



Select Committee on the Long-term Sustainability of the NHS

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

Tuesday 6 September 2016

11.55 am

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

Evidence Session No. 5

Heard in Public

Questions 59 - 68

Witnesses

I: Sir Muir Gray, Honorary Professor, Nuffield Department of Primary Care Health Sciences; Professor Katherine Checkland, Professor of Health Policy and Primary Care, Institute of Population Health, University of Manchester.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Sir Muir Gray and Professor Kath Checkland

Q59 **The Chairman:** Can I welcome Sir Muir Gray and Professor Katherine Checkland? Thank you for coming today to give evidence; it is most helpful to us. Please introduce yourself for the record, and if you have any opening statement to make or anything you want to say before we start, please do so.

Professor Katherine Checkland: I am Kath Checkland. I am professor of health policy and primary care at the University of Manchester. I am also a GP and have been working in general practice for nearly 30 years now. Some of the things I will say today will be based on my academic work and evidence, and some may be based on my anecdotal experience as a GP for a long time.

The Chairman: Whatever you have to say is most welcome.

Sir Muir Gray: I am Muir Gray. I am a consultant in public health at Oxford University and the hospital. For the last five years I have been working for the NHS Right Care programme. I do not believe that the problem of sustainability is one of demand; it is on the supply side. The Right Care programme believes that there are £11.5 billion of resources that could be switched from lower-value activity to higher-value activity. I have brought along one of our atlases of variation, which we publish to destabilise the professions, to show huge variation: a fourfold variation in amputation; a twofold variation in the percentage of people dying at home; a fiftyfold variation in knee ligament surgery; and a hundredfold variation in rheumatoid factor interventions—all by people who thought they were doing evidence-based medicine.

I could not produce the CCG report for Dundee, but I have brought along a *Commissioning for Value* pack for the Prime Minister's constituency. You cannot see it on its website. You can see a lot of detail about service provision but not about the fact that they are spending £0.5 billion a year. We have shown them where they are outliers and where the savings are. I will be speaking for myself. I have now handed this over to Paul Baumann, NHS England's director of finance, but I will be speaking mostly about what we have been doing in the Right Care programme or the last five years on the concept of value in healthcare.

The Chairman: Thank you very much. If you would like the Committee to have that as evidence, perhaps the clerk will be in contact.

Sir Muir Gray: I have brought copies for everybody.

The Chairman: Thank you very much for that. You are welcome. We worked together many years ago when you were in the different job of screening, so you keep reinventing yourself.

Sir Muir Gray: Like Dolly Parton, yes.

The Chairman: We do not need a song. Lord Ribeiro.

Q60 **Lord Ribeiro:** Sir Muir and Katherine, we are pleased to see you. I will come back to your map of variations, because I remember you coming to challenge us about that at the Royal College of Surgeons when I was president. What is your understanding of demand management in the NHS? In particular, what is the difference between demand management and rationing?

Professor Katherine Checkland: My take on that is that demand management focuses on users and need, and on trying to work out what healthcare is required. Rationing focuses on supply, so it focuses on what is offered. Obviously, those two things are linked and they overlap, but rationing is on the supply side; it is making decisions about what thresholds and what levels you are going to provide, whereas demand management is about looking at needs and the behaviour of users.

Sir Muir Gray: We decided fairly early on that the issue lay with the professionals on the supply side. It is not the public who lead to the fact that there is twice as much money spent on musculoskeletal services between the highest CCG and the lowest. That is something that we have inherited through 70 years of drift. We still cannot answer the question: how much do we spend on asthma? Is it £1.2 billion or £1.3 billion? The supplementary to that is whether asthma care is better in Somerset or in Devon. We can tell you about every hospital and every health centre to the nearest pound. We decided to look at it from the point of view that we have drifted after 70 years of growth into a position where we do not know what we are spending the money on.

We gave priority to programme budgeting, and certainly in primary care demand comes from the public, but if you look at the system as a whole there is what Jack Wennberg from the Dartmouth Institute called a culture of back surgery in one place or prescribing in another, often driven by the hospital specialist, and the GPs then having to respond because patients come with something that is generated. That is where we say there is unwarranted variation; that is variation that cannot be explained by variation in need or explicit choice of populations or individuals. Demand is very important, particularly for GPs, but our approach is to look at the budget as a whole and to think of the programme spending—£5 billion in respiratory medicine, which is £100 million per million population—and think about the dynamic. Why has one place got into a certain style of practice and another place into another style?

For me, rationing is another word for prioritisation. They are two sides of the one coin. We are seeing CCGs doing things such as cutting hearing aids for people with milder hearing problems, but they are not looking at the fact that they are spending 20% or 50% more on one service than another. They are diving too much into the detail. Perhaps they are scared of the word “rationing”, but prioritisation is the key word that we have to face up to, as John said in his earlier presentation to you.

Lord Ribeiro: The King's Fund in its report about rationing referred to "rationing by deflection". At the time you came to talk to us, one of the big issues was the improving outcomes guidance on oesophageal cancer. Many surgeons at the time were very unhappy about the movement of services to other areas. We now know that the outcome evidence has suggested that was the right decision. Can you think of any other areas in healthcare, and there must be many, where this could be applied? With surgery it is very obvious—it is measurable and there are outcome indicators—but it is not quite the same for other specialties.

Sir Muir Gray: In 2003, a decision was made to introduce programme budgeting. I think Alan Milburn signed the paper. He cannot remember why he signed it, but he did. Programme budgeting is standard in industry. We want to know how much we spend on cancer and mental health. For example, when I am on the road I ask, "We spend £5 billion on respiratory, £4 billion on gastroenterology and £7 billion on cancer. How much do we spend on mental health?" I get the room to vote, and usually the answer is £1 billion to £2 billion. The correct answer is £11 billion. It may be that we should spend more, but we need to start people thinking that way. In relation to eyes and vision, for example—I do not think there are any ophthalmologists on this Committee—ophthalmologists are saying that they want more money for cataracts. Also, we have the fact they are using Lucentis when Avastin would be equally efficacious. They are letting slip in something I managed to stop: glaucoma screening. They do not actually know what the word "glaucoma" means. It is like blood pressure; there is no threshold. They are letting in many million invasive glaucoma surgeries; slipping little grommets into the eye while they are doing the cataract. We have been trying to say to all the ophthalmologists, optometrists and the patient groups, "Ladies and gentlemen, we are spending £2 billion a year, so what do you think is the priority for development? If you have some innovation, how are you going to find the resources by stopping lower-value activity?" We can see that in every programme budget; for example the laser treatment of endometriosis without knowing that it is really the cause of pelvic pain. I am pointing at the gynaecologists at the head of the table. The thing is to get the clinicians and the patient groups to understand that they can campaign for more money, but they then have a responsibility for prioritisation within the programme budget. That is the approach that we have been taking through the Right Care programme.

Professor Katherine Checkland: I think of demand management as reflecting appropriateness within what we are already spending, and that is making sure that everything is the most appropriate. The other aspects of demand management are prevention and self-management. Part of the problem is that a lot of the expectations of demand management are overblown. There is the idea that by prevention you will save a lot of money or that doing things out of hospital will be a lot cheaper than within. The problem is that the expectations have probably been too high.

Lord Ribeiro: Do you imply that being more transparent about the

figures and the costs would actually have a greater impact on demand? How are we failing to get that message across?

Sir Muir Gray: There is the example of the Windsor, Maidenhead and Ascot CCG. This is its *Commissioning for Value* pack. I would be very pleased to send all of you the geographically appropriate pack for your local population. This shows them that compared with the 10 CCGs most like them—so we are not comparing Oxfordshire with Tower Hamlets or Salford; we are comparing it with Cambridge and Hertfordshire—if they perform to the average, a lot of resources will be freed up. The average is not necessarily right. but then we also show them the outcomes in the pack; this is also online. Even though we do not have many outcomes, we show them what we call SPOT: the spend and outcome tool. We use the work of people such as John Appleby, if it is not available as routine data, and then we show people high spend, good outcome; high spend, bad outcome; low spend, good outcome. It is very simple stuff, but it has not been grasped. Partly, of course, it is the way in which we have split the budget.

If you take a CCG, that has only half the money going to a population. Oxfordshire's budget is £600 million, but the total budget for health and social care in Oxfordshire is £1.2 billion; specialised commissioning, prescribing, social care and public health. That is where sustainability and transformation plans in England are very important. Catherine Calderwood's work in Scotland on realistic medicine is fantastic, and I am going there next week. In Wales they have called it prudent healthcare. Northern Ireland has also taken this approach of saying, "Yes, we can campaign for more money", but, as John has said, it is not quite clear what you get for putting more in. Essential to controlling demand is educating the public about self-care. I always say that it is interesting how doctors use less healthcare than non-doctors; they are cautious about having their hip or knee replaced.

The key issue for the resources that we have is to say, "There is £115 billion on the table, there is a twofold variation in allocation of money and a tenfold, twentyfold, fiftyfold variation in activity, and we cannot see that explained by need or explicit choice". It is about thinking of programme budgeting and getting clinicians and patient groups together to think about whether we are making the best use of the resources we have for this population.

Lord Willis of Knaresborough: Excuse me for being rather simple, but what we are saying seems obvious. Why is it not happening?

Sir Muir Gray: There is a split between purchasers and providers, and game-playing goes on. We know to the nearest pound what we spend in every hospital. I can tell you what we spend on car parking in the Oxford University hospitals trust because it is in the annual report, but no one you meet in Oxfordshire could tell you how much we are spending on women's health or on respiratory, because the GP prescribing is over there and the hospital over there. When Simon Stevens and the new board came in I made a presentation to the non-execs who were from a

business background. I said, "It is like a supermarket, really. Every country you go to you see the same aisles: meat, vegetables, fish—respiratory, elderly people and mental health—and as you walk down the aisle you see the same bays: glaucoma, cataract, AMD and retinopathy, and we just think in that way". What we have done, and it has had advantages, is given greater priority to a bureaucratic approach of primary, secondary and tertiary, which is absolutely essential. We have been saying you need to have a matrix, so as well as saying that you know what is happening in every health centre and the CQC is visiting, to ensure good primary care, you need to be able to answer the question, taking quite a simple problem: is care for asthma better in Somerset or Devon? There is a need to have what we call a hybrid organisation, and that is what is coming in with the sustainability plan.

Professor Katherine Checkland: From my perspective as a GP, one of the issues driving demand is multimorbidity in the elderly. It is very difficult to split it up. You need to prioritise for each person. For a particular person their glaucoma may not be a problem and they are more concerned about their orthopaedic problems and their multiple problems. That is one of the problems with the idea of splitting it up into very individual pots. In practice I am experiencing populations of very elderly people with lots of different problems, and it is a matter of managing them and what matters to them.

Sir Muir Gray: We have also introduced programme budgeting, and if you were to ask, "How much do you spend on children?" or, "How much do you spend on elderly people?" no one can answer you. We have two types of programme: one is by disease category, such as cancer; and the other is by baby/children/teenagers, healthy men/healthy women/young disabled people/homeless people and—the most important—people in the last year of life, and there is probably £1 billion spent in the last year of life that does more harm than good.

Q61 **Baroness Redfern:** Katherine, do you see more helpful and more integrated work with GPs and local authorities—I am thinking of people with mental health issues—rather than the dishing out of prescriptions and green issues, such as getting people walking, losing weight and being less isolated, in a growing population of young children as well with obesity problems? Do you think that more integration can affect demand management and manage it really well?

Professor Katherine Checkland: The answer is that yes, obviously, there are lots of benefits to be had from functional integration; benefits from the patient's perspective and benefits as a practitioner. I am not sure that big reorganisations that try to structurally integrate are necessary. Whether the functional integration of us working more closely together and across boundaries will save money or reduce demand is, I think, a very different question. There is not much evidence. A very good review by Nolte and Pitchforth found that improved integrated care increases satisfaction, but there is no robust evidence of cost reduction.

Baroness Redfern: Even in mental health illness where patients are

occupying beds for a long time?

Professor Katherine Checkland: I do not know the exact figures in the mental health field. It is probably cost effective, but cost reduction is a different thing. A lot of things are cost effective but are unlikely to reduce costs overall.

Lord Scriven: I am absolutely fascinated by the fact that basically you have turned the clock upside down and said that the real issue here is supplier-led demand rather than demand from individuals. Clearly, if that is the case and there are huge savings and improved outcomes on the back of that—I think that is what you have been saying—based on this programme budget base, what does that mean for how health services are structured in the future? I do not mean the structure necessarily of the health service because it completely changes the whole basis of the autonomy of a doctor, the decision-making of doctors; I mean that it completely changes the way in which healthcare has to be delivered and, within that, the cultures and assumptions that have been made. What are the other implications, rather than for the structure, for following this type of model if it were to be introduced in the future?

Sir Muir Gray: I speak as a veteran of 22 structural reorganisations of the NHS, most of which have made no difference at all. I remember one where the chief executive of Oxfordshire said on the front page of the *Oxford Times* that he would like to reassure GPs and the public they would not notice any differences as a result of this reorganisation. Let us leave the structure, as you say.

That leaves two other issues: systems and culture. We have been saying, as you say, that the integration of structures is not important; it is the culture of the different professional groups and the patients. We have called it—and Public Health England is leading on this—population healthcare. That is healthcare that focuses on populations defined by whether you have a symptom such as pelvic pain, a condition such as asthma, or a characteristic such as multiple morbidity. You get people in the room, lock the door and say, “Ladies and gentlemen, this is what we are doing, this is how we are spending the money, this is where there is game-playing going on”, which is sometimes aggravated. Remember that Gandhi said that no structure will make a bad man good but the wrong structure will make good men and women behave badly, so there is the question of tariffs and referrals and those sorts of things.

Right Care has now appointed 20 people to take over from the team that I set up, because I did the development work, and they are now bringing every CCG together to say, “We have to look in a different way”. We are also thinking a lot about language. I never use the word “savings” with doctors, unless there is overspend, because it is about value improvement. We have called this value-based healthcare. There are three types of value. Allocated value is how you allocate the money between old people and children or cancer and respiratory and then the clinicians; how you allocate the money between asthma, bronchitis and sleep apnoea; or how you allocate the money between prevention and

treatment. Secondly, there is technical value, which is much more than efficiency, which the Americans write about, as John said. Technical value means that you also have to take overuse—are there people having operations who do not really benefit—and underuse into account. In the NHS the rate of knee replacement in poor people is a third of the rate of knee replacement in wealthy people. Then there is personal value. We have tried to change the culture. We have financial systems called programme budgeting systems, and they are not sensitive enough to multimorbidity yet, but that is shifting the matrix of the hybrid organisation, as Andy Grove called it. That is the approach that we are now trying to develop in NHS England.

Professor Katherine Checkland: It is probably not fair to think that CCGs are not sensitive to this thinking or not doing it. We do a lot of observational research in CCGs where we sit in on their meetings and watch what they are doing. They talk about this stuff a lot and they compare themselves with others, including their spend. One of the problems is that their spend is driven by PBR and it is very difficult to make these changes when your spend is delivered by individual referral decisions and the payments that follow those. I have looked at these packs. CCGs compare their spending with other people, and most of them will know where they are outliers, but making those changes happen is difficult in the current structure.

Q62 **Bishop of Carlisle:** Moving from that bigger picture more to the specifics, you threw out an absolutely fascinating comment—as an illustration of the general point you have been making about the possibility of shifting funding from one area to another—about end-of-life care, set at £1 billion, and funding being wasted on end-of-life care. Could you expand on that a little to give a flavour of some of the specific points?

Sir Muir Gray: We can have a good GP perspective on this too, but let me start. The word “waste”—this was very like Toyota when I was doing their screening programmes—means anything which does not add value to outcome. The Japanese word is “muda”. There is another great Japanese word, “mottainai”, which is a feeling of remorse for having wasted resources. I do not see much mottainai in the NHS. We have been interested in these words “waste” and “value”. Waste has won over value. What do we mean by waste? There are some things which most clinicians would agree are futile, but these are difficult ethical choices. If someone comes in with a bleeding aneurysm, and there is no advance care plan, there is a huge grey area for the anaesthetist, the patient and the relatives. I am working with some excellent people in the gold standard framework group, who are looking particularly at people in care homes. Often, however, because there is inadequate home nursing, the bank staff panic in the care home, they phone 111 and the resident goes into the ambulance and into hospital. This is starting to look at things such as people with multiple morbidities dying in intensive care. I am not saying that no one with multiple morbidities should go into intensive care, but they may have slipped in there. It is tied in with people having

explicit advance care plans at a much earlier age. That is the sort of area where economics moves into the ethics and these difficult decisions of clinical practice.

Professor Katherine Checkland: It is a moot point whether you could actually save that money. My experience is that we underspend massively on community care and care in the community. Community nursing is paid for in a block contract and my experience is that as community nurses' workload goes up they work harder and so no more money goes into the community care side of things. Research has been done, including a literature review by the Health Foundation, looking, for example, at the notion of virtual wards and whether, instead of people being in hospital at the end of life, it is cheaper to care for them intensively at home. The answer is that it is not cheaper; it is better but it is not necessarily cheaper because of the amount of care required at home. We talked earlier about the disappearing costs. Where have those 25% of people gone who are not getting publicly-funded social care? In my experience as a GP the answer is that they are paying for it themselves, but we have no idea who is paying for what. There is no way of capturing that because people pay for it privately from an agency; there is absolutely no way of capturing the amount of money that people are paying on private social care.

Sir Muir Gray: I am not advocating savings—we do not use the savings word. However, taking end-of-life care, we have to say that also in that budget is polypharmacy and hospital use. Looking at the idea of a population-based budget, that would mean you would have to either lock a hospital ward or pull the mattresses off—if you take the mattresses off they cannot admit people—and shift the money. We are starting to look at ways in which we do not talk about money but everything is expressed in the number of district nurses. For me, the two highest-value activities are district nursing and chiropody. That motivates clinicians. Clinicians are motivated by savings and by doing things differently. That is the approach of taking a very complex and ethically difficult area such as end of life and applying what we call a system budget and then thinking how to move the resources to give more district nursing and more home support.

Professor Katherine Checkland: That is very difficult in the current funding system.

Q63 **Lord Warner:** Can I bring us back to the funding gap? Ever since about 2010 the funding gap identified for the future has placed very high expectations on demand management. Much of that demand management has had a strong focus on patients and the gate-keeping function, and traditionally the GPs have been gatekeepers since 1948. From what we are hearing today, given the time it takes to get the physicians to change practice, how realistic are the expectations now being set nationally for making the books balance through demand management?

Professor Katherine Checkland: I do not feel that they are particularly realistic and that a lot of the things talked about as making cost savings will not necessarily do so. For example, it is not necessarily cheaper to care for people in the community; it is not necessarily cheaper to look after people properly out of hospital. We all know that generally costs in the NHS are driven by proximity to death rather than by age per se, so however good you are at prevention, people will reach the point where they are going to die. There is no good evidence that you can save money overall. There is a lot you that can do on better allocation and managing people in better places, and you can get more cost effectiveness and better outcomes for patients, but the evidence is not necessarily that you can reduce costs overall. There have been quite a lot of literature reviews about, for example, doing more things closer to home. A lot of the work that Martin Roland has done—who I am sure has given evidence at various different committees over the years—showed that bringing things out of hospital, although it may be better for patients, is not necessarily cheaper. There are a lot of assumptions that are probably not true.

Lord Warner: Pursuing that further, once you get into hospital you are captured by PBR. Is the issue of demand management still, as it has historically been, back with the GP? You guys and girls are sending these people into the high-cost area where the PBR system starts to come into operation. I am trying to get a sense of how we break out of that cycle. Most people get into the system through you and your colleagues.

Professor Katherine Checkland: There was a very good review recently by Ray Pawson from Leeds for NIHR, which looked at demand management and planned care, and at referral management and how we keep people from being referred. I can send the report to the Committee. The conclusions are interesting. There are lots of ways in which you can do referral management and reduce referrals from GPs into hospital, but there is no one way that works because a lot of it is relational; a lot is driven by relationships between patients and doctors. For example, there is some evidence that if you have continuity of care you are less likely to refer on. If the doctor knows the patient and the patient knows the doctor, there is a reduction in emergency care, so people turn up less at A&E and there are probably fewer referrals. You can set up referral management centres where there is an intermediate step to manage the referral process, and that seems to work where there is professional buy-in and where people feel ownership of it, but it does not work if it is imposed top down. It is complicated but, yes, there are ways in which you can reduce the number of referrals. However, there are not necessarily clear cost savings to be made, because often those people need other things or they need them in different ways.

The other one that comes out a lot is giving GPs direct access to tests. That is quite an interesting one, because that can rule out a referral. You might do a test and then not refer somebody. There is some evidence that that tends to reduce the threshold, so you do more of them and you get this capture, because you do a test and the thing you were worried

about is not there but you find something else, an incidental finding that needs to be chased down, so you get that technology-driven demand.

Lord Warner: Sir Muir, if we cannot stop them getting into hospital, what are you going to do to stop them getting the higher-cost interventions?

Sir Muir Gray: My question to the chief exec of a hospital is: are you in the real estate business or the knowledge business? We have a real estate business that is driven, as you were saying, by the Gandhi principle that there are things making good people behave badly, because you have to refer. You cannot phone a specialist; you have to refer. I see an organisation as three things: a structure, systems and culture. We have fiddled with the structure 22 times in my career, but we do not have systems. In Right Care, first, we published these atlases to destabilise that showed huge variation in almost anything you look at. This one is on elective breast surgery. We did them on paper because you cannot run away from paper. On the internet you can click away from them, but these are very powerful and written for emotional appeal, not for information-giving. Secondly, there is programme budgeting, to create a culture of stewardship and, thirdly, systems. I have brought along a copy of a handbook on systems. A system is a set of activities with a common set of objectives.

Let us take something that we did in Public Health England; atrial fibrillation. There would be 5,000 fewer strokes and 10% less dementia if you managed atrial fibrillation as well as they do in Bradford. The GPs in Bradford got together and sorted it out, but no one had written down what they were trying to do. We then wrote down a system specification. Based on Toyota, I did this with screening, but most healthcare is much more complex than screening, so we used a theory of complex adaptive systems. The ant colony is the best example. All the ants work together for a common aim. This has also been used in military thinking; the strategic aim is set once and then the operational command will deliver the service differently in different places. Atrial fibrillation was addressed very well by GPs and haematologists in Essex. You do not tell them how to do it; you set an objective. The key thing is starting to do it.

We have done this with quite a few things, including complex problems such as women with pelvic pain, and this has started moving to a new way of working. As I say, we never use the word "savings"; we ask, "Is there better value?" If you wanted to improve the system for people with atrial fibrillation, you would start within the present budget. Then there might be a case for switching money from neural or anticoagulants to other areas, or you might have to move money from heart failure into rhythm disorders. You start to think in a different way about how you do it. It is not structure, it is systems, and that is where it is starting to evolve now in the NHS.

Professor Katherine Checkland: It can work in very simple, practical ways. I have an excellent local cardiologist in Chesterfield, Dr Cooke, who is fantastic, and if I have a complicated patient I can ring him, I can get

advice and I can manage the patient myself without referral. One of the difficulties with the system we have is that those direct lines of communication do not need structural integration but the ability for me to get the advice I need at the point I need it. However, that also needs me to have time. One of the problems in general practice at the moment is that we are so overloaded that that time element goes and it is quicker to refer than to take the time to get a consultant on the phone when you have queues of patients at the door. It comes back to some of what John was saying earlier: that if you have an overloaded system at the moment, it becomes a less efficient system because you do not have time to do the things that would make it more efficient.

Q64 Lord Warner: At the national level, assumptions are being made about what demand management will produce for NHS expenditure. That is the political and public reality that we live in. How quickly can the kind of ideas you are talking about, on the supply side, produce measurable numbers that you can produce, for example, to the Chief Secretary to the Treasury?

Sir Muir Gray: I am being replaced in the Right Care team by 20 people. However, I worked with only a small number of CCGs. We have a team led by a chap called Matthew Cripps, and I think it would be good for him and Paul Baumann to tell you what they are doing. They are going to every CCG and showing them where they are. The health service does not manage knowledge properly, so if someone has managed atrial fibrillation well in Bradford there are also very poor ways in which other people learn that. We are setting up a casebook, as you would in any well-run organisation, where people can say, "Okay, we have a problem with emergency calls in Scunthorpe, and this is what the Blackpool Ambulance Service did". Learning from within the system needs to be accelerated greatly.

Professor Katherine Checkland: That will improve distribution and outcomes, but it is a moot point whether it will produce measurable savings that you could take to the Treasury, because I do not think it will.

Sir Muir Gray: But I am not in the savings business; I am in the value business.

Professor Katherine Checkland: I do not think there is any evidence that it will, because there are large parts of the system that are underfunded, such as district nursing and community care. If you are going to do these things well, the money needs to be moved. I think it is overstated that it can be saved.

Baroness Blackstone: I would like to ask a supplementary to Sir Muir's big macro question that is slightly more micro. Surely demand management should be partly about access to different levels of skill, training and cost as far as the workforce is concerned. To give an example, you say that GPs are terribly overloaded. Should work be done on how you filter out people with very minor ailments visiting GP surgeries so that they are not seeing highly trained and very experienced

general practitioners but are seen by good but less expensive nurses, for example?

Professor Katherine Checkland: Some work has been done on that. My colleague, Bonnie Sibbald, at Manchester did quite a lot of work on skill mix and the idea of getting nurses or less highly-qualified people to see patients in primary care. They found that it is safe and acceptable to patients but not cheaper, for the simple reason that the less highly-qualified people take longer.

On the savings that you think you might get from changing skill mix in primary care, certainly the work that Bonnie did showed that they take longer to do it. The same goes for triage and having people at the front door. There is some evidence that the more highly qualified the person the patient first makes contact with, the more efficiently the patient is dealt with. When I used to be on call at the Stockport Doctors Co-operative many years ago, we used to have GPs or highly-qualified nurses doing the front-line triage, and we saw far fewer patients than when you had less well-qualified staff dealing with an algorithm, as they have with 111.

Baroness Blackstone: Can that not be resolved by training? Are you not being somewhat defeatist?

Professor Katherine Checkland: That is the evidence of how it works in practice. Can you speed the nurses up? "I do not know" is the simple answer to that. However, when they have tried to do it, that is what they have found has happened.

Q65 **Baroness Redfern:** We have talked about demand management. What is the role of integration of health and social care in managing that demand?

Sir Muir Gray: The point has been made that changing the structure will not necessarily do it. I went to Northern Ireland many years ago with a single budget and there was the same problem: the doctor did not get on well with the social workers, the social workers did not like the nurses and the nurses did not get on with the doctor. It is a professional problem. We have to focus on culture; the culture of collaboration and identifying obstacles to common sense, as we were saying. Sometimes the consultant who speaks to a GP on the phone is given a row by their chief executive for not encouraging a referral.

Professor Katherine Checkland: Or for not charging it.

Sir Muir Gray: That means there is a disincentive. We have to stay away from yet another structural change.

Professor Katherine Checkland: One of the problems with social care is the huge unmet need. I am very sympathetic to the notion that we should think of overall spend but we do not know the depth of unmet need out there. I worry about the health budget being swallowed up, if you like, by some of that unmet need.

Baroness Redfern: You do not think there are any savings in acute services to have that joint working?

Professor Katherine Checkland: There is no evidence yet that there is. I would not say whether it is potentially possible or not. The integration pioneers have looked at that in the work that has been going on, but there is no evidence yet. A lot of people working on integrated care at the moment are using the integrated case management model and taking the most at-risk patients and putting together multidisciplinary teams for case management. There is pretty clear evidence now—in work done by one of my PhD students—that that does not reduce admissions to hospital. We know that now, but we are still pursuing that. Focusing just on those high-risk patients does not make a difference. There is certainly potential for improvement in patient experience, but I would be very sceptical about whether it saves money and reduces demand overall.

Sir Muir Gray: The proportion of people dying at home varies from 78% to 46%, so there is something going on at the local level that is very difficult to recognise. The question is getting people to start looking at where they stand in comparison to others. Both the 78% and the 46% of people will think that they are working their socks off. We have been trying to say to them, "Why don't you go and see these other people and see how they're doing it?"

Professor Katherine Checkland: However, it is not necessarily cheaper.

Sir Muir Gray: No, but it is the value. I have never used the word "cheap". The word "value" is quite tricky, of course—remember that contaminated meat was on the value stand at the supermarket a few years ago. We are always using the word "value" for professionals: "You want to increase value, don't you?" How can you shift resources? Often the professionals have a bit of resource hidden for the next pressure that comes along in the hospital; they hide away inefficiencies. We have to listen collaboratively—the ant colony again—to say that we all have to work together. You say that healthcare is what people do for themselves, and we need to think not just about changing professional roles but about the role of the internet. Why did a hairdresser tell me that hairdressers use the internet more than the NHS? I said that they have been to university for five years and then six years of postgraduate training and they are a member of the royal college of hairdressers. We are completely off the pace. We now have a new director of digital, Keith McNeil. I do not know if he is on your list. We have to think of ways in which we can start to look at reducing the pressure on clinicians. The internet is there and will increase pressure, but I do not feel that we have adapted yet. In my view, the mobile phone will have a bigger impact than the human genome in the delivery of healthcare. We need to think of how that is supported.

Lord Warner: I am sitting here thinking that you have done all this stuff on QIPP and you have all this data, so why do the budgetary flows not follow those findings? This hearts and minds stuff is all fine and dandy,

but the reality is that the money is very short. The direct way to this is to say that you have done five years' work and changed the budgetary system to implement that on a population basis. Does that not start to deliver?

Sir Muir Gray: Yes, we have to go for programme budgeting, not just for conditions. There are about 30 programmes such as elderly people's morbidity, and in the sustainability plans in England at the moment there is a bit of a battle between the provider and commissioning sides. They have to work together with a single budget, and that does mean a change in the bureaucracy of the budget as a cultural change.

Q66 **Lord Kakkar:** All this has been covered with regard to the sorts of demand management that the NHS should be implementing, but perhaps you would like to comment on that. Specifically, is there a role for devolution and much more community-driven and community-based approaches towards the question of demand management? Baroness Blackstone also raised the issue of the relationship between the demand for healthcare and what that will do for workforce demand.

Sir Muir Gray: The paper I have prepared for you shows that there is a twofold variation in spend in mental health, a twofold variation in spend on musculoskeletal, a 1.8-fold variation on almost everything. That is what we have inherited. You cannot lay down nationally that you should be spending this on eyes and vision and this on cancers. It has to be at the level of the population. I should know; there are 44 sustainability plans. Scotland is moving to seven populations, and Wales, too, is moving to four or five. We have to focus on populations, probably ones that are a good bit bigger than the CCG populations, of maybe 1 million or 1.5 million, put all the money on the table, lock the door and get people to work together. It has to delegate to that level. In England, the FPP is at about the right level at about 1 million to 2 million.

The Chairman: Do we have any examples of where this is working?

Sir Muir Gray: Yes, I think we do now. I can see it happening in Manchester, obviously, and there is something called the Oxford Value Improvement programme. The key issue is one of trust and collaboration. Still, the providers are under understandable pressure and trying to defend their position in the hospital budget. Look at the spend in general practice compared to specialists in the last 10 years.

Professor Katherine Checkland: It has gone right down.

Sir Muir Gray: It is this issue of getting people into the room and locking the door. Put the map on the wall and look at it.

Professor Katherine Checkland: Also, the current rules make it quite difficult. There is a lot of working around going on with everyone pretending.

Q67 **Lord Scriven:** It is becoming clear to me that you are saying that demand management is a concrete approach to dealing with value in

healthcare; getting the biggest bang for the buck. Do you think that demand management is going to work by itself? Do you think that demand management is not the solution? It is quite a fundamental question, because it is where we are going.

Professor Katherine Checkland: What do you mean by work?

Lord Scriven: The objectives: working to drive out inefficiencies, dealing with sustainability and making sure that outcomes are improved in the long term.

Sir Muir Gray: This is the most complex business on earth. War is comparatively simple, because at least someone drops a bomb on you and you have to respond in some way. This is the most complex thing. There is no single panacea—call it what you want: commissioning, demand management or whatever. We found that we need to move on from quality and safety because you can have high quality and low value. The approach that we are taking is population and personalised value. Demand management is one of the interventions for that. The question, as Lord Warner said earlier, is: what is the outcome? You have to have outcomes that relate not just to the patients being treated—that is quality—but to the whole population.

Professor Katherine Checkland: You can certainly get better outcomes for the money that you are spending, but I do not think it is a way to save money.

Q68 **The Chairman:** We have had quite a broad-brush discussion. This Committee is focusing on the sustainability of the NHS to 2025 to 2030 and beyond, and we have different sustainability projects, which have been referred to. What would be your suggestion for a change that this Committee could recommend to support the long-term sustainability of the NHS?

Sir Muir Gray: I would recommend that you ask every part of the country to get people together who will be leading the health service in 2036 and set them the challenge: here are the resources, the resources are finance, carbon and time—the time of professionals, the time of patients. Expecting old people such as me and the 50 year-olds to come up with these longer-term solutions is not the approach. If you get together GP trainees, specialist trainees in their final year of training, nurses doing massive programmes and finance trainees, we need to take a longer view, as John Appleby was saying. We are looking specifically at getting the 2026 and 2036 leaders on the case. They come up with much more radical and inventive solutions than the people who are managing the service at the moment.

Professor Katherine Checkland: My prescription would be not to have an overblown expectation of what can be delivered by demand management. Prevention is an interesting one. There was a report for the Scottish NHS by a guy called Ian Craig, a health economist, who suggested that if we are thinking about prevention we should not be thinking about NHS spending but about things such as reducing income

inequalities and reducing unemployment—so thinking about spend across the piece. Many of the things that we know would work or that would make a difference are small things such as continuity of care and good local relationships. Give people time and the autonomy to re-engineer their processes, because people want to do that. One of our difficulties is that everyone is running like mad to stand still, so we should build in space in the longer term so that people have the space to think about what they do. Functional integration is the aim, not structural integration; there is no point in pinning your hopes on structures.

The Chairman: We hear that in the long term we need more healthcare to be delivered in primary and community care, we need to reduce the pressures put on acute services, and we need to change the model and have more skill mix in the workforce. That will reduce the demand both for people going into care and acute services and therefore reduce the cost.

Sir Muir Gray: Changing the culture is more important than changing the model. In Derbyshire, we asked how many people there were with type 2 diabetes, and no one could answer. We asked them what the deficit was and they said £16 million. These are clinicians. Changing the culture is the function of leadership; it is partly behaviour but it is also the language.

The Chairman: Who should provide that leadership?

Sir Muir Gray: Leadership is a combination. In our estimation there are about 400 people per million of population, not just the top management, which would include perhaps 60 or 70 GPs and 70 consultants. The military are very good at getting the language clear: words such as value, savings or efficiency. Everyone uses this in a different way. The military would be much tighter on doctrine.

Professor Katherine Checkland: Better care in primary care and the community will not necessarily save costs. You can pull things out of hospital, but it is not necessarily cheaper. It is important to be aware that the evidence is that it is not.

The Chairman: Thank you both very much for a most interesting discussion, and thank you for coming today to give evidence. If there is any material or other information you wish to send, please feel free to do so.