce?" It starts with the basics, which are not to keep counting it in the same way. At the moment, the processes and systems ask providers to say how many doctors, how many nurses and how many of the individual professions they think they will need next year. We are working with vanguard sites to start talking about skills, care functions and the design of work and the design of skill and competence to enable that new service. It is happening now, bottom up, in vanguard sites, stepping away from the processes and systems that demand that you count the same and model the same. Strategically, we take that work to Health Education England to say what we are learning through those sites and how it informs strategic direction, not just the workforce planning pieces but strategy around skills and training pipelines.

Michael Macdonnell: I would add three things strategically, drawn from this and from international examples. One is that we certainly need more generalists than specialists. The number of hospital doctors has grown at three times the rate of GPs in the past, and we need to turn that round. We may need other generalists—geriatricians and so forth. We need maximum flexibility between roles, because we do not know—

Lord Willis of Knaresborough: Whether they are going to come.

Michael Macdonnell: Exactly. We need people to be able to work across hospitals, in mental health, physical health or social care.

We need more incentives for people to work as a team—in multidisciplinary teams. All the international examples are about autonomous teams being able to work around patients, and I do not think we have the funding flows.

The Chairman: Thinking long term, one aspect is the pool that you have to recruit people from. If that pool is not big enough, you cannot recruit people. The second thing is retaining them, and the skill mix that Lord Willis referred to. We need to do some thinking out of the box. You say that we need more generalists, and we agree. Sitting around the table, there are five specialists. Why do people choose a specialism? Because that is what they want to do and there is an opportunity. If you increase the pool you draw from and you do not control its size—the number of doctors we train—your pool will be bigger and you can say to the pool, “We need more generalists”. Why do we not think out of the box?

Caroline Corrigan: We take those challenges to colleagues at Health Education England and say, “How do we do this? How do we change the training pipelines? How do we pay better attention to the labour markets that sit around STPs, for example, and consider the workforce model of the future differently?”

The Chairman: Good.

Lord Ribeiro: One of the problems with a pipeline, whether it is for doctors or nurses, is that it takes a heck of a long time. That has probably predicated British policy on recruiting from overseas. We have one of the highest recruitments of nurses from overseas, compared with many other countries. Given that we are leaving the EU and that 10% of our doctors and 4% of our nurses come from there, you must have done some planning. The Government have been accused of not doing any planning if we came out, but you must have done some on what would happen if we no longer had access to those staff. What have you done on that score?

Caroline Corrigan: I can refer both to work that Health Education England has done with the Centre for Workforce Intelligence on some of that modelling and to some of the work that is flagged in Health Education England’s commissioning and workforce plans, which flagged those sorts of issues. It talks about some of the European labour market

analysis and whether that is sustainable. I am flagging; I have knowledge of Health Education England's work in that area rather than our work.

Lord Ribeiro: The Centre for Workforce Intelligence work, looking to 2035, must have been done before we decided to exit. Therefore, those ideas have not been introduced into it. Will there now be some thinking?

Caroline Corrigan: I would need to check with Health Education England colleagues and the department.

The Chairman: When we have them as witnesses, we will pursue that. Lord Scriven, is your question answered?

Q41 **Lord Scriven:** I declare my interest as a member of Sheffield City Council. Clearly, in the new world of integration, workforce planning means much more than just healthcare planning. Beyond STPs, which are a bit patchy around the country, what is the thinking regarding joint healthcare planning, looking at what will be needed in the new network-type approach to delivering services, rather than just within organisational boundaries?

Michael Macdonnell: STPs are our main mechanism for trying to drive this. They are patchy, although Sheffield is a good one. We need to make them better, not to find many other planning mechanisms. STPs have to be a way in which we look across the system, across multiple years. There are smaller, more localised examples—the vanguards are some of them—where social care has been planning together with physical and mental health services. However, when it comes to getting together a geography or place-based plan that brings together local government and health, that is how we want to drive it across the country.

Baroness Redfern: Did you say "place-based"?

Michael Macdonnell: Yes.

Baroness Redfern: I must declare that I represent a local authority. How do STPs play with devolution, on the boundaries and the commitment? How important is that?

Michael Macdonnell: One of the things that we expect to see is horses for courses out in the country. Not everywhere will be amenable to a Manchester-type settlement, but we want to invite as many places as possible to take control of their own destiny. We see STPs doing that. There are graduated steps along the way—

Baroness Redfern: There are flexibilities built into that, if you issue a good case.

Michael Macdonnell: Yes. We are giving them an indication of their blended budgets. We are trying to get joint governance and decision-making in place between local government and healthcare. In some places, we may put control totals in place. We can talk about that, if you would like. There are a number of steps along the way—depending on the

strength of their plan and, much more importantly, on the strength of their leadership team—that go some way towards a more devolved system.

- Q42 **Lord Lipsey:** Can we turn to integration, particularly health and social care integration? We know that big efforts are being made to move that forward, but there seems to be quite a contradiction between the belief among many people that you can wave a magic wand and all the problems will go away, and some of the actual estimates. The NAO said that the evidence for any savings was not strong. When the Department of Health saw us, it put them at the top end of £500 million. Can we resolve the contradiction between this as an ambition and the rather modest estimates for savings?

Michael Macdonnell: There are different types of integration—horizontal, vertical and so forth. My take on it is that, when we talk about savings, we are talking not about cutting money but about spending less than we otherwise would, on the projections Sam has talked about. We are trying to bend either the demand curve or the supply curve—or both, if we can. Those are the sorts of savings that we are looking to get. We are seeing green shoots in some of our vanguard sites. It is early days, and we need to do much more work on it, but some of them are getting reductions of as much as 30% in non-elective admissions. If that carries on, it is a material reduction in demand and cashes out in lower funding requirements down the line. If you are looking as far as 2025 and are able to bend that demand line—or to moderate it slightly—it makes an enormous difference. To my mind, that is what we are looking for. You are right to say that the evidence is not cut and dried. However, if we do not start now, I do not know when we will. We have to get on with putting some of these reforms in place.

Lord Lipsey: Could I follow that with a supplementary? There are two big things that need to be considered for integration. One is joint budgeting, on which various experiments are taking place. The other, which is joint payment systems for the individual, is much trickier, because healthcare is free at the point of use and social care is not—it is means-tested. Even on the modest Dilnot proposals, which would not have eliminated that difference entirely by any means, it would be £3 billion by 2025. If you start talking about free social care, on the Scottish experience I guess it would be £8 billion to £10 billion, which just will not be available. That is cracking on for nearly 10% of the health service budget. I do not know whether you think that you can do a good deal of integrating without integrating the amount that people pay.

Michael Macdonnell: On global integration at a national level, there are different systems of eligibility and different levels of funding. In my view, that needs to be resolved before we can go any further out. There are two other ways in which to integrate. One is in provision terms. That is much more meaningful for patients, as they see people able to manage services around them and can navigate through services. Some of Caroline's work is based precisely on that. There is also more localised budgetary blending. Personal budgets are an obvious example of that.

We want to expand it to many thousands over the coming five years. People will be able to blend their social and healthcare budgets and will have control—or partial control, alongside advisers—of those funding decisions. There is a lot that we can get on with locally. Internationally, I remember meeting somebody who had looked across all 800 ACOs in the US. They said that, although they are very different, the one thing that they had all done was invest in what we would call social care, because that is where the costs come from. That will happen locally and organically, even if we do not solve our national question in the next couple of years.

Q43 Lord Warner: Could you walk us through a bit more what you are seeing from the STPs? I will not hold you to the 30% figure, but these are stonkingly big gains. What are the implications of that? Is it widespread? What are the implications for learning out of this experience? What barriers need to be removed? What are the implications for the workforce? What will you change there? Traditionally, people in social care have been rather good at stopping medicalisation of problems, which is much cheaper than medicalising problems. What lessons are there? For the purposes of this Committee, how quickly will we get them from some of the STPs?

Caroline Corrigan: You asked about the learning to date from the vanguard programme. What are we learning from the sites? What are the enablers? What are the blockers? We have information that we can share with the Committee on exactly those things. Based on evidence when the programme was set up, we knew that we would need to do work on workforce and clinical leadership to take forward the changes would be critical. We knew that IT and digital would be important enablers. That is what we are learning from the vanguard sites.

Now that the vanguards have been up and running for nearly a year, in some cases—in others, it is less than that—we are pulling together information on what green shoots we are starting to see, in which sites and how they have made that happen. The vanguards themselves are probably the best advocates and the best people to talk with their peers about how they have made the change, what journey they are on and what they need to do next. Where we are seeing a spread of the vanguard sites or the specific examples where there are green shoots—where they are starting both to spread the learning and to persuade clinical colleagues that this is a good thing—the strongest voice comes from the vanguards themselves. We can share information about the green shoots, the sites themselves and what they are focused on. From the workforce perspective in particular we can share information on the notion of multidisciplinary teams. It is not new, but the most effective areas are those where multidisciplinary teams of staff from different organisations come together, look at the health and care needs of individuals, and plan and manage those. It can be quite simple. It does not require big organisational change; it requires great clinical leadership and great team leadership. We have examples of our teams significantly changing, improving care for patients and making that more cost-

effective. That is the sort of work that we are doing in the vanguard programme. We are happy to share those green shoots.

Lord Mawhinney: Can I bring integration down into the lives of real people and patients, particularly those who are most exposed to it—namely, the elderly, for health and social care? The NHS constitution says that the NHS “is there to improve our health and wellbeing ... to the end of our lives”. It is the “end of our lives” bit. In the context of integration, what are the most recent improvements in health and well-being for people who are in the last couple of years of their lives? How will that improve even further over the next five or 10 years?

Caroline Corrigan: Can I pick up some examples? I am flicking through some papers that I have here. I am thinking particularly of the work that we are doing with care home sites. As part of the vanguard programme, we are supporting six care homes, with the systems in which they operate, to make improvement in end-of-life care and to improve workforce issues, such as the workforce that sits between health and social care and how those people move between the sectors. Those six vanguard sites in and around care homes are focused on improving frail-elderly and end-of-life care. We can give you some examples therein of the difference that they are making.

Michael Macdonnell: Here are two tangible ones that I have seen. The small example is a red bag for people who are towards the end of their life and go into hospitals very often. It enables them to have all their belongings and information with them, so that they do not get medicated wrongly and they know whom to call. That has made an enormous difference in one of the care home vanguards. Another is Airedale, which has used technology to link GPs with care homes so that people do not have to go into hospital. GPs themselves are giving them care and keeping them where they are.

Lord Mawhinney: Do you want me to believe that the NHS constitution is satisfied if you are making real progress for 2%, 3% or 4% of the public and that it does not really matter what happens to the other 90-something per cent? What will you do more generally to improve the health and well-being of the frail elderly? For example, bed-blocking has been a significant, disgraceful problem in the NHS for years. Everybody says that it is somebody else’s fault. What happens, first, to the poor patients who cannot get into the beds and, secondly, to those who cannot get out of the beds? How does that fit into improving “health and wellbeing ... to the end of our lives”?

Sam Higginson: The point about the vanguard programme is that, rather than being a top-down thing, where we think up some ideas here and try to impose them on everyone, it is a bottom-up thing, where places get to try out ideas and to understand what really works in their locality. In the next phase of the work, the idea is to try to spread that as quickly as possible around the country. Going back to your 2% versus 96% argument, while we have only a small number of vanguards working

at the moment, the idea is that we will spread that to the rest of the country as quickly as possible. You will then improve your reach.

Lord Mawhinney: If it comes from the bottom up, how will you spread it?

Michael Macdonnell: There is a mixture of ways in which we try to spread this, but it is not invented ourselves. One way is to reduce barriers or to give enablers. One thing that we can do is create new blended contracts that give control of our primary and community care budgets. We can also use our purchasing power in a harder way, to make sure that people implement what we know works.

Lord Mawhinney: Just before the Chairman tells me to shut up, can you explain to me what you are planning to do about bed-blocking?

Michael Macdonnell: We have a couple of things. It is not something that we can solve by ourselves. The better care fund has been put in place for that, in part. Perhaps it has not had the success that people wanted it to have, but in some places we are seeing real success. One example is Oxford, where the new chief executive has employed his own social care workers and closed 75 beds that were previously blocked, as you put it. There is progress, but we cannot solve it all ourselves. It goes back to some of the initial arguments about the implications of social care not being properly funded.

Lord Turnberg: It will be interesting to see how the vanguard sites work out. As you say, it needs long-term, high-quality leadership. Unfortunately, that does not grow on trees. The Committee is probably a bit fed up of my banging on about Salford Royal hospital, which has had a chief executive in post for maybe 15 years. He has a very good team of clinicians working with him. He has taken on the budget for social care from the local authority and has all his GPs linked up to his IT system. I would be interested to know whether you have made an assessment of that. It can work, but it needs these people. How do you get them?

Caroline Corrigan: Where to start? At a strategic level, what is our plan for growing leadership—the sorts of leadership that we need for the services of today and of the future? The work between NHS Improvement and Health Education England in particular on leadership and development strategy is really important. Clinical leadership is where we need to focus more of our energy. You have described great organisations that have great leaders. Most usually have great clinical leadership teams. There is something about whether we invest enough in clinical leadership versus what is sometimes termed heroic management leadership. At a strategic level, it is coming together. More questions are being asked about how we invest in leadership development, who we invest for and what type of leadership we are really trying to grow through these pipelines. Are the leaders of today fit for the future?

Locally, through the STPs and that process, we are seeing a reinvigoration of the conversation about the sort of leadership that we

need and how we invest locally, not just nationally, in the type of leadership that we will need. We are likely to see more regional and local leadership development, versus a national strategy that says, "We are the only place that can grow them". I could go on. There is much commentary out there. It is a great step forward that we have NHS Improvement, with Health Education England, refreshing—that is probably the best word—the leadership strategy going forward.

Michael Macdonnell: Of course, one other response to the problem is to make that leadership go a bit further. David Dalton is a good example of where chains, hospital groups and so forth are an attempt to make use of the limited resource that we have in that sort of leadership.

Q44 **The Chairman:** When I listen to you talk about vanguards, the STPs, et cetera, it is obvious that you do the thinking. You are responsible for running NHS England. You were the first ones who came up with a forward view of how the service could develop over the five years. You have answered my question. Are you not able to go beyond that and say, "In 2030, this is what healthcare, social care, the preventive aspect and everything else should look like. If that is where we want to be, these are the steps to get there, and this is what the cost will be"? I accept that you are not charged to do that, but somebody needs to be charged to do it. If you are the kid who comes around the block only every five years, we will not get that long-term sustainability of the NHS. Is that correct?

Michael Macdonnell: The part that we do not do, on a much longer time horizon, is the funding or the resources, for some of the reasons that we have discussed. We do a lot of other thinking further down the line. The new care models programme is based on a vision of where we want to get to.

The Chairman: Okay. It would be helpful to this Committee, whose task is to look longer term, if you would submit as evidence what you are doing that will make the NHS sustainable in these areas if we do X, Y and Z now to get to that position. At the same time, in the evidence that you submit, you could say what things you are not doing because you cannot do them or are not asked to do them—giving the honest answers. That would help us. I hope that it would help you, too, in the long term.

Lord Warner: Can I follow up on that point? Could you take a specific part of the country and, based on what you know about vanguards and STPs now or what you will know in the next few weeks, say what the health service in that geographical territory will look like in 2025? I am not asking you to do more than your best guess; no one can ask more than that. We are struggling to get a picture of what the NHS will start to look like in 2025 or 2030. No one seems to be able to give us that picture. You are the nearest that we have for that, because you are looking at new service delivery models.

Michael Macdonnell: I can put some stakes in the ground. We can write—

Lord Warner: You need not answer the question now. It was really just to get some stuff flowing to us.

Lord Mawhinney: You have told us about good things—vanguards, STPs and so on—and have given us an example of where bed-blocking has reduced, but I do not have any sense of how quickly that will become the norm. It would be extremely helpful to know when you think 25%, 50%, 75% and 95% will be achieved on these sorts of things.

Baroness Redfern: I feel sorry for Richard, because he has not had an opportunity to speak on public health.

The Chairman: We will come on to that.

Baroness Redfern: Following on from Lord Warner, with the STPs and the vanguards, can we also see how public health has played its part, and the part that it will play in future, in the sustainability of the NHS?

The Chairman: We are coming on to a question specifically about that. Lord Willis will lead on it.

Baroness Redfern: Okay. I beg your pardon.

The Chairman: Lord Scriven, you have a question before that.

Q45 **Lord Scriven:** Yes. I want to look at data and digitisation. In the last two evidence sessions, it has become quite clear that the NHS does not have a good record on collection, use and sharing of data. Everyone has said that it is really important to help us to move forward and to help with planning and delivery of healthcare. What is the thinking about improving collection, sharing, use and analytics of data going forward, to help to make the NHS more sustainable? The second question is: what role do you see for digitisation of services in the delivery of healthcare? How is the NHS looking at the implementation of only effective services in that field, as it would for any other service that it introduced?

Michael Macdonnell: You are right. You asked the Department of Health to what extent this service is digitised. That is a very difficult question to answer, because the service is broken up into sectors. We think about patient records, services to patients, back-office—

Lord Scriven: That is why I asked the question.

Michael Macdonnell: At the broadest level, we are moving towards a much clearer focus on setting the basic standards that are required nationally and then letting people locally build what they need to around that. Interoperability is a good example of that. In the past, we have pushed out a single solution nationally. That is no longer where we want to be. It is certainly not the direction that Bob Wachter will recommend that we go in when his report comes out. It is about getting and enforcing some basic standards that allow people interoperability, so that they can work together and share data. We have some different mechanisms to do that.

Lord Scriven: A lot of it is not about machinery—it is about human behaviour. You can have all the correct IT kit in the world, but this is about human behaviour.

Michael Macdonnell: Absolutely. We can do only so much about that at the national level. One thing that we can do, for instance, is put clinicians at the heart of this and in leadership positions. That is why we have just appointed a clinical CIO. We will expect other systems to go down that route. Indeed, we will help some exemplar systems to show how this is done better, in a world-class way. For instance, we will work with some of our emerging chains on showing how IT can drive standardisation. We need to show what best practice is so that others can replicate it. Equally, there are some parts of the country that have solved the data-sharing problem better than others. Lancashire and South Cumbria is one I have been to recently. It has solved all kinds of problems that other people say cannot be solved. We need to push that outwards. That is what we can do.

Lord Scriven: Making it sustainable is about finding good practice. In everything we have talked about, one of your roles is getting that to scale, using your management overhead nationally. What will you do to bring this to scale, so that it helps the NHS to become more sustainable, more efficient and more effective, and to get better outcomes?

Michael Macdonnell: Beyond identifying those standards, we need to start enforcing them. We will start increasingly to do that in our commissioning decisions. We will not buy from providers that are unable to meet the standards that we require. Minimum standards on interoperability are one example of those. We can also support that directly through funding decisions. We have a £4.2 billion fund, through the spending review, that we need to use judiciously and conditionally to drive the spread of this sort of best practice.

Caroline Corrigan: Having those sorts of leaders and those sorts of things done addresses your point about human behaviour. In the meantime, there is also the job of role models—clinicians—talking to other clinicians about why they can do a Skype call and how it works behind them, in the clinical services wrapped around that type of simple digital. Yes, there are levers and contracts, but clinicians have a part to play in scaling this, by stepping forward and role-modelling it.

Lord Scriven: One of the key issues that we have heard in previous evidence is on the analytics—the use of big data, which is beyond the local, to drive improvement. What systematically is the forward thinking about the use of big data, integrating it into the work of the NHS and making sure that the analytics about health information are used appropriately to drive improvement, efficiency and effectiveness?

Michael Macdonnell: We are still in the foothills of this. There is no claim that we are using big data far and wide. Clearly, we need to encourage more of that. The area where I see green shoots most is in increasingly predictive analytics about populations and their health risks.

One area I am in touch with—Rochdale, up in Manchester—is working with part of Google and building a predictive analytical platform that looks not just at health and care data but at other data to try to understand better when people are likely to get sick or to have different needs, so that we can make better allocative and, indeed, operational decisions on them. Several other parts of the country are doing that.

Lord Scriven: From what the Department of Health said and from what you have said, I do not get the feeling that anyone has a grip on this strategically. There is a lot of good practice and you talk about a lot of things, but where is this in the strategic planning and focus to help to deliver a more sustainable, effective and efficient NHS? Who has the lead? What is happening to get this at scale, across the board, to make sure that it is delivered in a way that is effective in helping the NHS to deal with its problems?

Michael Macdonnell: We have the lead. On our board, Matthew Swindells has the lead and has appointed a new CCIO, who works on behalf of the system. We accept the accountability on that. We may not be doing enough, but it is baked right into the forward view and right into the STP process. We have digital maturity assessments. We are trying to bring it up the strategic planning agenda. That is quite different from saying that it is as widespread as it needs to be.

Bob Alexander: I may be able to help a little more on that. There is a national digital 2020 strategy, which is backed by the existing Secretary of State for Health. As Michael said, it is backed by some funds that were made available in the spending review. The appointment of a clinical chief information officer who will lead that strategy on behalf of NHS England, the department and NHS Improvement has been an important part of that. The strategy is broken up into particular domains, each of which has a governance and a work programme. Frankly, some are more developed than others. As Michael said, there is a bit of foothills stuff here—some are better than others. That can be made available in evidence to the Committee, now that you have opened your evidence door.

The piece about digital maturity and assessing how patches are has been done. The trick now is to map it into STP environments, to make sure that there is congruity and that the STPs themselves are switched on to it. The real trick is both to back exemplars as best-case demonstrators, to encourage other parts of the country and to show what the art of the possible is, and, by the same token, to identify parts that will not get there by themselves, with the best will in the world, because of capability. We must support them either by linking them through to the exemplar piece or by working across arm's-length bodies, as Michael has intimated, to make sure that we support the right people. We can make something available to the Committee as part of this.

Q46 **Lord Willis of Knaresborough:** I would like to end with a very easy set of questions to Richard, who has waited very patiently. As you have mentioned before, in his foreword to the five-year review Simon Stevens said that we had to have a radical approach to prevention. When you look

at the figures, you find that obesity is costing us £5.1 billion, smoking is costing us £3.3 billion, alcohol is costing us £3.3 billion and inactivity is costing us nearly £1 billion. Those are huge sums of money that we need to tackle. Public Health England was set up to address that and to improve the health of the nation. What is happening at the moment that you can project after the five-year plan that will give huge savings that can accrue to the health service and solve the problem that Sam and Michael have?

Richard Gleave: All the time we are jumping between the now and the future. Let us start by doing some of the “now” stuff and then look forward to what that means in the future. If we look at what is happening now, of the 180 or so indicators in the public health outcomes framework, 82% have remained stable or have improved over the last three years. As we know, life expectancy is going upwards really markedly. That is an international phenomenon, but in this country, in some places, it has been happening at a faster speed than in other countries. One of the big issues is that healthy life expectancy, although increasing, is not increasing at the same rate as life expectancy. That is creating some of what we have called in the five-year forward view the health and well-being gap that is there.

The radical upgrade in prevention has a whole set of aspects to it. It is about prevention to improve people’s quality and length of life—their health status—but it is also about prevention of use of high-cost health services by looking at the alternatives. We have talked quite a bit about that component of it.

Lord Willis of Knaresborough: Can I stop you, Richard? The Committee and I know all that. What are we doing to project forward to address these issues? Wanless had some ideas, but that seems to have gone into the long grass. What are you doing now to create a platform so that, by the end of this five years, we really have a platform to address these fundamental issues? Ten per cent of our children are leaving primary schools overweight or morbidly obese. That has huge problems 10 years down the line.

Richard Gleave: We are taking practical steps now, for the five-year forward view. We have identified six areas of interventions. In another 13 areas, we have provided very specific advice to STP teams about interventions that they can put in place and fund in order to address the five-year forward view. I can run through or share those, which have been sent to STP leaders. They are very practical. I have the alcohol one here, if you want me to run through it.

That is the foundation for the next five years. In effect, it creates a platform on which the longer-term sets of issues then need to be addressed. Some of them are about rolling that out across the whole country. In today’s hearing, we have already talked in a number of settings about the rollout issue—how fast things roll out. Inevitably, with public health, which is not a tightly managed and controlled system and puts together the multifactorial set of interventions that Jennifer, Nigel

and Richard talked about—national government legislation, taxation incentives, personal behaviours and services that the NHS and local government commission—sometimes that rollout is not as fast as we would like.

Lord Willis of Knaresborough: I understand that. I am just asking you what traction you have with the rest of government to address some of those fundamental issues. We know that education and housing, for instance, are fundamental factors in improving health and life chances. Do we have any traction in those areas, or will it all be left to Public Health England? You have no money to do any of this. Do you just pray?

Richard Gleave: We are not a commissioner of services. The commissioning budgets sit with NHS England, for national public health intervention, and with local government.

Lord Willis of Knaresborough: Yes. They will not take any notice of you unless you can say to them, "By doing this, we will save Y".

Richard Gleave: With NHS England, there is a whole series of examples where we have said, "This is what the best-practice advice and the evidence base say". We see that around vaccination programmes. We have a world-leading vaccination programme in this country that NHS England commissions. We are seeing it in the diabetes prevention programme, with a significant investment in diabetes that is looking to the post-five-year return, as well as the in-five-year return. You have to do both those things. There is a set of interventions we want to talk about on obesity—both childhood obesity and adult obesity. Adult obesity is where the bulk of the cost implications are now, but child obesity is where they will be in the future.

That is with the NHS. With local government, we talk about a massive range of areas. We have the framework around the public health ring-fenced grant and the way in which that is used, with a series of mandated services and functions for local government to commission on. We provide evidence, advice and support around those. E-cigarettes are a really great example. The advice on stop smoking services and what you do about stopping smoking is changing as a result of our report on e-cigarettes. That is a dramatic change. We have a world-leading piece of research there about the practical implications of e-cigarettes for tobacco control.

Lord Willis of Knaresborough: Yes, but there are some clear things missing. For instance, on mental health—I am sure that Lord Bradley will come in here—the smoking cessation programme did not touch people with mental health issues, because you could still smoke in centres. However, there is research going on—not by Public Health England, because you do not have any money, but by other organisations, in Sheffield—that is looking at that and will be rolled out across the country. Where are you doing your research? Where are you gathering the evidence to say, "This will be the next important initiative for us to address"?

Richard Gleave: There is evidence that we have put into the public domain very recently. I have mentioned the report on e-cigarettes. The sugar report that we presented has made a major impact on the public debate about sugar. There are other areas where we have reports forthcoming. We are doing some work around air pollution, which is an important area across government. We do a lot of research around new and emerging infections and future threats. That is not an area I have heard about in the evidence that you have collected so far. The national risk register has influenza as the No. 1 threat to civil contingencies. It is an absolutely central area of debate. There is also work around alcohol. We will have a report on alcohol coming out in the future. Those are some examples.

Q47 The Chairman: My point relates not only to this issue but to other issues that we have already discussed. This Committee is all about long-term sustainability, to get a health service in 2030 that meets the needs of the population in every respect for a preventive strategy—not just for the primary prevention of disease, which you mostly focus on, but, linking with NHS England, for the secondary prevention of disease. Stopping people who are sick getting more complications requires a different kind of delivery system. How do you get all that joined up? Are you not working in silos? You have NHS England, Public Health England and NHS Improvement, all sitting separately and thinking in different ways. Are you not sitting in the wrong place?

Richard Gleave: Most emphatically, that is not the approach that we have on the ground. We have that embedded—

The Chairman: But you are sitting in the wrong place. You are not with NHS England.

Richard Gleave: We have staff who are embedded in NHS England. If you look around the country, you will find about 300 Public Health England employees who are embedded in NHS England. We are really joined up about this.

The Chairman: Why do you not just be part of it?

Richard Gleave: That decision was taken in 2013 by Ministers. You would have to ask government why it structured it as it is. My job, and the job of my colleagues, is to deal with the system we are employed within, to make that system work as effectively as we can. We have a great set of partnerships around public health.

Michael Macdonnell: If we had to recreate the system, none of us would recreate what we currently have. However, given what we have—just to add a vote of confidence in this—under the five-year forward view, the chief executives meet every month to drive this agenda. They meet on many other occasions, at different levels. We are trying our best to co-ordinate and provide a much more unified voice. We have achieved some of that, but clearly there is more to do.

Richard Gleave: The role of local government is absolutely central to this. About a month ago, we were at the Health Select Committee. Members of the Committee said—not in a report, but as individual members—that there was no doubt in their minds that moving public health local leadership to local government was exactly the right thing to do. That addresses the wider determinants. Earlier Nigel said that healthcare was accountable for about 20% of the improvement in health. McGinnis says that it is 10%. It is not the major factor here. We have to mainstream this into what local government is doing. It is about places and making the health of local communities absolutely central to the agenda. We must then bring healthcare services in in order to play a crucial and complementary role within that. The STPs have been set up to do that.

The Chairman: I will take questions from Lord Bradley and Lord Warner. Then I will bring the hearing to a close.

Q48 **Lord Bradley:** I will rise to the challenge from Lord Willis. Another figure in the NHS forward view is that not tackling mental health is costing £100 billion—the whole of the NHS budget. All the examples that you gave—as we found last week with the Department of Health—can be caricatured as physical health interventions, rather than mental health interventions. The cost of not having early intervention, particularly for children, in mental health learning disabilities and wider complex needs is horrendous. The long-term sustainability of the NHS depends on those interventions coming in now, within the five-year forward view, and then rolling forward. What is your strategy around mental health on early intervention and prevention?

Richard Gleave: It is a central part of the overall approach within the STP. The Mental Health Taskforce has a series of specific recommendations on prevention on which we have been asked to lead. A working group on prevention has been set up as part of the five-year forward view mental health group. We play a central role in that. We act as a co-ordinator. We are not the only people who are doing important work on this. There is a major emphasis on suicide prevention, which is a big issue that appears in the taskforce report. That is a particular area of work that we are focusing on. However, there is a whole series of other issues relating to having a mentally healthy population that is sustainable. It links very crucially into social isolation, and the wider issues around isolation, and the work on work and worklessness, which is a crucial issue. That is referenced in the five-year forward view, but it is part of a major theme across government. The Department of Health has a unit set up jointly with the DWP around worklessness.

Lord Warner: Richard, I do not want you to get excited by what I am about to say. What you are saying does not sound very different from what Mark Davies told us a week or so ago. I cannot get my head around this. We have several agencies. I am sure that everyone is working in a very co-operative and collaborative way, but we have Public Health England, NHS England, the Department of Health and local authorities. It is not clear to me who is in charge and who makes sure that things

happen. I am a simple soul. Can you explain to me who is in charge and who makes things happen?

The Chairman: Very briefly.

Richard Gleave: In charge of what?

Lord Warner: Public health and prevention.

Richard Gleave: The Department of Health undoubtedly has oversight of the system and is thus in charge. That is the overarching body that oversees all the bits. Many of you have played crucial roles in the NHS in a whole variety of different settings. In the NHS, there have always been different organisations that have different sets of responsibilities around them. What we have now is a national public health agency, which we have never had before in this country. Most industrialised countries have national public health agencies. France has recently merged three to create its one, so it is moving in the same direction. A national public health agency is a central part of a powerful and effective public health system. I think that we are doing a good job on that, but there is more to do and more for us to learn about doing it.

The Chairman: I think that you answered the question by saying that, for the long-term sustainability of a strategy related to public health and prevention, we have to rely on the Department of Health.

Richard Gleave: That is undoubtedly the Department of Health's job. We are operational arm's-length bodies that work together around the system. We have an interest in the long term and contribute to it—I could talk about that, but we have run out of time—but our job is about operational arm's-length body executive issues.

The Chairman: Thank you very much for coming today. I know that it is always difficult for witnesses, because you do not know what we are going to ask and sometimes we get quite excited about the questions that we ask. You have a clear message—that you do a lot of thinking and a lot of work. There is a constraint on your ability to think beyond the next five years, at most. We recognise that. There is also a constraint in that much of your thinking relies on the resources that are available. That issue is not under your control; you cannot control that. All of you have said that you have plenty of work in progress that you would like to submit to us about the work that you have done and the work that you are about to do.

Please look at our call for evidence. If you could address the issues in that call for evidence and submit your evidence to us, we would be very grateful to you. You will pick up from the transcript all the things that you have promised to send us. We will be tracking that, to see whether you do so. Please look at the transcript. You cannot change it, but if there is anything wrong with it, please let us know, because it will be published soon. Thank you again for coming. I appreciate your evidence.