



Select Committee on the Long-term Sustainability of the NHS

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

Tuesday 13 September 2016

11.15 am

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Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Bishop of Carlisle; 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. 7

Heard in Public

Questions 76 - 86

Witnesses

I: Professor Andrew Street, Professor of Health Economics, Centre for Health Economics, University of York, Professor Nick Black, Professor of Health Services Research, London School of Hygiene and Tropical Medicine, Andrew Haldenby, Director, Reform, and Jeremy Marlow, Executive Director of Operational Productivity, 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

Professor Andrew Street, Professor Nick Black, Andrew Haldenby, and Jeremy Marlow

Q76 **The Chairman:** Thank you very much, gentlemen. Welcome. Just to warn you, this session is being broadcast. If you see that sign, it means we are live. If you speak, it might be picked up, so be careful. That applies to Committee members too. Thank you for coming. If you want to introduce yourselves first for the record, your name and your background, and if any of you then want to make an opening statement, feel free to do so. Can I start with you, Professor Street?

Professor Andrew Street: Yes. Thank you very much for inviting me here. I am Andrew Street. I am a health economist. I work at the Centre for Health Economics at the University of York.

Andrew Haldenby: I am Andrew Haldenby, director of Reform, which is a cross-party think tank that looks at productivity in public services in the UK.

Professor Nick Black: I am Nick Black, professor of health services research at the London School of Hygiene. I also chair the National Advisory Group on Clinical Audit & Enquiries, which advises NHS England.

Jeremy Marlow: Hello. My name is Jeremy Marlow, recently appointed executive director of operational productivity at NHS Improvement, and before that I spent a year working with Lord Carter of Coles on his review into the same subject.

Q77 **The Chairman:** Thank you. Do any of you want to make an opening statement? No. Then we will kick off straight away then with the first question. I would like to explore with you the NHS and social care system as we have it now. Is it sustainable over the longer term beyond 2025-30? How are we going to make the systems sustainable, and what reform of the funding system will be needed to bring about the sustainability of that long-term agenda? What funding increase might be required year on year to make it sustainable, without which it might not be? You might disagree. As you have been working with Lord Carter of Coles, but others too, what increased productivity levels might be required for controlling overall levels of funding for both systems? That is a broad brush question.

Professor Andrew Street: I was born in Coventry, and Coventry was completely destroyed after the Second World War. There were no factories, no houses, no food in shops—shops that did not exist—and there were no schools. Three years after the end of the Second World War every household in Britain received information saying that the National Health Service was to be created, free at the point of use, funded through taxes. Of course, there were many priorities for funding at that time. The whole of Europe had been destroyed. My grandparents' generation did not say, "We cannot afford a National Health Service" in that situation. They said instead, "We cannot afford not to have a

National Health Service.” That system of course has been sustained for almost 70 years, and its fundamentals remain.

The crisis we had with the recession in 2008 is nothing compared with the crisis we had after the Second World War; it is nothing like as deep. I think the fundamentals of the national health system remain the same; it remains a sensible way of funding for now and for the future. I think it is still the case, as my grandparents’ generation would have said, that we cannot afford not to have a National Health Service, because the alternatives are going to be more expensive and they are going to leave us worse off.

Andrew Haldenby: If the question is whether the NHS and social care systems are sustainable over the long term—I will try to say this quickly—at one level, as Professor Street has said, the NHS will definitely be here in 2030 and it will be funded through our political system. Parliament raises funds for the NHS and social care, and if the NHS needs more money, it will raise more funds to do that, and if there is a sense that the NHS budget has to be controlled down, it will do that too. In that sense, does the political system that we have today mean that the NHS and social care will be there in some form? Yes, it certainly does.

The force of the question, though, is: are we going to have a good NHS and social care system in 2030? I would say that there is optimism and pessimism. On the optimistic side, much of our work now dwells on the opportunities of new technology to improve the way public services work and the way they address the problems of citizens. I met a company yesterday, Cerner; I am sure they will not mind me saying so. They are now working with 20 hospitals in England. They can combine data on patients both in the hospital and from primary care. They can join up those systems, which has been difficult to do before. From that they will be able to identify so-called frequent fliers, patients who have a lot of contact with the NHS. Those patients can then receive special attention, with the aim of preventing further ill health in the future. That is one example, but the technology revolution is real and should enable much more productive use of healthcare resources in the future, and that will only improve.

Briefly, on the pessimistic side, from our evidence from our discussions—I do not have a metric—we would say that the current NHS productivity programme under the *Five Year Forward View* is not on track to meet its targets for 2020. Simon Stevens, in his article for the *Daily Telegraph* in the summer, said that the share of the NHS budget that is going on hospitals rather than other kinds of activity—prevention and so on—is rising, not falling. That is an indication that the NHS is not changing for the better. I would say that broadly Ministers do not make the case for NHS productivity; they make the case for more spending, more inputs, more doctors, nurses and so on, but they do not make the case for sustainability and productivity.

I think I have answered that question in three ways. I am saying that the NHS will certainly be here in 2030. The technology revolution should be

significant support in its performance over the long term, but given where we are today I would say that the movement towards greater productivity seems to be slower than government targets would want.

The Chairman: In brief, on the question I asked about whether productivity would be important you are saying yes, but on the financial question on funding you are saying that funding also needs to be—

Andrew Haldenby: There will always need to be a vote for a sum of money for the Health Service, and the NHS will always have to do the best it can with that money. At different periods, the funding side and the productivity side may need different emphases, but in other public services where there is a guaranteed spending level—in defence, for example, there is a target of 2% of GDP spend, and in aid it is 0.7%—those spending targets do not in themselves guarantee good services. There are major reform programmes going on in those departments, and major efforts to ensure value for money, so perhaps I am saying that we need to think about both sides of the equation.

Professor Nick Black: Yes, the health and social care system as a publicly funded system is absolutely sustainable. This is a political question. You have lots of technical know-how in front of you and other people coming to see you. We can provide a certain amount of ideas and advice—I hope helpful—on how we can do it better at the micro and meso levels, but the macro level—sustainability—is a political question, and politicians have to answer two questions for society. One is how much do we want to spend on health and social care as a society? That is an explicit discussion. The second is how fair do we want the distribution of those services to be? Those are two political questions. I have my strong views on both of them, as has probably everybody in the room. They may not all be the same, but we have to have a much wider political discussion.

How can we move forward? I think there are three priorities. One is engaging the public in an informed discussion. That does not mean that at the end of it the public will agree to rationing, because there will always be rationing. There is rationing in every country in the world, and it is inevitable given the brilliance of our biomedical industry, medical profession and nursing profession to come up with new things that we all want, but we have to have an adult conversation so that the public understand that you cannot have everything. We need much greater courage from politicians to address the really tough questions. Second, the one thing that has to change in the system—we can perhaps talk later about the details of governance, commissioning, management and so on—is that we have to make the NHS and social care system much more comfortable about risk taking; it is far too risk-averse. You have lots of brilliant ideas bubbling up, which is vital because sustainability is going to be solved from the bottom up, not the top down, but managers risk losing their jobs if they go ahead with something that does not fit the national mandated way of doing things.

Those are the three things: engaging the public, the courage of politicians, greater tolerance of risk taking and not punishing those when some of those risks turn out to have been a mistake.

Jeremy Marlow: On the question of whether it is sustainable over the long term, I do not believe it is as it is currently configured and the way it performs. There are three areas that I know you are looking at and that you need to think about here. One is the quantum of the funding. As colleagues here have said, and I know you have looked at it, questions about what is affordable for the public finances are critical to that. You cannot look at that in isolation; they are big political decisions that have to be taken as we look at that time horizon.

The second is how the funding is distributed. We have a mix of ways of doing that at the moment. They are not at all optimal in the way they drive productivity and the outcomes that we have, but there is a blend that we need to look at in relation to those long timescales. Thirdly, what I am most interested in the job I do is what we obtain for the money we allocate, and the way we allocate the funding.

For me, there are three main areas that we need to think about over the medium and long term. The first is to address the unwarranted variation in the system. I know you have heard a lot about that; it is a common theme in the system, and you see it in other systems around the world, but I think we have a long way to go in how we address it, particularly using the wealth of data that we have out there to do that, but we are just not very good at using it at the moment.

The second is how we go about improving the productivity of our clinical work force—the non-clinical too but particularly the clinical—what they are doing, how we deploy them, how we motivate them, and how we best obtain the clinical results from what they do. The third and final area we need to think about is the way we scale up our services, primary through to tertiary care, to address what we see in some areas as the fragile and unsustainable services that we have out there in an environment with increased technology and increasing specialisation, particularly in acute, in the care that we give.

Q78 **Bishop of Carlisle:** I would like to come on to new technologies. You were talking about new technologies and the huge possibilities that they offer. At the same time, earlier on we heard that new technologies are adding considerably to the cost of the NHS. I wonder how those two balance out.

Andrew Haldenby: Indeed, there will be both a cost and a benefit, and the technology has to be paid for. The example I pointed to was the benefits of new technology coming online today and providing particularly better information on patients, which we have not had before, and enabling greater targeting of resources on certain patients in order to treat them more quickly and to prevent costs down the track, but technology is indeed also a cost. The witnesses in the previous session talked about management, and part of the management challenge of the

NHS is to be able to invest correctly in technology, understanding that it should be able to make a return. It would be a tragedy if new investment in the right technology was not done because it could not be afforded today, if there was a sense of that.

Professor Andrew Street: New technologies need to be seen in terms of the costs and the benefits that they produce. Something may be more expensive, but if that means that people live longer and live with less disability and less discomfort, investing in those new technologies may well be worth the cost of their procurement. In the United Kingdom we have a very good committee, the National Institute for Health and Care Excellence, which was set up to establish the costs and benefits of new technologies and new medicines, and the UK has been at the forefront internationally in setting up that type of arrangement and those ways of evaluating the costs and benefits of new technologies so that we can assess whether new technologies are worth investing in in terms of the benefits that they secure.

Bishop of Carlisle: That is very helpful, thank you.

The Chairman: Does anybody else have any other comment to make? Going back to the funding issue, in the long term—I do not know that you have all had the opportunity to comment on the long-term funding issue beyond 2030—what funding adjustments to the current system would be required?

Professor Andrew Street: We have a funding crisis now. The *Five Year Forward View*, which Andrew alluded to earlier, summarised some of the evidence on what the funding gap would be at the end of this parliamentary term were funding levels to remain flat, and that suggested that we would face a £30 billion funding gap at the end of this parliamentary term. That had been estimated by a number of independent organisations in order to work out what we need to meet the demands on the healthcare system over this parliamentary term. The question is how we meet that funding gap.

The *Five Year Forward View* put out three key things that need to be done. One was that the NHS needs to meet annual productivity gains of 2% to 3% a year—I will come back to what productivity means later and whether or not the NHS has been meeting that. The second thing that was said was that the Government needed to increase funding in 2020 by £8 billion over 2015-16 levels. It has not done that. The Government are instead increasing funding by only £4.5 billion, as the Health Committee said in its report previously. The Government said that they were going to provide £8 billion; they are not doing so. The remaining gap between what the Government are promising in increased funding was to be met by efficiency savings produced by the NHS as a whole, and those efficiency savings in the *Five Year Forward View* would have been £22 billion. Because the Government are not meeting their commitment, that rises to £25 billion. That is simply not achievable, and because the NHS is not receiving the funding it needs and on top of that social care cost

funding has been reduced, that is one of the reasons why we are seeing so many problems in the health service now.

Professor Nick Black: I am glad Andrew added social care, because it is in the nature of the beast that healthcare is always the one that captures the public's voice and the politicians' ear, for obvious reasons. Social care is not as sexy; it does not make the headlines. If I were putting more money into this field as a Government today, I would put it all into social care. I would not give the NHS any more money. The majority of patients are elderly and very elderly, and most or many of their needs could be dealt with much better through social care than healthcare, and that is one of the crises. I would be really tough on the NHS. That is where the courage of politicians has to come in—looking very radically at our current provision and talking to the public about their expectations. Dilnot started to address sustainable funding of social care but that seems to have been kicked into the long grass. We have still not, as a society, addressed the issues of social care, end of life care, or the needs of the very elderly. That is where I would focus.

Q79 **Lord Warner:** This question is probably to Andrew and Nick Black. Underpinning the Five Year Forward View was a very clear statement by Simon Stevens that there had to be adequate funding of social care, so all the figures that you mentioned, Andrew, also had underneath them adequate funding of social care between the time of the Five Year Forward View and 2020. Has any work been done to show how the gap has become worse as a result of the trend line for the funding of social care, in so far as we can discern it, up to 2020?

Professor Andrew Street: Yes, there has. The Health Committee reported in July on the spending review, and as part of that evidence they looked at the funding requirements and promises for the NHS and for social care. A number of studies and evidence have been presented to that committee, which were summarised in the report, on the growing funding gap for the social care sector. We see that there are fewer people now receiving social care support than used to be the case, and that is having knock-on consequences for the NHS. If people are not receiving the support they require to live independently, they are more likely to fall into crisis and they are more likely to show up at A&E departments, and that puts more pressure on A&E departments. Similarly, if social care support packages are more difficult to arrange for people who are already in hospital, that leads to delayed discharge, and essentially the health and social care system as a whole runs less efficiently because constituent parts that are designed to support people on a timely basis in the optimal location are not now being delivered.

Lord Warner: Can we put a number on it? What is the gap? Is it £2 billion, £3 billion? How much worse is it by 2020?

Professor Andrew Street: The figures are all in the Health Select Committee report, and the gap has been calculated for each year over the parliamentary term. I cannot remember off the top of my head what it is, but the gap is in the billions.

Andrew Haldenby: Briefly, on social care and a word on the previous question on funding, I think the fact that the current Government introduced the new precept on social care in the Autumn Statement indicates that they know that cuts in social care funding have gone too far. That does not answer your question on the future, but it shows that the Government know that.

I wanted to make an obvious point. No doubt everyone would like to spend more money on the NHS but there are trade-offs, and at a time when the public finances remain in an unprecedentedly difficult position, at least in recent decades, with net debt at 80% of GDP, still in deficit, as we know the new Prime Minister has said that the likelihood of the new finances going back into surplus is not going to happen in this Parliament. It will be at some point after that, so the public finances are extremely difficult and it is hard to find new areas of public spending that can be easily transferred to health.

What is the public appetite for greater taxation? In a poll last year, we asked the public "Would you support an increase in income tax to pay for the NHS?" Sixty-seven per cent of people said no, a third said yes. The other thing is the trade-off between departments. The NHS is so big that, as my fellow witness pointed out, the NHS was only going to have an increase of £4.5 billion compared to the £8 billion that it had been promised. If the police service were here, it would say, "Goodness me, £4.5 billion is a third of our entire funds for the year." You have to be a bit careful. It is a small amount of money for the NHS but it could wipe out other public services. I am just trying to put context around it. It is not easy at the moment, at least in the short to medium term, to envisage big spending increases for any public service.

Q80 **Baroness Redfern:** I think we all agree about the health and social care and how we would like to see more money go in; more money has gone into the acute sector. Can I go on to the capital side on fixed costs? We have a very expensive NHS estate. Do you think there is any mileage in looking at how we utilise our buildings as we work with other partners?

Professor Nick Black: Yes, absolutely. We have estate in the wrong place, as every healthcare system does, because we inherited a historical legacy. Facilities were where they were for all sorts of good reasons at the time, which are no longer. In a nutshell, the key change needed is a reduction in the hospital secondary care estate and an increase in the primary and community care estate.

Baroness Redfern: Have we started that work? I am getting at the thinking.

Professor Nick Black: Very slowly. Your colleague Lord Darzi suggested something along the lines of polyclinics. It may not have been quite the right model. There was debate and discussion.

Baroness Redfern: There are some serious efficiency savings.

Professor Nick Black: The danger for those of us in London—it is true of all my colleagues and perhaps all of you—is that it is a very different in London to the rest of England. One of the mistakes that government has made is to try to come up with solutions for London and the rest of England, but they are different challenges. I spend quite a lot of time in Kent, where there has been fantastic primary care and community service development over the last decade or two—stuff that you would never see in London. That is one issue: that we do not try and solve the problem that we see within five miles of this building. It needs a different approach from the rest of the country.

Professor Andrew Street: I think we missed a big opportunity over the last 10 to 15 years in trying to think about the configuration of the healthcare system. We had a time of income growth, and lots of hospitals developed PFI schemes and had major rebuilds, but they all did those in isolation without thinking about what the system as a whole needed to look like for the future and how their new build would impact on and be influenced by the new build happening in the neighbouring city or down the road. Essentially, we overcapitalised, particularly in the hospital sector, and we are now living with a legacy of an overcapitalised healthcare system, which is not at all easy to sort out because of course the payoffs for new capital build are over a 30 to 50-year time horizon. We lost a great opportunity to think about the configuration of the healthcare system, not just in the secondary care sector but as a whole, over the foreseeable time horizon. It is very difficult to row back on that.

What can we do? Some things happened in that period that were quite useful. You mentioned in the previous session the development of treatment centres as a different model of delivering care; small, self-contained, specialising in particular treatments, and although they were expensive to set up in the first place, they now tend to deliver high-quality care at a lower cost, with lower lengths of stay and better outcomes for patients, than they would case if they had gone through the normal run of the hospital sector.

Lord Willis of Knaresborough: The discussion was about whether the NHS and care system sustainable beyond 2030. Mr Marlow, I was particularly interested in your three points. One of them was fundamental, because if 70% of the costs of the NHS are in staff, you said that the clinical work force basically has to change. I have read the Carter report, and I see little evidence in it of those solutions. It is silo-laden, hierarchical, steeped in the past, and if that does not change what hope do we have of a sustainable healthcare system? What ideas do you have? This is your job now.

Jeremy Marlow: It certainly is, and I relish it. I think you are right; it is very siloed. I have been a user, also known as a patient, of acute hospital care. In that setting you cannot help but see it. I recently had the privilege of an undesirable customer journey to have my hip replaced earlier this year, and I saw for myself the silo nature, the baton changes that happen in the system.

The theme throughout the report and my theme in life at the moment is that that does not happen everywhere. There is unwarranted variation in that it can be appalling, and it leads to the inefficient use of the people, it demotivates people when they do not feel part of a team, it costs money, and it is bad for the patient—sometimes really bad for patient safety. However, there is cause for optimism here in that work is being done on the diversity of the skills mix in hospitals, with healthcare assistants working alongside qualified nurses, physicians' assistants, nursing practitioners in clinically-led teams, and how they deliver that care in the emergency setting and in the elective setting—in the acute. There is cause for hope in that that can be done. I do not underestimate the professional interests and the protectionism that we might see in doing that, but I passionately believe that the vast majority of clinicians are there for the good of the patient and that they will see, especially when you use the data—because they are also scientists by background—that there is evidence that working differently, doing things differently, delivers better results for the patients. As I say, you do see that in some settings.

- Q81 **Lord Mawhinney:** Can I take you back to the funding of social care, which is largely through local authorities. Should it be, or are they dealing with so many pressures that it would be better handled through an entirely separate, freestanding organisation? If so, what would you recommend that we recommend?

Professor Andrew Street: I would recommend the recommendations of the Dilnot review.

Lord Mawhinney: Which specifically?

Professor Andrew Street: They explored a variety of different ones and suggested a number of different funding models. Essentially they suggested a social health insurance model whereby people are obliged to make some sort of commitment to their future costs, with some cross-subsidisation across the population.

Lord Mawhinney: But should the cross-fertilisation be local authority-based or separate?

Professor Andrew Street: The solution at the moment is the social precept, as Andrew mentioned. Most local authorities are implementing the social precept for social care. The concern is that they are not all doing it, and that those that are tend to be better off local authorities. That means, if they are in those local authorities, that the social care support of the people most in need of it is likely to be underfunded. The social precept is a bit of a fudge and it might accentuate inequality.

Lord Lipsey: Dilnot said absolutely nothing about the provision of social services. It is all about who paid for it, the balance between the individual and the public provision. What we are talking about from the health point of view is how much of this social care we should provide in order to complement and work with health provision. So Dilnot cannot be the

answer, with great respect.

Professor Andrew Street: No, but the question was how it ought to be funded. There is another question, how the social care and healthcare systems need to work in integration, and that has been an ongoing problem historically. For years we have been grappling with that problem, and different parts of the country are trying to deal with that. One of the suggestions in the *Five Year Forward View* was that we need to have a less fragmented health and social care system, but of course to do that we need to invest and we need to think about different ways of ensuring that we have different arrangements between local authorities and local NHS commissioners. Different parts of the country are doing that. I am working in Somerset, where they have been thinking about integrated care arrangements. Some of those have been frustrated by contractual arrangements and other difficulties, but the recognition is that there is a problem and there is a will to move towards a better system.

Lord Mawhinney: Can I make one more attempt to have you answer my question? My question was: should we stick with the local authority or should we look to a different type of framework? Your answer was that the precept works but primarily with the rich ones, not the poor ones, so it is the people in most need—which does not answer my question.

Professor Andrew Street: Which is why a social health insurance type of system, where people are paying in on a social health insurance basis, might be preferable.

Lord Mawhinney: And we should get rid of the local authorities?

Professor Andrew Street: That would be the implication, yes.

Q82 **Baroness Blackstone:** All of you touched on productivity in answer to questions about funding, but I wonder if we could focus a bit on efficiency now. Perhaps you could say what you think about whether the NHS is efficient, whether it is becoming more or less efficient, and what the evidence is—whether more competition would drive up efficiency or not.

Professor Andrew Street: I think we should have clarity first on what productivity and efficiency are.

Baroness Blackstone: Do you want to define them in ways that you think are helpful to the Committee?

Professor Andrew Street: Productivity is the simple accounting arrangement of trying to see what the relationship is between the outputs that the system produced compared to the inputs used to produce it. For a given amount of input—staff, machines, equipment and so on—an organisation is more productive if it produces more output than another. We obtain productivity growth if the growth in output is increasing faster over time than the growth in input. Efficiency is somewhat different, but they are complementary ideas. Efficiency requires us to appeal to our understanding of best practice. Is this the best way of organising care? Are we managing care according to the best clinical guidance? Are people

receiving high quality, timely care at the time they need it? Efficiency is about best practice. Often those go hand in hand. The more productive you are, often you can be more efficient. It is a bit like thinking about what our achievements are. They are partly about hard work, perspiration, 99%. Some of it is about inspiration, 1%. It is the same sort of idea; you achieve better productivity by working harder, you achieve better efficiency by smarter working. We need to think about better ways of working smartly.

The Chairman: The question was also whether the NHS is becoming more productive.

Professor Andrew Street: It has become more productive over time, but there is still scope for efficiency. Let me just make it clear. We have said here that there are problems with productivity, but the NHS can celebrate the fact that its productivity has been improving over the last 10 years or so. If we look at productivity gains in the NHS up to the recession in 2008, productivity growth in the NHS pretty much tracked that for the economy as a whole. After the recession the economy as a whole has stagnated. In contrast, year on year productivity growth has been positive, improving year on year since then. The latest figures were that we have annual productivity growth of 2.2%, so the NHS is becoming more productive over time and it is outperforming the rest of the economy.

The Chairman: Do any of the rest of you want to answer that? Before you do that, Lord Willis, you were going to focus on productivity. Do you have a comment?

Lord Willis of Knaresborough: My question has been answered.

The Chairman: Can we continue with the question that Baroness Blackstone asked.

Professor Nick Black: To focus on healthcare for a minute—I certainly do not have expertise on efficiency or productivity of social care; others will provide that for you—the NHS could be more efficient and more productive, no question about it. There is still a huge variation in costs. We tend to focus on variation in outcomes. This is what I spend most of my life on. Variations in outcome are very slight. It does not matter which hospital in this country you go to for a hip replacement, the outcomes according to patients do not differ. What differs is the cost. We have just done a study of a small bit of healthcare, memory clinics. Only £200 million a year is spent by the NHS in England. We have found that the basic costs of assessing and diagnosing the new referrals for dementia vary. The range is 17-fold, a 1,700% variation. Even if you take out the outliers, the majority still vary 6-fold, a 600% variation. When we are looking at outcomes we are excited if there is a 5% difference, so this obsession with outcomes, which of course I share—measuring outcomes and developing measures is how I earn my living—but efficiency is mostly driven by cost and we do not know very much about variation in cost.

Worse, I do not think that most boards of provider trusts are fit for purpose. I say that because I do not think that most of them have people on them, either executive or non-executive, with the ability to take something like data on variations and to work with the clinicians. They are the ones whose behaviour has to change. Boards need to look at how they are producing a hip replacement, how they are producing a birth, and look hard at the staffing levels, at the costs, because there is huge potential for efficiency gains. That is just the hospital sector. We have even less data on general practice and primary care. We do not really know how efficiency varies in primary care.

Jeremy Marlow: I agree that the variation is enormous, which is what Lord Carter and I looked at. Another question is what we do about it in that context. You are absolutely right that the prices that trusts pay for everything, from paper through to the hip implant, for the same thing, can vary enormously across that piece. I forgive trust execs and boards a little more than you in that they are not aware of it. They do not have the information in front of them so that they can know that they are paying considerably more than someone else in the system. We have the benefit of such a large system. It is not unprecedented. There are other health system provider networks the size of ours, but we do not use that information smartly at all, and we do not give it to our execs and non-execos on the boards so that they can know that this is happening.

We have to do something about that, which is what I want to do. We have to bring that data out there and share with them the fact that if their costs and their commissioning behaviour is such that they are forcing their procurement teams to buy things they should not be buying and that there are cheaper products out there that give exactly the same outcome, and sometimes probably better. Orthopaedics is an area that we have looked at a great deal. I have two clinicians working with me, one of whom, Professor Tim Briggs, has led a fantastic piece of work over the past three years looking in depth at orthopaedic practices, and he has drilled right down, absolutely mined the data that is out there, in all sorts of places. It is not easy to get at, and one of the things I have to do is make it easier to get at. This is not patient-level data, this is aggregated data that is out there to use.

You are absolutely right that in infection rates for hip and knee replacements alone there is a range of 0.5% to 4% across the system, which is big, and it affects patients, I can tell you. I did not have an infection, thankfully. If we could reduce that to 1%, 6,000 patients would suffer less and it would save the £300 million cost of being readmitted across the system, but we have to make both the administrators and the clinicians aware of when it is happening in their system, and then help them to do something about it. That is what we have to scale up and do in NHS Improvement. It has to be clinically led when we do it, and I am pleased to say that the work that Tim did in orthopaedics is now expanding into 11 of the major surgical specialties, and we are going to expand it again into the same amount of medical specialties as well, supported by my colleague sitting behind me today, Professor Tim Evans.

Baroness Blackstone: Are you saying that the regulators now need to do very much more in relation to both productivity and efficiency, providing more information to providers on what the costs of what they are doing are? It is difficult to do this, coming back to your remarks, for every separate trust, because they do not have the benchmarking data in order to understand better which areas of their activities need more attention from the point of view of efficiency. I am asking should this not, at least in terms of the data available, come from the centre, and that data be more widely disseminated, to make the pursuit of efficiency easier?

Professor Nick Black: I disagree. There is plenty of data and the boards have access to that data. I do not buy that the problem is they do not have access to it. Over the last 10 years—all credit to CQC and other bodies—we have greatly enhanced the quality of data both about the quality of care and to some extent on costs, though Andrew knows more about that than I do. The problem we have is that most of it is falling on stony ground. That is why I come back to my point, which might sound over the top, that there are a few exceptional trusts in this country but the majority do not have an executive or non-executive board member who knows how to handle that information and to have the really hard discussions. It is not easy—and I am aware of various eminent surgeons in the room—to go, say, and talk to your senior surgeons and say, “Why do you have two nurses in theatre during that operation when other places do it and achieve the same results with one?” That is a really tough thing to do. I do not believe we have on most hospital boards people with the confidence and the know-how and the skills, the relational skills, to handle and manage the change that needs to take place. Whilst the cost of the bits and bobs and widgets is important, it is a tiny bit compared with the staff costs of who is doing what and the decisions that clinicians make on who is admitted to hospital, what happens to them and how long they stay. Those are the big cost drivers.

Baroness Blackstone: Can I just come back on that? I should declare an interest because I chair a hospital board. I think what one needs to understand is that there are huge pressures which come from politicians, regulators, NHS England, on quality, and you constantly get push-back in terms of, “If we did this in the way that you are suggesting, we will not meet the quality requirements of what we are doing in terms of our output”. You have to look at the counter-pressures on achieving what you are proposing, which I identify with, in all these many institutions.

Professor Nick Black: I recognise and accept that, which is why one of my three main opening comments was that we have to change the relationship between the centre and the periphery so that the periphery is not in fear of taking risks and making radical changes.

Baroness Blackstone: Well, they are.

Professor Nick Black: That comes through NHS England, NHS Improvement, the CQC and the Secretary of State for Health. We have to take that pressure off to allow you and your board to say, “We are going

to do things rather differently, because we have seen something in Spain or America, and they do it quite differently." You should be allowed after a year to say, "Ah, it didn't work", or, "Things are worse. We are now going to try something else", and not be punished for it.

The Chairman: Nick, in our conversation you remember that we are talking about long-term sustainability of the NHS and not trying to fix today's problems. Mr Haldenby wanted to come back.

Andrew Haldenby: I thought Lord Rose's report on NHS leadership, published last summer, was very relevant to this conversation. Coming in as an outsider, he was gravely concerned about the kind of bureaucratic goo that was gumming up the NHS, in his view. He had a phrase for it—"The NHS is drowning in bureaucracy". Members of this Committee may be wondering, "How can it be? We have an NHS where there are headlines every day about financial deficit, but here we are presenting evidence that the NHS does not think properly about its costs. It is missing the wood for the trees". But I think that that is what is happening. I think the volume of central guidance and requests for information from the centre to your trust are giving you plenty to do but are not encouraging you to look, on the productivity side, at some of the things that really matter.

Q83 **Lord Warner:** I should declare two interests. First, I am a member of the advisory board of Reform and—listening to some of the earlier conversation—I was a member of the Dilnot Commission. I have talked to Andrew privately. I think he may have got hold of the wrong end of the stick about what the Dilnot Commission was about. It was capping individuals' responsibility for funding their social care.

I have been twitching here, listening to this discussion about efficiency and productivity. When I was a young civil servant, like Jeremy, in the fast stream, I was taught the difference between efficiency and effectiveness. Lord Carter of Coles, who is a personal friend, has produced a brilliant report, but even if you do everything, it produces £5 billion, which is a long way short of plugging the gap. Let us do it all, and I agree with everything that has been said about trust boards and all the rest of it, but it produces £5 billion.

Let us then talk about productivity, and have a go at that. Andrew was very positive about NHS productivity. The lion's share of that productivity was achieved through pay restraint. Of course, if you cut the cost of your inputs, you will achieve a productivity increase. It is arithmetically impossible not to. We are being asked to back a couple of horses, productivity and efficiency, which does not produce sustainability on the levels that we need. The game in town that is discussing effectiveness is the Five Year Forward View. The Five Year Forward View is trying to change the models of delivery. My question to you is: let us do productivity, but not necessarily the way it was done before, and let us do efficiency; but how do we return to the sustainability of an effective NHS funded through taxation? Starters for 10. Where are the answers?

Professor Andrew Street: The *Five Year Forward View* set out a productivity challenge but it also said there needs to be investment in new ways of doing things—of making the system more efficient. We need to have more-effective public health and prevention; we need to develop new models of care and new arrangements to deliver care. Those are the types of investments that will secure longer-term efficiency gains. The problem is that the NHS is having to deal with deficit situations, which means that the investment funds that were to be used to transform the service are not available to do that, so the efficiency challenge will not be met; and as you rightly say, the productivity gains that we have seen over the last few years have really been about dampening growth in inputs and, of course, keeping wages low. That is not a long-term solution either. The update of the *Five Year Forward View* that Simon Stevens produced in the summer said the plan for the future growth in wages would be 1% over the parliamentary term annually. They are going to grow by more than that in the economy as a whole. In that situation, it is going to be very hard to retain and recruit the staff that the NHS needs, and that will make it difficult to maintain the productivity gains that we have seen in the past, and it will undermine the efficiency ambitions of the *Five Year Forward View* as well.

The Chairman: Do any of the others wish to comment briefly?

Andrew Haldenby: As I tried to say at the beginning, the *Five Year Forward View* has, as I think people will agree, a lot of good ideas. The question is: is it going to achieve them any time soon, certainly before 2020, which is the target? One of its big ideas—and I do not have all the answers—is prevention, to prevent ill health before it happens. People tell me that we might need to pay NHS providers differently in order to encourage them to do preventive activity rather than responsive activity, and that those changes in funding have not happened, so there has been little progress on prevention. On new care models, in primary care there are new and very big primary care operations covering 100,000 or 200,000 patients done in completely different circumstances, such as GP surgeries, from those we might have in mind. So there is some care there, but at the hospital level there has not been the pace of change that people would have expected.

Lastly, on pay and numbers, let us compare it to the police. The Government no longer argues that there have to be more police officers to have lower crime. It has an outcome target—"Lower crime, please"—but it says to chief constables: "What you do with your work force is up to you." Still in the Health Service it says: "We want better health, thank you; but you absolutely must employ more nurses and more doctors." I am not advocating massive cuts in the NHS, but what is the question Ministers are asking of the NHS, and what are the constraints they are putting them under to deal with issues of work force and pay?

Professor Nick Black: I agree with you. Things like the Carter proposals will make a useful contribution but they are quite marginal—£5 billion is unlikely but £2 or £3 billion might be possible. On prevention, looking at

2030, even if we started today, it is not going to have much impact on demand for care in 2030. That is not an argument against prevention, but it is not an immediate thing. Therefore there are two things that have to happen. I think there needs to be more resource—more money for health and social care. As I said earlier, I would focus it mostly on social care at the moment, at least for the next five years, because social care has been so reduced and the impacts on healthcare are enormous. We also need to look at radical change in how healthcare and the NHS are organised. The STP model of getting to 40 health economies that are managed will work only if all the players at the table—be it local government, foundation trusts, CCGs or whoever—will come to the table and drop their sectarian interests. Will a foundation trust chair or chief exec accept that the outcome for the public in that million population might be a reduction in the budget for their hospital, and will they go back and deliver that to staff? That is where I come back to the politicians' courage, because I would extend politics here to non-execs and chairs of boards acting politically with their local population. If that does not happen, it is a rather gloomy outlook.

Jeremy Marlow: I am sure you would expect me to disagree with Nick on some of what he said there. There are two fundamentals that we are doing in the next five years that are going to be really important to the long term. What we are doing in the delivery of Lord Carter's report is, yes, about short-term cash savings in some areas, such as the consolidation of pathology. You will be aware, Lord Warner, of the long ambition to get that done. We have to get on and do it. There are other areas that will deliver some improvements in productivity but are fundamental to the long term, which is the clinically led area of work, where we have to standardise and remove the variation in the system. That is not going to be done in five years. That is a decadal or possibly generational thing where it has an impact on junior doctors going through med school at the moment, in the way they operate and behave in 15 to 20 years' time.

The other is the innovations, the thinking that is going on out there, in terms of the way we configure our health system, and with social systems—such as what is being done in Northumbria and the innovation and courage being shown in Greater Manchester to integrate services across the health and social care spectrum. That will shine a light on the way forward for the long term. It is not all going to be delivered in the next five years. We are not going to see massive, universal change in the way that our health service is provided in the next five years, but it will set out the path for the longer term if we are successful in doing that.

Q84 **Lord Kakkar:** I remind the Committee of my interest as Chairman of University College London Partners. I would like to turn to the question of NHS Improvement and how it is contributing to the efficiency and productivity of the NHS in the long term, and in particular focus on a couple of issues: first of all, what progress has been made with the Carter review? We have touched on this but it would be good to have clarity on where you think it has got to. Secondly, is the single definition of success

which NHS Improvement has provided a contributor in terms of the long-term sustainability question? Thirdly, who is actually in charge of the strategy and taking forward the delivery of these efficiency and productivity potential gains within the NHS? Is it NHS Improvement or, as we have heard, the multiple other regulators and arm's-length bodies that exist in the NHS currently? Finally, how would this Committee and others be able to determine whether NHS Improvement is really delivering?

Jeremy Marlow: I had better answer that one. Regarding Lord Carter's report and the progress in implementing it, many of the recommendations in the report were directed at NHS Improvement. When it was written and published back in February there was no such thing as NHS Improvement. It did not formally start until April. Any machinery of government changes, any public sector changes, cause a huge amount of upset and turmoil that has to be gone through. Such is the nature of things. Certainly, from where I sat then and where I sit now, we have gone through that at a fair old pace but it has meant we have had a couple of months where I would have liked us to have gone faster had we had the capabilities there to do it, but we were not able. However, I am now building up the team and we are on track with most of the recommendations in the report. There were 15 big recommendations, broken down into 87 sub-recommendations. I have a plan, which is to deliver that. You are right—£5 billion of savings is what we have to do over the next five years, cashable and non-cashable.

There has been good progress in areas. Because of the work that Sustainability and Transformation Plans and footprints are bringing together in the areas of pathology and back-office consolidation, we are out there helping people do that at the moment. In the clinical space, as I have said, I have the funding to scale up the programme in that work across 22 clinical specialties in that sector. We are recruiting senior clinicians to lead each of those strands as we do that.

In terms of your question about who is in charge of the overall productivity and efficiency area, it is the NHS, so it is complex. That is the answer to that. The *Five Year Forward View* has obviously a set of objectives which are more than just about efficiency when it comes to closing that £20 billion gap. It comes down to prevention and crude pay restraint, as you say. There are various organisations responsible for delivering their part of the overall package. What we are responsible for at NHS Improvement is the operational productivity side of things. How do you remove the unwarranted variation that is there among providers in the acute community and mental health sector? How do we shine a light on it in the first place to help boards and chief execs do their bit? How do we give people the standards, the best practice that colleagues talked about here, in a way that is meaningful to people working out there? That is why, in my view, it is so important that it is clinically led—that it is not just me, a civil servant. Everything I am doing I am trying to do jointly. Something I learned in the States when I went there a few weeks ago was that they always deliver improvement in what they call a

dyad, where they always have a very senior clinician partnered by a senior operator and always deliver it in that way. You cannot do it without both of them. That is the model I am trying to build.

Lord Carter himself is a non-executive on NHS Improvement and will be chairing a sub-committee of the board to keep my feet to the fire and make sure I am delivering. He is also going to be working with me from next month to look in depth at community health and mental health providers, which we did not look into during the first review but we are aware we have to do. There is about £30 billion spent in that area. It will be very tricky. It does not have the wealth of data that we had available in acute, especially in the community sector. I know you have taken evidence from people on that before. It is an area we must look at because I am sure we will find just as much unwarranted variation, if not more, when we have an in-depth look at that.

Andrew Haldenby: Part of that question was who should be responsible for driving NHS productivity? A large part of the evidence this morning focuses on the boards and leaders of individual NHS organisations. We have to emphasise that. Taking it right up to the political level, the policies of Ministers and, indeed, the Prime Minister do matter. Just thinking very briefly about the politics of the health debate in recent years, the previous Prime Minister, David Cameron, did not push the arguments for NHS efficiency and productivity particularly hard. That was not the main part of his pitch to the electorate on the NHS; it was much more about protecting it, protecting its budget and so on. Interestingly, after the last election, when he obtained his majority, he toughened up his language. His first policy speech in this parliament was on the NHS and is well worth reading. He spoke about the need to deliver both high-quality care and efficient care, and the fact that those two things could go together, not be in opposition. That was a toughening of his rhetoric—and now he has gone, as we know, and we wait to see. I do not think the new Prime Minister has said anything on healthcare thus far. I am just trying to say that for all of NHS Improvement and any of the agencies' efforts, inevitably they work within a broader policy framework. As I say, Ministers and, indeed, Prime Ministers need to set a direction towards productivity, if that goal is to be achieved.

The Chairman: Does anybody else want to comment?

Professor Andrew Street: I do not think just providing information and encouragement is enough to change behaviour. We need behavioural change at board level and within organisations. A lot of the attention in Monitor and NHS Improvement, particularly at the moment, has been around the hospital sector, because we are dealing with the deficit situation. I do not think that the things that are being put forward to change that, unless they change behaviour, will be sufficient to deal with the problem. There is a mentality in the hospital sector that the way to get out of financial trouble is to grow your income, which means doing ever more activity—so you do more activity, your income grows. That will not work, because the income you receive is based on average cost

minus a 4% efficiency target. If you are above cost, you will not get out of financial difficulty by growing your income; you will get into worse financial difficulty. Since the annual 4% efficiency targets were introduced in 2011, hospital deficits have been growing worse and worse, because hospitals have been doing more and more work.

How do we change that mentality? As Nick said, we have to think not just about the income implications of doing more work; we have to think about the cost implications of doing that work, and hospitals need to make a decision about what work they do and how they expand or contract their services on the basis of both the income consequences and the cost consequences. The problem is that very few hospitals look at cost information, and very few hospitals have decent cost information to look at. Only 50% of hospitals have invested in patient-level clinical-costing systems in this country. That is almost 14 years after we introduced national tariff arrangements. Without that information you do not know how income is going to impact on your deficit or surplus.

Hospitals have to change their mentality and they have to do that themselves, and it is not enough to give them information and encouragement; they have to be incentivised properly. It is NHS Improvement's job to encourage them to do that, but ultimately it is going to rest with management and boards within hospitals to change behaviour and mentality.

Lord Kakkar: How then would NHS Improvement most effectively incentivise that behavioural change at institutional level to contribute to sustainability in the long term?

Professor Andrew Street: It is clear that the 4% efficiency target has not worked because hospitals have not responded to that. What has happened with that 4% efficiency target is basically that it has just gone into deficits. I suppose it has paid off for hospitals because they can now say, "Bail us out." In terms of a long-term strategy, that is fine; they have been able to get away with running up deficits, because they just could not meet a 4% efficiency target. That was impossible. The efficiency targets that need to be set need to be not just across the board; they need to be focused on specific areas where there is variation and where there is evidence that in this area there is much wider variation in costs, in length of stay, in outcomes, than in another area. The incentive regime needs to be more sophisticated and more targeted at where we think there are gains to be made. If it is across the board, you will have an across-the-board response, which is probably detrimental to the system as a whole.

Professor Nick Black: On NHS Improvement, I think the shift of culture and approach from Monitor and TDA to quality improvement is welcome, and Ed Smith and Jim Mackey are genuine in that they see it as not so much to regulate as to support and help. There has to be that shift. The role of NHS Improvement should be to help those boards do what they should be doing and are not currently doing. The problem over the last 5 to 10 years is we have recognised at the centre a problem with the

calibre of managing our resources locally, and instead of trying to enhance and improve management, we have reached for regulation. You do not run an organisation, certainly not of this size, through regulation. Regulations are very specific, and regulation has grown and management has withered slightly. We need a wholesale change, and I think NHS Improvement is genuinely supportive of that. It has lots to do to help and support boards, so they do not feel, "NHS Improvement is on our back" but that, "It is holding us up and helping us."

Lord Bradley: Just on that point, I again declare my interest as a non-executive director of Pennine Care and having had a hip replacement operation. Is there not a tension currently with NHS Improvement, with a very blunt instrument of annual control tariff claims which undermine the ability of boards and management to look at innovation, to look at how they can change the way in which they practise? They have this short-term financial pressure to deliver on a control total which NHS Improvement cannot justify in any rational way. It is a mechanism to reduce deficits rather than looking to the long-term changes that need to be made within the NHS and social care.

Professor Nick Black: It is this eternal issue of control and command from the centre versus local autonomy. As you will have gathered from most of my comments, I would favour much more of the latter and let go of the control and command, take risks, allow mistakes to be made in certain places. Looking back in five, 10 or more years, we will have achieved much more, which we are not achieving with so much control and command at the moment.

Lord Bradley: Do you think the so-called devolution of health and social care, say, in Greater Manchester, is an opportunity to break out of that?

Professor Nick Black: Yes, very much so. If Devo Manc does not achieve half of what we hope it will—it will be great if it achieves half—the outlook is quite gloomy, because that has to be the way.

Lord Bradley: But as Professor Street said, you need that injection of resources up front to change the pattern of care.

Professor Nick Black: You need more money, yes. It cannot all be done with existing resources.

Lord Warner: What is the danger that the poor old NHS out there, down at the local level, is a bit confused as to what they should do? You have Jeremy and his colleagues pushing down the NHS Improvement route, and you have Simon Stevens and NHS England saying the future lies with STPs, which is a kind of "control your own destiny" type of model. Having sat in Richmond House and sent signals down to the NHS and then found that my colleagues had sent another lot of signals down to the NHS, I wonder whether there is not a risk, looking at 2030 and not 2020, that we are giving confusing messages to the NHS as to what they should do?

Professor Nick Black: Absolutely, yes. It has come about partly from the fragmentation of the centre since 2012. That is not to say that, in the Department of Health, all the parts spoke to each other. We all know there was fragmentation despite being in one organisation, but it has not been helped. You have clashes and fragmentation at the centre, which is not helpful to the periphery.

Jeremy Marlow: However you configure this thing, whether it is 136 acute trusts or 44 STPs, whatever, ultimately there will be wards and out-patient departments and in-patient departments working. I and my team can help at that operational level, whatever configuration you are in, to know whether what you are doing is optimal or not both for the patient and for the cost of what you are providing. As I say, one advantage that we sometimes do not think about in the scale of our system, with the wealth of data and understanding we have, is that we have fantastic experience and pockets of excellence out there. The tragedy is we just do not identify it and share it with others and get them to do the same. We are too afraid. I agree the fragmentation that has come about has meant that we have not had the capability to do that. However you configure this going forward, you are always going to want to do that. People often say that with our NHS we are the envy of the world. I am not sure, but in that regard, everywhere I go, people are envious of the amount of data and knowledge we have across one system. They look at me quizzically and say, "Why on earth aren't you using it?"

The Chairman: In this session and the previous session we have concentrated on efficiency and productivity and all of the issues on the hospital activity side, but why do we not have data on the primary care side, or is it efficient?

Professor Nick Black: The sad thing is that we were on the cusp of getting it with the GP systems and you and others round the table will know about the various issues and concerns genuinely held by some people about confidentiality, access and misuse of the data. If we had been having this discussion five years ago, I would have said, "Yes, we are starting next week and we are going to be able to drill down and have information on 50 million people in England on their GP records", but that has not proved possible yet. Until we can, it is very limited. There are things that can be done. The Health Foundation, the Nuffield Trust and others, as Andrew is referring to, are trying to look at segmentation of populations in primary care, but it is desperately slow because of the problem of access to data and use of that data. That has to be resolved within this building as soon as possible.

Professor Andrew Street: I would echo those sentiments entirely.

Q85 **Lord McColl of Dulwich:** Can I go back to preventive medicine, because it seems to me that the only certain way of reducing the costs is to get the millions of obese people down to a normal weight. I was a bit alarmed to hear it said that it was going to take 10, 20 or 30 years. In fact, it would be possible within a year or two for an obese person to reduce their weight. The problem is that the Department of Health and

NICE misled Parliament and misled the people by saying it was due to lack of exercise. It is nothing to do with exercise. Exercise is good for other things. The Government, the Civil Service, NICE and all these organisations need to give a clear lead. You do not tell people what to do, just tell them the facts—that the answer to obesity is to eat less. It is nothing to do with exercise. What does the Department of Health do? It tells doctors they must not call patients obese. It is nonsense. It is judgmental, they said. It is not judgemental; it is simply accurate diagnosis. We need that.

The Chairman: That is a message you might transmit more widely.

Professor Nick Black: The point about the health costs is yes, somebody could start losing weight tomorrow and by the end of the year have lost weight. The health implications of all the young being obese are not going to be felt for 20 or 30 years, because they are not actually going to become sick in their 30s, 40s, 50s. It will come later. They are not going to need bariatric surgery until much later. That is why I said, even if we were successful in prevention starting tomorrow, it is not going to have much impact on the 2030 perspective. Of course I am all in favour of people losing weight. I share some of your personal views on that.

Q86 **Lord Willis of Knaresborough:** Could I first of all declare an interest as a consultant at Health Education England and the NMC, and I have not had a hip operation.

The Chairman: Yet.

Lord Willis of Knaresborough: Do you know something I don't know?

I am staggered after this session. I go back to my point about 70% of the budget being spent on staff, yet none of you seem in any way to see this as an acute need to change the way that staff work. If in fact you have these new proposals, whether they are coming from NHS Improvement or anywhere else, or individual trusts, unless staff can work in a very different way, be differently skilled, be multi-skilled, be able to break down these barriers, quite frankly, this is pie in the sky. None of you seem to have any real urgency about tackling the particular issue of the work force.

Andrew Haldenby: I think we may have slightly taken it as read but, just to give one piece of evidence, our last paper on primary care pointed out that of all the GP appointments taken in the country, only 62% now are taken by an actual GP. The remaining 38% are taken by other members of clinical staff—nurses, pharmacists in some cases, physiotherapists and so on—and there are greater opportunities to further reduce the proportion seen by GPs. That is an example of a much greater skill mix in primary care enabling better use of skilled and more expensive staff.

Lord Willis of Knaresborough: The biggest fundamental barrier, particularly in nursing care, is the use of drugs and to be able to either

prescribe or deliver. At the moment all that is restricted to registered nurses. The idea we proposed in 2014 of the nursing assistant is still going through the system, even though Ministers agreed it, people agreed it, in order to have those capacities. If the speed of change is so slow, you cannot make the sorts of changes that you need in the whole system.

Professor Nick Black: I think you can make a lot of changes despite that.

Lord Willis of Knaresborough: You cannot, because the rules say you cannot. The regulation says you cannot. The Royal Colleges say you cannot.

Professor Nick Black: I agree all of those are factors but if you take my example of memory clinics, where they have a 600% variation for the majority, leaving the wide outliers out of this, that is because of the staffing; that is driven almost entirely by the numbers of doctors, nurses and what they are doing. That is about looking at the most efficient way of providing a memory clinic. The expensive ones have more doctors. Do they need to be there? Patients seem to receive just as good a service when it is a much more nurse-led one. Absolutely, that is part of the solution. The same with STPs, looking across the whole sector, whether it is in primary care or secondary care, redesigning clinical pathways, and inherent in that is what our individual professions do. I agree there is some limitation from central bodies which have other agendas—like Royal Colleges, I quite agree—which may not be in the interests of the NHS and the public. It might be too much in the interest of the profession, on the grounds of maintaining good standards. We have to get that balance right. I agree it is not right now.

Professor Andrew Street: There are two ways to look at this. One is at the national level and one is at local level, and we need a strategy at both levels. At national level, in a report earlier this year the Public Accounts Committee was scathing about the lack of work force planning for the NHS over the last few years. We need good work force planning. It takes seven years to train a doctor, three or four years for a nurse. You have to have a good work force plan in place to ensure we have the right numbers and they are specialising in the right areas. Our work force planning over the last few years has been very poor, and that needs to be rectified, because if we do not have the work force in place, we require recruitment from overseas and we will be spending more on agency staff.

There also need to be incentives at local level for organisations to work out what the best mix of staff is and what the best mix of capital and labour is. It is organisations, clinical teams, at the local level that are the best to do that. What we need to ensure is that the incentives are in place for them to work out the best way of organising care—to work out what that is and to implement it locally—and to ensure they have the resources available to be able to do that. We need a work force strategy at national level, so we have the work force in place, but with incentives

at local level to ensure that organisations are incentivised to pursue efficient ways of organising care.

Lord Kakkar: Just to pick up on a point of Professor Black's, is the system that we have for commissioning sufficiently robust to drive down those changes and variations in practice? Quite frankly, should not a commissioning system be able to look at this and define clearly what needs to be commissioned, and then providers have to provide at a local level and meet those requirements?

Professor Nick Black: No, I do not think they are, for a number of reasons. One, we have far too many commissioners. With all respect to some wonderful staff in CCGs—that is not true of all of them—we could probably staff 40 local commissioners around the STP footprint and have really high calibre, and my comments about the shortcomings of provider boards I would also apply to the shortcomings of commissioning boards. Again, I think the know-how, the skills and the calibre—it is an incredibly difficult task we have given them, and a lot of it is just rubber-stamping what we paid for last year in a sort of accountancy practice, rather than addressing and pushing the local health economy to implement better clinical pathways that meet all these requirements we have talked about.

Lord Warner: If NHS Ltd was a FTSE company facing an existential threat because it had the wrong product lines, its board would probably say we need both a strategy and an investment plan. Where is the investment plan?

Professor Andrew Street: The *Five Year Forward View* set out a strategy for investment and prevention in public health, recognising that we have an obesity crisis now and in the future.

Lord Warner: Sorry, let me just stop you. It did not say that on the investment plan. It sent out a wish list for money.

Professor Andrew Street: Yes, but you need a vision, and that vision was supposed to be set out by the Sustainability and Transformation Fund. As I have said before, at the moment that has been swallowed up by sustainability, not transformation, and without that we do not have investment. The vision set out by the *Five Year Forward View* needs to be backed up by investment. Without it, we are going to be muddling through from one crisis to the next, which is what I feel the NHS is doing at the moment.

Andrew Haldenby: In this case, unhelpfully, in the Sustainability and Transformation Plan "sustainability" does not mean the sustainability that you are talking about in this Committee; it just means breaking even. The NHS is focused on sustainability, just not the sustainability that you are talking about in this Committee.

Professor Nick Black: Like you, I am hoping—perhaps this is a forlorn hope—that the STP plans currently being developed and produced are actually investment plans that say, "This is where we want to get to, but

to get there we will have to change some of the facilities and buildings as well as the relationships and clinical pathways—the lot”. That should be the investment plan, whether or not it is funded or sent back to the drawing board to work on further. Yes, I share the model you are suggesting.

Lord Warner: But there is no bank, is there? We have no bank for this. If you are a company, you go to your investors to try to produce the money to get you from A to B. What I am trying to understand is whether you guys think there is an investment plan. There is a vision possibly.

Professor Nick Black: With those 40 investment plans put together, if they are going to require an investment of £10 billion, NHS England has to go to the Treasury and No. 10 and say, “That is what the investment plan will be”. That is the bank. If politicians were courageous, they would then go to the public and say, “This is what is going to be required. Do you want an NHS? We are going to have to raise that money.” Income tax is only one form of tax revenue. We have to raise the money and pay for it. I am not suggesting you take it from the military or the police, who are all squeezed even more.

Jeremy Marlow: I just want to come back on some of the work force points that Lord Willis raised. I am sorry if I have not expressed the degree of urgency that I and the organisation are giving particularly to this. Job planning is a really important part of this for the work force we have now. Do we know what they are doing and are we using them as best we can? That is not just doctors. It is nurses, healthcare assistants and other allied health professionals.

I agree completely about the role that regulation plays in sometimes stifling the innovation and what we can do with our work force. We plan our work force, as others have said to you before, in a very Soviet-type system where, because we have such a specialised work force, to think we can plan it 15 to 20 years out, which is what we are going to do, is rather optimistic. Maybe if we try to create a more flexible, adaptable work force, we will not need to plan it 15 to 20 years out down to the degree of specialisation that we do at the moment.

I do not know why I am defending the Royal Colleges but I think I might for a moment. There are about 1,000 physicians’ assistants in the country, and the Royal College of Physicians is hosting the first event for those to get together in a few weeks’ time to think about some of the regulatory aspects to what they do. There is hope again out there, regarding the way we have always worked, that there is fresh thinking and an acceptance that we have to do this. If we are to use our resources more effectively and more flexibly in future, we have to plan for that now, because, as I say, it takes 15 or 20 years to get people in place in the first place.

The Chairman: Thank you all very much for coming today to give evidence. It has been most helpful. In questioning you may have thought about some other issues or answers. We are very happy to receive any

further evidence from you, so if you have any, please send it. Thank you for coming today.