

Health Committee

Oral evidence: Department of Health and NHS Finances, HC 693

Tuesday 11 October 2016

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Dr James Davies; Emma Reynolds; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford

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Witnesses

I: Sir Amyas Morse, Comptroller and Auditor General.

II: Chris Hopson, Chief Executive, NHS Providers, Julie Wood, Chief Executive, NHS Clinical Commissioners, and Rt Hon Stephen Dorrell, Chair, NHS Confederation.

Written evidence from witnesses:

- [NHS Confederation](#)
- [NHS Clinical Commissioners](#)
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Examination of witness

Sir Amyas Morse.

- Q1 **Chair:** Welcome, Sir Amyas Morse, and thank you very much for coming to this session about NHS finances. It is unusual for you to appear before the Health Committee, but we are keen this afternoon to give you the opportunity to tell us what you think the public need to hear about the concerns that you have set out so clearly in the reports that you gave but also to give you the opportunity to tell us what you can about the emerging evidence that is going to be building towards the next report that you have said you are going to publish this autumn. Would you tell us what you think we need to know about this?

Sir Amyas Morse: First of all, if I can give a general view, it is clear that the health service is under a lot of pressure. Everybody knows this and I apologise for starting with something that everybody knows. The reset at least gives a bit of financial capacity and space to get things stabilised and moving forward in a positive fashion. The question of whether or not some of the reset money will be spent swallowing up larger than expected deficits, rather than really improving things, we will not know until we see.

I see the situation. We publish six reports a year on the health service. They are pretty consistent, and have been consistent over the last few years, in talking about the unsustainable position, which sadly has continued to slide, in terms of trusts in deficit and difficulty. I do see that the reset operation and the five-year forward look is intended to try to find a way out of that and we will be watching very alertly over the current year for signs of whether the ship is answering to the helm. I am already a little concerned by the fact that the deficit rate is higher in the current year than was expected. Without wishing anything other than good results from this, it is concerning and we will all have to be very much on the alert to see what the emerging trends are.

- Q2 **Chair:** Certainly the previous reports are very gloomy about the picture for 2015-16. Would you like to set out in more detail what your concerns were about the way that the short-term measures were used?

Sir Amyas Morse: Thank you. These were particularly in relation to the accounts. As you know, in order to stay within the spending limit, it is quite normal for there to be some year-end adjustments and even some minor attempts to try to bring in the accounts on target. It has been normal in the health service for there to be some of this, but we felt that there was an extraordinary amount of activity and some quite surprisingly large mistakes that had been made, all of which, by the way, happened to have an effect of bringing the Department up to being able to meet the limit.

When you look at all those adjustments, you can see that they are mostly one-off, non-repeatable adjustments. If even one of them, that is to say



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the national insurance mistake of £400 million, had not been there, then we would have been in a position of having an Excess Vote. The reason we decided to set out all these adjustments in a report was because we felt it was concerning that these were not sustainable and we needed to point to that.

To really understand the accounts, you need to get a clear picture that, while individually these items were not against the Treasury rules, and therefore we were not qualifying on regularity in the accounts, I considered it most important that people were able to see just what had gone into not incurring an Excess Vote in this case and not get a misleading picture perhaps of what was happening.

There was another reason for putting a clear report like this in. I had a chance to have a meeting with the new permanent secretary at the Department of Health, and I made it clear that I would be very concerned if there was a repetition of this scale of activity again at the year end. I have received assurances on that account, which I will expect to see carried through.

Q3 Chair: Thank you for clarifying that. Another matter I want to raise with you is that this year is a year of relative plenty for the NHS, but when we look to subsequent years, a 0.7% and then a 0.3% increase, in your next report are you going to be setting out a longer-term view of how sustainable those levels of increase are?

Sir Amyas Morse: We certainly are going to be setting out a view of what the leading indicators to watch will be. In other words, there are interventions contained in this reset that may or may not work or that may work to some greater or lesser degree. Therefore, rather than saying I am going to make an assumption that they will not work, I simply say that, if you have the sustainable transformation fund dependent on carrying out certain agreed actions, it may be that if those actions are carried out it does create some improvement. Will it be enough to stabilise the system financially, or, if it falls short, by how much will it fall short? Those are the questions we are going to be very much alert to pick out as quickly as possible going into the next financial year and in subsequent years, to understand where all this is going. I think it will be possible to pick up some indicators for this quite early on.

Chair: Of course, then, there is the issue of whether or not there was any transformation money left at all, but we are going to come on to that in greater detail with you in a moment. I am keen to pass over to Emma, my colleague, for the next question.

Q4 Emma Reynolds: Thank you very much for coming to our Committee. I would like to ask you about trust deficits, and many of the trusts are in deficit. First, we are trying to get a handle on whether this has become a normalised thing in the sector rather than the exception to the rule. Certainly the numbers point in that direction. Is that your assessment?



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Sir Amyas Morse: Bluntly, yes, it had become a normalised thing. If the majority of trusts are in deficit, then it has become fairly normal. In thinking about that, it is important to understand the difficult position that trust boards find themselves in. They are trying to balance a number of pressures—the pressure for providing care, for having the resource to pay for that care and the pressure to run a balanced budget coming from NHS England and the Department. Since those pressures have not in the past been presented in a readily reconcilable form, then the trust boards are left having to make that judgment for themselves. If you see a hospital getting very publicly blamed for any shortcomings in care and you are making a choice between shortcomings in care or financial deficit, it may not be surprising that some hospitals have tended to veer in the direction of care in the past years, and I know people who are on the boards of hospital trusts who have described to me that they are keen to try not to be in deficit but they find these pressures very difficult to reconcile.

Q5 Emma Reynolds: It will be interesting to get your thoughts on what we should do about that. It seems to me—and it has been highlighted today in *The Times*—that the pressure is on social care, that the acute sector is sucking up a lot of the money, and unless we can do something about that then the rest of the system is being starved of additional resource.

Sir Amyas Morse: Yes, and you will forgive me if I sound a little note of scepticism. There is obviously a close relationship between social care and aspects of the health system. In particular, it is part of the primary care complex—no doubt about that, and we have done quite a lot of work on that—and it is also connected with the ability of people to come out of hospital and go back into the community in various forms. Again, it is quite clear and covered in a quite recent report on older people coming out of hospital.

There is no doubt about it, but it is worth remembering that we found in that particular report earlier this year that, although social care availability was a factor, it was not the biggest factor in delaying people leaving hospital. I want to make sure it does not become too much of a convenient reason for things that could be fixed within the health service. It is a factor, but we find it is not the only factor and it is possible to get led down that path a little bit too much.

We observed something similar about agency staff. There is no doubt that agency staff and profit mark-ups made on agency staff have been a factor in budgets, but the shortfall in training and developing own-sourced staff has not helped. We should be careful not to allow internal factors to be obscured by valid, but none the less not the only, factors that are external to the health service and therefore play a little bit differently.

Q6 Chair: You will have seen the comments in *The Times* today saying that in fact, if there is any uplift in funding, it should be prioritised for social care. Would you dispute that or do you feel the balance is about right?



Sir Amyas Morse: If there is an uplift in funding, the system is so huge that it would be easy to put funding into a lot of places where it would be well spent but would not necessarily in the short term produce any great difference. I am tempted to say, "What about putting more money into preventive care?", but unless you know how much prevention you get for your pound, you will want to do it but you need to have some better information about how long it will take to make a real difference in demand push. There is a massive amount of demand push in the system. There is the ageing population, obviously, but also policy announcements for improved mental health care and for parity of esteem in mental health. Who would not support it? None the less, as you start to speak about it, you are creating, I would imagine, some demand push with people saying, "If this is what they are saying, surely we can move forward with this." You can see a lot of demand push.

We also did a report on growth in spending on specialised therapies—specialised services—and we saw that that was growing at a compound rate of 7% or 8%. In having a chance to interview the chief executive of NHS England, it was not apparent that there were any very clear levers for slowing it down.

So there are a lot of things that are pushing costs into the system, and, yes, I can see that if in a footprint there is a view that spending more on social care will, net, produce a better result, then that is the way to do it, but I would argue for a nuanced approach based on the difficulties in the system now, which are very considerable, not just one particular solution for everything. There is too much pressure in too many different places for there to be a simple answer.

Q7 Chair: Is the effect that cuts to social care are having on the NHS something that you are going to look at in more detail so that we can have that more nuanced approach?

Sir Amyas Morse: I am sure we will come back to it. We have looked at the interaction between social care and healthcare, and it is an abiding interest of ours. We are not planning to do it in the very short term just because we are looking at sustainability and so on, but it is certainly a subject that, if I take a reasonable period of time, I am quite sure we will come back to, yes; and of course we have a good dialogue with the Committee and are interested to hear the things the Committee as well as the PAC would find interesting for us to look at.

Q8 Chair: It is in order for the Government to take a more evidence-based approach in the NHS.

Sir Amyas Morse: Particularly when there are so many pressures, yes, you do have to take a more evidence-based approach. I will repeat myself: there are so many places where you could put more resource into the NHS and it would just be absorbed and not make a very noticeable difference.



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Q9 Dr Davies: As you point out in your report, the Department of Health has been transferring moneys from capital into revenue budgets, I think in the order of £1 billion a year, in an effort to mitigate deficits. What do you think the impact of this will be on planned service improvements and on the ability of the NHS to make savings in the future?

Sir Amyas Morse: If you keep on not investing, it is not a good thing. I do not think that is the most profound statement in the world. First, it tells you that the revenues spend system is out of kilter. There are a lot of signs that say the spending capacity is under great pressure. Constantly going to the capital budget is a sign of that. Secondly, if you look at any hospital, you know that health facilities need constant reconfiguring and constant investment. It is not some remote thing, and it will make a difference to efficiency in the system if we find ourselves starving capital investment over any significant period of time. I do not think anybody in the Department of Health would disagree with that either.

Q10 Helen Whately: You have talked about demand push on one side. You have cautioned us against looking too much at external answers to the sustainability problem, whether it is on the agency side or social care. What in your view does need to be done to put the NHS back on a more financially sustainable footing?

Sir Amyas Morse: I am not applying for the job—let me put it like that. I think it is in able hands at the moment, frankly, but I will allow myself a couple of comments. First, it is good that the NHS is looking in the longer term. It needs to plan more rigorously in the longer term. A five-year view, yes, is good, and even having more precise planning instructions that have been brought forward and planning a two-year more detailed approach within that is all positive development. Having some lever to try to encourage transformation in a positive way by having conditional funding is an intelligent thing to do. I do not look at them and wonder what they are doing with this stuff. It looks like prudent moves to try to direct things in the right way.

However, I will come back to the problem about any model where you have one wall of the house that is missing. The wall of the house that is missing would have “demand” written on it. You can heat the house all you like, and if you have a wall missing all the heat goes out into the demand. There is a massive potential demand. If you compare us with other countries in the world and look at the spend per person or the spend as a percentage of GDP, you see that we are not anywhere near the top of the list in how much we spend. If you then you look at the detail of the population that we have, you realise, taking all of that together, there is going to continue to be a lot of demand push in the medium term. How do you deal with that? Somewhere we have to address the question of how we are supposed to deal with making prioritisation judgments against such a massive potential demand. Coming up with an answer that stabilises the system without somehow addressing that is a very difficult question—an impossible question,



maybe. I think you are not going to stabilise the system without somehow coming to that.

- Q11 Helen Whately:** You seem positive, though, about what you describe as prudent moves to shift to a slightly longer-term planning window. Is there anything that could be done to encourage that shift and make sure that shift continues to be looked at through the longer window versus the short-term balancing of in-year budgets?

Sir Amyas Morse: One thing you could do is to get on with it. In other words, the CQC is supposed to be looking at the balance between care and use of resources, and the guidance for that has not come out yet. The guidance for how the transformation funding is supposed to be regulated has not come out yet. There are quite a lot of things that need to be got into place. We are now into the year. We need to get the foundations right, otherwise we might find ourselves on an unstable base—trying to move forward off a base that has already moved away from us a bit.

Oddly enough, with longer-term planning we need to get moving quite fast and we need to be quite highly adaptive to when it turns up. It will not turn out the same as people thought when they set these plans up. That is inevitable because there are so many unknowns—it is not a fault—so we need to be highly adaptive as we go through this. We need to be ready to change our plans and be quite quick and agile. If it turns out that the reset is not getting the job done, instead of waiting and carrying on pretending it is working for a long period of time, we need to be quick about taking additional action. That is what I would say. Having a longer-term planning horizon does not mean that you do not take fast action now. It is the reverse of that.

- Q12 Helen Whately:** Can I ask you specifically about the sustainability and transformation planning process—the STPs—and what level of confidence you have in that process as taking the NHS on to a sustainable footing?

Sir Amyas Morse: It has elements in it that make sense, but I am sorry to say this: it is all in the execution. If it is not executed quickly and sensibly, it will not produce very much, and—I am going to repeat myself—we are starting off this process in a somewhat worse position than we thought we were starting in. We need to adjust the measurements set quickly to take that into account. If it means we do not have enough money to sort things out, there is a question to be asked: is sticking to the original plan still wise if you find a lot of it is going to be swallowed up in trying to get to the start point? A lot of this is not about having the plan but about how you execute the plan. I am going to repeat myself: it is not wrong, in my view, to try to do this sort of thing, but I have my remaining big strategic concern about addressing how you manage the demand side of the picture.

If you simply pass the demand side out, if the CQC examination criteria turn out to be very tough still on care quality, quite rightly probably, and



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not terribly clear about how they are going to look at the use of resources or are not very skilful in doing that, you may find yourself slipping back into the same posture we were in before quite quickly. It is all about very alert management quickly pushing on the areas that do not look as though they are working.

- Q13 **Maggie Throup:** In response to Sarah's question about whether more money should be put into social care, you talked about demand push. I want to pursue that a bit more. If we could wave a magic wand and there was more money available to the Department of Health, where, in your view, ought it to be directed to have the biggest impact on the financial sustainability of the NHS?

Sir Amyas Morse: I am going to answer that in a slightly minimalist way if you do not mind, because it is such a huge question. At the moment the biggest deficits appear to be being generated in acute trusts. Does that mean they deserve all the resources? No, but it probably means that is where you need to focus attention. If you carry on with acute trusts generating large deficits for even a reasonably short period of time, the whole system starts to be under strain again. So there is something there. You need to look at the source of instability in the system and think about what can be done about it. That is not a fair way of dividing resources; it is just trying to recognise what the actual dynamics in the situation are likely to be.

- Q14 **Maggie Throup:** So I have waved my magic wand and we have sorted out the acute trusts. What would be next on your list?

Sir Amyas Morse: Social care, obviously. I am sorry, I am not trying to be playful. Social care is very important, but let us remember something. We are talking about social care as if it was paid for out of the same budget. Of course, it is not. It is paid for out of local government and we need to look at what the funding position of local government is for a minute. This does allow me to make an important point. Government needs to recognise that, because it habitually runs and funds policies out of separate pockets, it does not mean they are not connected to each other. If you are busy looking at local government funding levels and they are under pressure, you should not be surprised if they are not fulfilling what you would like them to do on social care. You have to have regard for the position of local authorities that provide social care, as to which, in fairness to them, the ones we look at are prioritising social care and have tried to protect their social care budget, but they have come down quite a bit now.

You have to have regard to that, consider how those policies are feeding through in terms of local government and what the effects of them are, and at the same time look at your health. I do not think the solution to social care is in the NHS, frankly, unless I have missed something. I do not see how that works.

- Q15 **Maggie Throup:** After acute trusts and social care, what would be third



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on your list?

Sir Amyas Morse: I am enjoying myself very much, but I am going to stop now because I think I gave you the right answer originally, which is that you need to make these decisions strategically, looking at situations on the ground in health footprints. That was the right answer that I gave you. I should not have succumbed to the temptation to answer you, but the right answer is really that one.

Q16 Dr Whitford: Obviously the idea of the sustainability and transformation plans is to try to develop these footprints and look at integration, but is it not that we have far too many structural things that go completely against that, whether it is the tariff that the acute hospital only earns if someone is in the hospital instead of where we actually want them to be, and also the kind of competition and fragmentation? In Scotland we have a totally different system, but we now have a shared bag of money between local government and the health board planning social care. It is already making a difference, and the first one only went live two years ago. It strikes me that the STPs were a good idea, but do we not need to change more about how the system works to make that function?

Sir Amyas Morse: That is a very good point, and, if I may, I will comment on a particular thing, which was that over the last years there have been aggressive efficiency targets in the NHS. I am sure they have produced some efficiencies, but they are also the reason, or one of the biggest reasons, why so many NHS trusts have found themselves in deficit. If you say we are going to have, as it kicked off, a 4% efficiency target, that is a lot. In a relatively low-growth economy that is a lot of efficiency, mostly not delivered. It had a very significant effect on the environment. Therefore, with some things that sound perfectly reasonable at the outset, and in fact may work at the outset, you need to constantly review whether they are still working now.

In saying that to you, I am paraphrasing some questions I was allowed to ask at the PAC of the head of NHS Improvement. I asked him whether the number of trusts in deficit has been affected by the efficiency targets. Of course, the answer to that was yes. I take that point and I have not answered you precisely on the point you asked me, but if you have furniture that you put in place that seemed like a good idea at the time still there years later, you need to revisit all of it and ask if it is really helpful. I agree with you. The question is whether the tariff is achieving what you thought it would when you started out with it where you were trying to run a competitive economy. Are we still in that game now with all the financial support that it has been necessary to give these trusts? Is that still a feasible way of approaching it? People should set themselves free to ask those questions within the NHS.

Q17 Dr Whitford: Is that something that you have looked at? Obviously, the whole landscape between CCGs and competing providers has become so complicated. Has there been any attempt to quantify the amount of money that is simply lost not in the frontline but in running such a



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complicated system?

Sir Amyas Morse: We certainly have looked at it. We have done several reports on sustainability of the NHS, and that has featured in every single one of them. Whether we have done as well as we could have done in being able to separate it I am not sure, but we have certainly tried and pointed to that issue several times. The reason I find it easy to agree about is because it is something that is very visible to me, which we have raised quite a few times and in committee.

Q18 **Chair:** Can I return to an earlier point that I was trying to raise with you about the picture in the years ahead? We are already in the longest sustained period of financial squeeze that the NHS has seen, and the picture is going to get worse in the future. I do not know whether you have had a chance to see the evidence that we have received from NHS Providers and the Federation.

Sir Amyas Morse: I have.

Q19 **Chair:** They talk about what the choices are ahead in terms of what happens next if there is not an increase in the funding. Would you like to comment on any of the points they have made? For example, they have talked about reducing the number of strategic priorities that seem to rain down on the NHS and the various other points about formally rationing care and reducing performance targets. Are there any of those for which you feel there is a good evidence base or that should be prioritised?

Sir Amyas Morse: I certainly think anything that can make it less perplexing for people who are running trusts and who have responsibility within the NHS to know what they should be doing to do a good job, as there is an awful lot of uncertainty upon their shoulders at the moment that is discernible in parts of the NHS, in morale terms as well, I think—so anything that makes it clearer and simpler where the context is set out clearly. One thing the centre can do, apart from making funding available, is to set the context as clearly and as uncomplicatedly as possible. Allowing for the complexity of the NHS, that is not easy, I know, but it is something that can be done. My general view is that, if you are trying to run something effectively, you want only a few leading indicators that you look at consistently. Having too many really does not work; it becomes almost impossible; it becomes an industry rather than something that is highly motivating. I am sympathetic to the idea of not overcomplicating the measurement or the initiative picture.

The other thing I would say is that it also becomes impossible to know what is working. If there are so many initiatives going on at the same time, how do you know which one is having an effect? It is almost impossible to tell. We will need to watch very closely—or the NHS and those who are interested will need to watch as well—if the expected results of the reset are clearly not being achieved. We need to not spend too long deciding that that is the case. Otherwise, we will find things slipping downhill again. It is important that the room to manoeuvre that



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the additional funding from the reset provides is really used to have the greatest effect possible. As to saying, "Oh, well, this is not quite working the way we thought it would. Perhaps we will keep going a bit longer and see what happens," no, please let us not do that. We need to move faster than that.

Q20 Chair: Although the argument is often made that some of these things take several years to have an effect.

Sir Amyas Morse: Yes, I have heard that argument. but if people say it is supposed to produce a certain effect and it is not—I am not forcing people to say what the result should be, but if people say, "We would expect the following result: more stable, fewer trusts in deficit," and find that is rapidly not the case—then quite clearly what they thought was going to happen is not happening and you need to take notice of that very fast.

Q21 Chair: My final question is: are you doing much work in costing some of the new initiatives that are being put on to the NHS—for example, seven-day services—and whether they are delivering an evidence base for value for money?

Sir Amyas Morse: I omitted seven-day services from my remarks about cost push, but obviously they are part of the cost-enhancement picture. We are doing work on this. We have done some work on what the possible implications of seven-day services might be in our work on access to GPs and primary care, which we published earlier this year, and we will do more work on it as more detail emerges as to what it is really going to mean in different areas of the country, because it is obviously coming out quite variably.

Q22 Chair: Do other members of the Committee have any points? Are there any questions that you have not been asked that you feel you wanted the opportunity to talk about today?

Sir Amyas Morse: No, thank you very much, but I did pause politely before saying that.

Chair: Thank you very much for coming this afternoon.

Examination of Witnesses

Chris Hopson, Julie Wood and Rt Hon Stephen Dorrell.

Q23 Chair: Good afternoon. I would like to welcome our second panel. It is particularly good to see our previous Chair of this Committee on the other side of the table. Thank you very much for coming, all of you, this afternoon. Would you like to introduce yourselves to those who are following this from outside this room, starting now in your new role, Stephen Dorrell?



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Stephen Dorrell: Chair, thank you very much for the invitation. I am Stephen Dorrell. I chair the NHS Confederation. For this purpose, it is also relevant to declare that I am, for a period at least, an independent chair of the Birmingham and Solihull STP. I was reflecting that it is nice to come back this side of the table, having briefly been on that side of the table.

Chris Hopson: I am Chris Hopson, the chief executive of NHS Providers. We represent the 238 acute community ambulance and mental health foundation trusts and trusts.

Julie Wood: Good afternoon. My name is Julie Wood. I am the chief executive of NHS Clinical Commissioners and we represent the 209 clinical commissioning groups in England.

Chair: Thank you. Paula Sherriff is going to open the questions this afternoon.

Q24 **Paula Sherriff:** Thank you very much for joining us this afternoon. Chris, could I put this question to you first of all, please? Can you tell us candidly how bad the financial situation is in the provider sector at the moment?

Chris Hopson: It is unprecedented in terms of the scale of the financial deficit. It is fair to say that, although the official published deficit is £2.45 billion, it is relatively widely accepted that that is about £1 billion smaller than it really is. The provider sector deficit, if you take account of the adjustments that Sir Amyas was talking about and the capital revenue transfers, is probably about £3.5 billion to £3.6 billion. The thing we would point to, which again Sir Amyas was pointing to, was the fact that it is not just a few providers who are running up big deficits; you have more than 65% of the entire sector in deficit and more than 80% of acute hospitals in deficit. The issue is that it is not just a small number of trusts in deficit; it is the vast majority of trusts in deficit. There is no doubt that the sector is under huge pressure.

I would make the point though—I think it is an important point to make, and I did put it in the letter I sent to the Committee—that there is a short-term plan in place to return the sector to deficit. We are currently on track at quarter 1. We have the advantage of seeing the month-by-month figures, and I think the month 5 figures suggest we are also on track, but clearly there is a huge amount of risk about whether we will deliver the end-year figure that we are being asked to deliver, which is minus £580 million at the end of the year. As we set out in the letter, what worries us is if you look at the funding increases that are coming over the next few years. Cost and demand, as we know, in the NHS rises by 4% a year, and we are going from a 3.7% increase this year to a 1.3% increase next year, 0.3% the year after and 0.7% the year after.



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One small, quick thing, which I thought was particularly interesting, is that we invited Andrew Lansley to give us a lecture—an interesting experience—about two or three weeks ago. Fascinatingly, he said, “We all recognised there was going to be a five-year financial squeeze.” He then went on to say, “None of us ever thought that squeeze would last another five years on top.” I think we came through the first five years up to 2015 in relatively good shape. I think we are clearly not in a good position in terms of the second five-year squeeze.

Q25 Paula Sherriff: Thank you. David Williams attended the Public Accounts Committee hearing on 7 September this year and suggested that there was an incentive to make the financial year 2015-16 look as bad as possible. Do you agree?

Chris Hopson: There is no doubt that 2015-16 was a particularly bad financial year, and again I thought Sir Amyas set out very succinctly how there was a huge bunch of pressures on the Department to do some slightly odd things that do not seem to us to be sustainable, but again I thought the Chair had it absolutely right for me when she said, “Let’s not forget that 2016-17 is the year of plenty,” and we are really struggling to make the 2016-17 numbers add up. We are struggling to make the numbers add up this year. I think all of us are asking how this looks when we go from plus 3.7% to plus 1.3% to 0.3% and then 0.7%. Our members would say they do the job that they always do. They tried to provide the best performance in 2015-16 but they found it very difficult, and they are finding this year very difficult even though, as I said, it is the year of plenty.

Q26 Paula Sherriff: Julie, may I ask you to give us the current situation in the commissioning sector?

Julie Wood: Yes. The commissioning system is under significant pressure as well. Last year we saw the commissioning system literally just balance its books with a tiny underspend, with 31 CCGs being in deficit. This year there are 39 CCGs that are in deficit and that number is increasing. As at month 5, the commissioning system is just about holding its own, but within that there are some quite heroic assumptions around efficiency and they are above what CCGs managed to deliver last year. We would say—and certainly our members are telling us—that the commissioning system is under significant pressure.

Q27 Paula Sherriff: Thank you. What is your opinion on the issue of the measures that are being taken to improve the providers’ situation? Will it simply transfer or perhaps exacerbate the problems that the commissioners are having? That would seem a logical explanation.

Julie Wood: What we see and have seen in the past is some sort of move in the bump in the carpet, and that is not going to help us. It is where the opportunities that STPs bring are valuable because it brings commissioners and providers with their local authority colleagues together around a place to look at the totality of the resource such that



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they need to make decisions about how to spend and how not to spend. You only make a saving if somewhere else in the system they do not have to incur that spend. So we do have to be mindful of anything that then shifts the risk across to commissioners from providers and vice versa. Certainly, tariff this year has, I think, shifted the risk back towards commissioners. We are now seeing that commissioners are having to look at how they balance their books and cope with the risk shift that they have seen, and that has consequences and choices, and we are beginning to see some of those play through.

It is something that Chris and I have conversations about from our different perspectives but we are clear that we have to have a system-wide approach. We cannot pitch commissioner against provider any more. It just does not work. As Sir Amyas said, we have a complicated system. We need to make sure we spend all our resource and energies in trying to live within the resources and getting the best return for the population that we serve.

Q28 Mr Bradshaw: Chris, in your evidence you laid starkly bare the choices that the service faces in the absence of any significant financial uplift, and that is between cuts, basically, whether reducing targets, not having so many priorities, closing services or rationing and introducing charges. Does the rest of the panel agree with that assessment, first of all? Is that the choice that is facing you policy makers?

Stephen Dorrell: The question of raising charges for NHS services is clearly not a matter for NHS management. That is a matter for this House. You do not need to know much about British politics to know that that is not a viable policy option. The exam question is how you deliver a viable NHS within the political framework that has universal support in the political world and within the budget that is available.

Julie Wood: Certainly, we agree that there are stark choices to be made. In our evidence, we have laid out five things that we think need to be done to look to address some of those things about having an open and honest debate with the public about how we make the very best use of the resources that the Government have allocated for the system to use.

Q29 Mr Bradshaw: In effect—and we will all have examples of this in our own constituencies—the cuts, the rationing and the failure to meet targets is already happening. Can you give me a collective picture of what is already happening on the ground as a result of the current unsustainable financial situation that the NHS is in?

Stephen Dorrell: Could I perhaps come in at that point, Chair, to say that across the health system, but actually outside the health system—and I want to pick up an earlier point—Sir Amyas was absolutely right to say that public services as a whole are connected to each other? There is a tendency for this to be focused on health and social care, but it is reductions in expenditure, in education, for example, where there are reduced services for mental health provision in schools, and in DWP,



where if you reduce support for independent living, unsurprisingly, you end up with more dependent living. What is happening across the range of public services, in my view and the view of the NHS Confederation, is that, increasingly, demand for NHS services is being built because other statutory services are unable to deliver the services that they are designed to deliver and that would deliver both better outcomes for citizens and better value for taxpayers.

There is a tendency—and I am obviously aware of this as a former Chair of this Committee—to focus on the health/social care divide, which is hugely important, but it is to understate the issue if you only look there. It is across the range of public services to deliver value and outcomes for citizens as well as sustainable budgets.

Chris Hopson: There is a slightly different connection I would make in terms of other wider public services. We feel as the health service that we have received a very clear message from the new Prime Minister and the new Chancellor, which effectively says, “We have sorted out our large public spending departments. We have reformed them without putting in any extra money. The NHS got a particularly generous settlement compared with other public services, so go and sort it out without any extra money.”

The three differences that we would point out would be, first, if you look at the level of demand increase that the NHS is currently experiencing—so 6% year-on-year demand growth, for some of the reasons that Stephen was talking about. But, secondly, if you look at what has happened in other public services, the workforce has been cut; the prison service workforce is 23% smaller than it was in 2010; the armed forces budget workforce is 12% smaller than it was three years ago; the police workforce is 18% lower than it was; in local government, service eligibility criteria have been changed and there are now 150,000 fewer people who are receiving social care.

Q30 **Mr Bradshaw:** I thought it was 400,000.

Chris Hopson: Okay, 400,000, even more making the point. With service standards, for example, some local councils and local authorities are only now collecting refuse once a fortnight rather than once a week. We know there have been numbers of different services that have been closed. That has been the reaction of public services coming under the degree of financial pressure the NHS is under. The point that our members want to make to you really forcefully is that none of those options is currently available to the NHS. We have very clear, set-out staffing ratios such that, if you fail, you lose your job as a chief executive. They are enforced by the most rigorous inspection regime right the way across the public services. We are not able to change the service eligibility criteria because they are enshrined in the NHS Constitution. We have to meet the performance targets because they are set in the NHS Constitution.



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The argument our members would be making to you is that it is simply no longer possible to effectively square that circle of every little bit of flexibility being nailed down with the demand going up by at least, in accident and emergency, 6% a year and the funding dropping by the levels they are doing. That is the reason why they are saying they cannot carry on delivering what you are asking for, which is the same service levels and no flexibility whatsoever, not the flexibility that is given to other public services, on the levels of funding that you are now talking about allocating. That is the point that our members say we have now reached.

Q31 Mr Bradshaw: Julie, your members have already had to make some quite controversial commissioning decisions, which we have all heard about in the media. What further or even more controversial commissioning decisions do you see in the pipeline if the situation does not change?

Julie Wood: First, I would like to echo completely what Chris has said. That is the reality that our members are facing. They are population commissioners from cradle to grave, so they already have to juggle and make difficult prioritisation decisions. What we are seeing playing out is that, because we are not able to do all these things, various things are happening. Our members are looking at potentially having to slow down the rate at which people are referred into the service for treatment based on some firm judgments about clinical thresholds around, "Actually, you are putting yourself under far greater risk if you have planned surgery if you are obese or you smoke," so doing it from a clinical perspective, not from an arbitrary cut or cap perspective; but they are also having to look at whether there is anything that we spend money on now that we are going to have to rethink.

As a country, we pay out £87.6 million on paracetamol prescriptions. Nearly 23 million prescriptions on paracetamol are dispensed. That is a huge amount of money when you can buy paracetamol over the counter for 23p. Clearly, the way in which some of those sorts of things would need to be implemented needs to be carefully worked through because that would be easier for some sectors of the community to respond to than others, but it is some of those sorts of decisions, where we are spending a lot of money on things, that, when we are looking at relative priorities, unfortunately, we have to rethink again.

Q32 Mr Bradshaw: What are Government Ministers telling you in the conversations that you have with them about what you should do to grapple with these decisions?

Chris Hopson: "We gave you £10 billion, more than you asked for. It is your turn to deliver."

Stephen Dorrell: If I might pick up another point Sir Amyas was making earlier about the need for nuance here and the need for local flexibility, that is what we are seeking to do in Birmingham and Solihull across the



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STP process, and I suspect the Committee will want to talk about this. The need is to look across the traditional silos. I wrote down earlier on, "The need for a system response." We have all heard that phrase, "We need a system response." It rather begs the question, "What is the system?" If the system is seen as the NHS, that is one definition. If the system is seen as the world of public service, that is a different definition of the system, and I think a much better one.

Just while I am speaking, Chair, may I add to Chris's blizzard of statistics? There are two that I hope the Committee will reflect on. Over the last 10 years, the NHS budget has risen by 25% in real terms. Social care has flatlined. That cannot be right at a time when the users of social care are disproportionately a growing proportion of the users of the NHS. If you look behind the statistics of NHS spending, at a time when NHS spending as a whole has risen by 25%, NHS spending on primary care has gone up less than 10%. NHS spending on the acute sector has gone up by 31% in real terms. At a time when Ministers of successive Governments have talked about the need to shift resource into primary and social care, what is actually happening is precisely what Sir Amyas was suggesting is an emergency response, which is to stabilise the acute sector and then get around to dealing with the community services, prevention and sustaining proper, ordinary lives. We have never got beyond dealing with the emergency. That is the challenge that STPs have to deal with.

Q33 Mr Bradshaw: We made exactly that point in our recent report on primary care, on which I think you helped us with evidence. A final question from me is that one thing that the new Prime Minister and Chancellor did from the start was to abandon their predecessors' deficit reduction target by the end of this Parliament. Have you been given any indication that any of this extra money might come your way or particularly into social care?

Chris Hopson: The indication so far has been that it is extremely unlikely that the NHS would receive any extra revenue in the autumn statement. However, the door appeared to us to be slightly open in that if the NHS could come with a proposition that might form part of the infrastructure—fund investment, that is, potentially capital—then there might be an opportunity, but certainly the mood music appears to be as I suggested, which effectively is, "We have sorted out large spending departments without any extra money. You got a particularly good settlement. Go away and sort it without any extra money."

Q34 Mr Bradshaw: If you could spend that extra capital funding on something, what would it be on in order to improve services and potentially save money as well?

Julie Wood: It would be freeing up some of the transformative out-of-hospital solutions that we so badly need. As Stephen says, the investment in primary care and community services has not kept pace



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with what is needed. If we do not unblock that now, we will go back round this cycle again and have an unsustainable NHS.

Chris Hopson: One thing that we would urge you to look at carefully and perhaps talk with others about—and I know who you are seeing next week—as part of this mini inquiry is to really ask them about the capital position. We have already agreed that we are going to pre-allocate £1.2 billion of the £4.8 billion that is scheduled to be spent on capital this year as a capital revenue transfer in order to make the books balance, and we have already lost 25% of the capital before the year even starts. If you go out and talk to our members about what their requirements are, if you look at the backlog maintenance they have, we are talking about probably something like £5 billion, of which there is only about a tenth of what we think needs to be spent this year that is going to be spent. That is before we even get to the point of saying, “Let’s modernise services.” It is before we get to the point of how we enable new care models. It is before we get to the point of service reconfiguration.

If you ask our members what their concerns are, they have a long list, but relatively high up that list would be, exactly as Sir Amyas was saying, that we are risking some big things if we do not spend the adequate amounts of capital money that we need to spend.

Stephen Dorrell: Can I land that in a specific story I was told last week of a health economy that wanted to spend capital on improving information flows to allow them to improve the connectivity between primary care, community services and social care—all the standard things we have talked about? It was a specific project and it relied upon the availability of capital to underwrite the delivery of that project. The chief executive was concerned that his ability to deliver his medium-term plan for his organisation was being undermined because he had been told that that capital was no longer available because it was being collected through the control total. That is capital revenue shift in action. It is undermining the ability of a trust to deliver a service transformation that this Committee has specifically endorsed as a principle many times over.

Q35 **Dr Whitford:** That was Simon Stevens’s suggestion as well: obviously, with borrowing as close to zero as we are ever going to see, should we not be doing that? We had a debate about the sustainability and transformation plans just before the conference break, and a concern of many members seemed to be that a lot of things were starting back-side forward, just, “We will shut this community hospital and we will axe these 500 beds because we need to free up the money,” instead of getting the chance to look at the footprint and work out what it is people need. In my health board, we have rebuilt as a modern version three community hospitals, because we keep talking about pushing the stuff closer to people. Yet what seems to be happening is that there is the danger of these things being shut and it all coming in the way.

Chris Hopson: If we are diving into STPs, the concern we have is this. We think it is a very important process. It is a process that has lots of



good in it. The idea of asking a local health and social care economy to come together and plan on a long-term strategic basis seems to us to be really important. Our members report growing relationships and effective relationships in many of the STPs.

However, there are two big risks that need to be managed. The first is that we are going at breakneck speed here. I heard Sir Amyas's comment about the need, but in some cases these organisations have not really spoken to each other before, and if you really want to get to a quality of plan they have to be given time. The other danger that virtually all our members say to us is that they are now being required to meet a 2020-21 financial allocation that is after our famed U-bend of where the funding is going to drop, so they are now looking at a set of figures that, to be frank, just look completely undeliverable. Our members very clearly asked the question in June/July, "Do you want a plan—any plan—that balances to that very reduced figure, or do you want us to tell you how far we can get?" The answer came back very clearly, "Do not submit a plan—you are not allowed to submit a plan—that does not balance to the 2021 figure."

Our members are saying to us that they are spending quite a lot of time creating plans that, in their view, are not deliverable and usually involve major structural service changes because that is the only way they can create a balanced plan. Our view is that that risks blowing up and destroying a process that seems to us to have a huge amount of fundamentally positive benefit. That is a consistent story that we are getting from virtually all our members.

Q36 Chair: I know that, Stephen, you want to come in on this point and then I will go to Helen, who has follow-up questions on this.

Stephen Dorrell: Yes, I would like, if I may, to comment on STPs because I think it is right—it is my view—that the objective of STPs is bringing different players together to create a system response, to create a medium-term vision of what you are seeking to do.

Incidentally, remember there are three gaps in the STP process that we are supposed to be addressing: the quality gap of the different range of quality of service provided; the outcome gap—the different outcomes achieved for citizens; and only then the finance gap. All three are intended to be the focus of STP activity and all that is, I think, a step in the right direction. But it is important, I think, for the Committee to be aware that although those objectives are very broadly shared around the health and care system—and, indeed, in the local authority world—there are very real concerns in the local authority world about the extent to which in some parts of the country local authorities are true partners in the STP process; the STP process itself, on the one hand, wants to deliver medium-term plans for sustainability and transformation and then, at the same time, is seeking to deliver a process governed by a series of spreadsheets, which in truth makes it very much more difficult for the



partners within the STP process to deliver the objective for which the STP process itself was set up.

I think the objectives are right, but it is a process that needs to be developed and we need to improve the means by which the STP partners deliver the objectives that they are asked to deliver.

Chair: I know Helen had a series of questions as well on this.

Q37 **Helen Whately:** I am keen to follow up on your views on the STP process. I am hearing positive things and phrases like “step in the right direction” and “growing effective relationships”—and from organisations that have not even talked to each other before, or scarcely, which is certainly what I have seen in my area in Kent. So there are good things going on through the STPs, but there are also concerns. Could you be more specific about what you think should be happening differently that would give you more confidence in the STPs really working and delivering on the quality outcomes and the financial gap?

Julie Wood: To kick that off, you need a balance between how you address those three gaps, as Stephen has said, and the predominant focus of STPs has been on closing the financial gap. We need to make sure that we are putting emphasis on the care and the quality gap as well as that so that we then make the right level of investment.

The other point is about the breakneck speed at which they are going. They do vary. There are 44 STPs. There are some that are absolutely the same footprint that local communities have been working with and in for a long time. I am thinking of Dorset and Gloucestershire, those areas where they are one and the same. Their plans are likely to be more advanced and developed because they have built the relationships, they understand their place and all those sorts of things. There are also STPs at the other end where for the first time organisations and people are coming together, so you would expect them to be further back in all of their working out of what their plans need to look like and then how they are going to implement them.

For me, the other key challenge is about support for taking the decisions that you need to take to close all three gaps. If the money does not stack up—and you have to do some fairly radical things to get the money to stack up but also re-liberate your expenditure so that you can do something to improve health outcomes—that has some consequences. Time will need to be taken to think about them, to consult and engage with people. That is the other thing that is going at breakneck speed such that we need to make sure we have the right level of support locally, otherwise, when it comes to implementation, they will not be successfully implemented.

Chris Hopson: I would echo the time one. The vast majority of people we talk to are saying it is just not possible to get to a quality of plan that we would like within the proposed timescale.



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The second thing people say to us clearly is that we have now been given this 2021 figure, which we have to balance, which is, as I say, after the plus 1.3%, plus 0.3% and plus 0.7%. It is a scary figure that has, in most STPs, hundreds of millions of pounds of gap in it, and effectively our members are saying they want to get a better balance.

Please do not misinterpret everything that I am saying, because every one of our members is up for a realistic, stretching efficiency challenge to get things better, but the problem is the size of financial hole that is now being created in 2021. If you are told you have to balance and you cannot submit a plan if you do not balance, that means that people are coming up with, to be frank, vastly over-ambitious plans that effectively rely on either vastly over-ambitious demand management plans or, more often, service reconfigurations that we know are not going to happen because they will not command the required political support and there simply is not the capital available, which comes back to that fundamental conundrum that I put in the letter to you, which is that we have now reached a point where you cannot make the circle square. Our members are trying to make the circle square by coming up with some very over-ambitious service reconfiguration plans that we know are not going work.

If that is going to be the financial envelope—and the Government have the right to set the financial envelope—we need a proper, more effective debate about what other ways we are going to use to close that gap. But the bit that nobody can deny is that, if you look at those figures that people are being asked to balance to in 2021, we are talking about hundreds of millions of pounds of gaps. The highest one I have come across is over £1 billion. Yes, of course, there is stuff like better prescribing, but we are not going to reach that kind of gap without doing something very different. Our members are saying, "Please do not force us into coming up with undeliverable silly plans because you are focusing on this financial gap."

Stephen Dorrell: You asked about the ways in which this process can be improved. I agree with Chris that meeting the financial gap in 2021 without additional resource outside last year's CSR is a very big ask. I do think that there are significant opportunities for real efficiency by looking outside the health service into a broader understanding of public service. We are often told the NHS has inefficiencies in it, and of course the NHS has inefficiencies in it, but the biggest inefficiency is to use NHS acute hospitals as forms of social care. So engaging in reconfiguration that puts resource where the priorities are is the biggest source of efficiency gain available to the health and care system.

The other points I want to make, which are very important points, are these. If we are going to deliver real change and efficiency gain through the STP process, first, this process needs to be strengthened to involve the professional staff working in the health and care system. It cannot be something that is done to them by a bunch of experts meeting in an STP



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committee. Secondly, STPs, where they are most successful, in my view, engage the local political community. The elected councillors engage through the STP process. There must also be national political engagement for the process of system change, which is implicit in everything that I have just said.

Chris Hopson: I completely agree.

Q38 **Helen Whately:** Can I follow up very particularly on the point of the breakneck speed? We know that in the NHS there is pressure, but there is also a time pressure to solve the situation. The Five Year Forward View was published by NHS England, was it, now nearly two years ago? It was a while ago. The STP is a critical part of the plan for delivering that. There has been a lead time of a couple of years to get to this point. How much more time is needed until we can come up with a plan to deliver it?

Chris Hopson: If I may gently suggest, the lead time for that particular element is not two years. The planning guidance on the STP was issued in December last year, and I think there are some real advantages in this process. Wherever I go, I get district general hospitals saying to me that they have never really sat down with their neighbours in a room, met relatively frequently and actually started to talk properly about how they might share wobbly acute services that each of them cannot have, such as, "We are all struggling, each of us, to find a rheumatologist, so why do we not try to run one rheumatology service perhaps with a rotating consultant around all three?" There are lots of advantages with that. Equally, though, as somebody said to me the other day, "We went to present our interim STP to Simon Stevens and Jim Mackey in September, and that was the third time, as a group of chief executives, we had actually met."

All I am saying is that in some places that is the situation. There are four or five plans on which I think there is a sense they are really getting there and are quite strong, and the interesting bit that is the common feature of all of them is that they are in health and social care communities where they have been meeting as a group of people for a long period of time and this is just another inflexion point along a journey that has been going for three or four years. Then there are the vast majority of places where these people have not met together to have this kind of discussion since January of this year.

Julie Wood: We must not slow down those plans where you have mature, developed relationships with clear plans, often with a lot of engagement of local politicians, patient groups and those sorts of things. They need to go at the pace they can go at and deliver, but we must not think that all 44 are at exactly the same point, because they are clearly not. Certainly from our members' point of view we have been advocating for longer-term planning cycles: let's not use all our energy up on annual contracting rounds; let's work together in terms of developing system-wide plans. That is all good stuff that we want to see, but for



some who have not been doing that up until now it takes longer than maybe for other people.

Q39 Helen Whately: When you say it takes longer, how long do those need or want?

Stephen Dorrell: There is a huge danger with this, which is that we imagine that until we have a fully worked-out plan that runs to 1,000 pages with 150 spreadsheets we are not allowed to do anything. Any change process must start by being a process. Absolutely, what Julie and Chris have said is right: in too many STP areas, these are people meeting for the first time, and getting to work together is part of the process. It is only 10 months old, but it is a completely fair challenge to expect that, given all the cash, demand, quality and outcome pressures that exist in health and care today, it is no good having a plan for 2020. This needs to be a process that is delivering perceptible, measurable, visible change to the benefit of citizens in the short to medium term.

Chris Hopson: There is also one really important thing, which is that, if these plans are to work, they need to do some really difficult things. Philippa, you talked, I thought very eloquently, about the changes that have been made in Scotland in terms of health and social care integration and moving care out of hospital. For a plan to work effectively, you probably have to get a district general hospital to agree to cut one or two wards. You then have to agree how that investment and, in a sense, capacity is going to be transferred to an out-of-hospital provider. You are going to have to have the debate about how you get primary and community care to liaise together effectively and how you get social care properly linked in. All I am saying is that the complexity involved in that process, particularly where it involves people giving up things that they are currently doing—turnover, staff, money, pathways, and so on—is really quite a complex process.

The other thing our members say to us is that, where they have tried to short-circuit the process of not aligning behind a shared vision of where they want to go, they find that when they get into the detail they have to go right the way back to the beginning and effectively spend the time agreeing what their shared vision is. Most people say to us, and again I know it may sound deeply frustrating, that most of the time they have spent in the first six months has been in hammering out what is the shared vision that they want to share, what that involves each of them giving up, and how they, for example, do the dull but very important stuff of getting the governance right in that they are now trying to transcend boundaries that have been in place for a very long time and create brand new ways of doing things. Our members say it just takes time.

Stephen Dorrell: I have one final point on this, Chair, and I am in danger of thinking of another point, but it does repeatedly come up in conversations with STP. Where local government is an effective voice within the STP, it is culturally different from the NHS, and in terms of answering the point we are being challenged on—how long this needs to



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take—local government leaders are quite often better at asking that question and insisting on an answer than some of the NHS leaders.

- Q40 Helen Whately:** I have one point on which I particularly want to follow up with Stephen Dorrell, which is your point on social care and that we need to look at the efficiency potential beyond the NHS, the whole care system, which is something that I think makes very good sense. I also hear it on the ground myself, although I do sometimes find there is a question of the data and I am interested to hear what gives you the confidence that an extra pound being spent on social care will definitely mean that that pound is not also spent, for instance, in the NHS—the confidence in that shift as well as confidence in the quality and the output on that side, because there is such a difference in transparency in social care compared with what we have in healthcare.

Stephen Dorrell: That is a very fair challenge and a challenge that will be put to anyone arguing the point about the extent to which these services need to be joined up. Anyone who is trying to run an acute hospital being asked to believe that there is going to be reduced demand coming in through the front door or increased facility for discharging patients through at the end of their care is going to ask precisely that question. The challenge for the health and care system, and public service more generally, in my view, is to recognise that there is expertise about managing information flows and managing risk. It exists by and large in other countries in the world, and I hope that our health and care system will be more open to using that expertise to manage tax-funded services, to use taxpayer pounds more effectively to deliver service to UK citizens. We do not need to reinvent that wheel.

- Q41 Dr Whitford:** I have two points. First, it strikes me when you read the STP paper that it talks about quality, outcome and finance, and in that finance is no. 3, but in the entire debate and for all the MPs who have spoken about it, it sounds to me like most of the STPs have started the other way round. Having been a surgeon on emergency receiving, people will still be coming to hospital until the community system works. You do not get to have a year where you have cut three wards and then you are going to build something out in the community, because people will be on trolleys in the car park and not just the corridor. It strikes me that we are always hearing from the Secretary of State about how quality ends up being more efficient. So do we not need to look at quality and outcome first and build back from the shape that would be sustainable rather than the shape that would be cheapest within the next five years? Sustainability is much more than just money. Staffing is the hardest one.

Chris Hopson: If you are arguing that there is a danger that the STP process has become mesmerised by the money, that is a danger, but I suppose, without wishing to sound too defensive, there are two good reasons as to why that has happened. First, people have been told specifically that they cannot submit a plan unless it balances to this very aggressive 2021 figure, and then when people look at their 2021 figures, to be frank, they are mesmerised because they are being asked to create



plans that talk about identifying hundreds of millions of pounds of efficiencies. Most people that we talk to can say they can pretty reasonably get half the way there. Some people say they can get three quarters or two thirds of the way there. We have not found anybody really yet who says to us they can, with complete confidence, get all the way there. That is the issue as to why people have been focusing on it, because, in a sense, there has been a real, clear requirement to do so. I agree with you, and I thought Stephen put it very well and you put it very well, that we have to get the appropriate balance between these three different objectives.

Q42 Dr Whitford: It is just that the tougher sustainabilities that we face in the next 20 or 30 years are our lack of doctors and our increased demand of the ageing population. They are much harder to fix. Having said we are not going for the deficit-matching target in 2020, we could say, "We will give you more sustainability money until you reshape your footprints." That would be much easier to do. We cannot grow doctors and make patients disappear. I am really scared that we are doing it the wrong way round.

Stephen Dorrell: If I may say so, I entirely agree with you and it is absolutely right that we have to think through the implications of this—we have not touched on it—for the shape of the workforce that is required to deliver these services, because demand, opportunities and skills are changing, so the training requirements need to change as well, including in-service training. All of that is true.

It goes back to this point that you cannot boil the ocean; you have to start somewhere. If I may, I will repeat an anecdote to the Committee—it is a grand-scale anecdote, but it is a significant one, I think—from the NHS Confederation conference this year. We were addressed by Jason Helgersen, the director of the Medicaid programme for the state of New York in the United States, one of the relatively few people in the world who can demonstrate in his track record that he has bent the demand curve. When asked how he did it—and it was a whole series of interventions—he said the single most effective health intervention in the state of New York was the introduction of air-conditioning units into low-income households. It was a spend on the housing budget in order to improve the quality of life of the citizens in low-income housing in, obviously, a New York summer. I am not suggesting that air-conditioning is the answer in your constituency, Dr Whitford.

Dr Whitford: We are the sunny bit of the west coast.

Stephen Dorrell: But the point is an important one.

Dr Whitford: It is the "health in all policies" point that you were trying to make earlier, which we are appallingly bad at. Thank you.

Q43 Maggie Throup: I think we had a decision at the meeting last week that we needed heat and insulation in the houses of the UK rather than air-



conditioning—to be a bit greener. What did you mean when you said in your recent evidence that we need an “open and honest public debate” about the service the NHS can provide?

Chris Hopson: We are a taxpayer-funded system and it is important to us that the public should have the opportunity to contribute effectively to a debate about the options that we think are being faced here. I had a very interesting phone call the other day from the Institute for Government, who asked me exactly the same question and asked if they could come and have a conversation with me. We drew three or four conclusions together.

First, we felt there is a real need for some evidence out there from an independent source that effectively sets out what are our long-term health needs, how much it will cost to fund them, what the consequences are of not meeting that funding and what options are available so that we can have a proper debate.

The second conclusion we came to was that it is very difficult for our politicians, particularly those who have been in government for six or seven years, to acknowledge that somehow things have reached a pretty parlous state and that, therefore, we needed a mechanism that was not on the one hand directly influenced by politicians but, equally, was something that they felt sufficiently close to that it would get traction with them.

The third thing we felt was that, exactly as Stephen has said, it is very important that the public, the clinicians and staff should have an input, but our sense was that this is a debate we are going to need to carry on having over the next five, 10, 15 or 20 years in terms of us seeing nothing other than a very big bulge in demand coming and there is still continuing to be pressure on public finances. If we wish to retain a taxpayer-funded system, we are going to have to have a proper conversation, and probably a regular one, about what is the appropriate amount of funding that should be put in and what are the options if we want to increase that funding that should be available.

I personally felt, to be frank, if you do not mind me saying, a bit disappointed about the quality of the conversation that we had at the last general election about this. It seems to us that what happens in general elections is that it turns into the “War of Jennifer’s Ear”, and such like, and we do not have that proper conversation. Our view would be that we need to find a way to have it, and those were some of the ways, when I sat down with the Institute for Government, that we felt it might happen.

Julie Wood: I would agree with that. The way the NHS delivers services is an accident of history in many cases and we can do things very differently these days; but the public hold on to institutions, and we can do so much more out of hospital and we need to do so much more in terms of prevention and all those sorts of things. We need to have an honest conversation in the way Chris has described about what the NHS



can and should be in the future. I have given some examples of how we are spending quite a bit of money on things that perhaps are of a lower prioritisation than other things. We need to start having some of those debates and making some judgments. We are spending a lot of money on specialised services commissioning and there is a debate about whether the level of services that we are commissioning for specialised services is in balance with the level of services for CCG commissioning services. We need to start getting all those relative prioritisation conversations out into the public and have a public debate.

There are more things that we can do. Think about some of the Right Care examples, where there is unwarranted variation. In some instances, that is totally unjustifiable and we need to be frank about how we start to get that out of our system so that we can liberate that resource and spend it on other things that will give better value and a better outcome for our population, but we need to get that conversation out in the open so that we can have it in a rounded way.

Stephen Dorrell: Can I approach this subject slightly differently? We need to learn a new language here. We need to stop thinking about the health and care sector of our economy as somehow a national overhead, a burden that needs to be borne. Health and care services are part of the wealth-creating sector of the economy. They employ people, they employ finance and deliver outcomes that secure better lives for people. That is surely not a bad definition of wealth creation, and as we get richer as a society I would hope that we would anticipate that that sector of our economy would be growing and that we should not be looking all the time to minimise the size of the health and care sector. It is a wealth-creating sector, and we should celebrate the fact that as a society and as we get richer we are able to enjoy better standards of living for the sick and the elderly, who are, after all, the principal beneficiaries of these services.

Q44 **Maggie Throup:** Too often we hear the bad news stories on the news because we have not had that debate, and I think the words here are “public debate.” Is that one of the barriers? What are the barriers to having this real, true public debate rather than between institutions, between bodies? We need to get it out there. What are the barriers?

Chris Hopson: I certainly feel again, and it is just a personal observation, that it is difficult to get that debate in a taxpayer-funded system where, by definition, you have a bunch of party politicians leading the system who, quite understandably—and I would not for one second wish to criticise, having been a special adviser myself and sitting next to a former Secretary of State—will want to pretend that all is well, particularly given that the NHS is, as Lord Lawson once said, part of our national religion. It is very difficult to see a group of party politicians who are responsible for the service leading that debate, which is why I think it needs to be at one remove.

If I was to be slightly controversial here, we feel at the moment that we are in danger of being in a position whereby we are misleading ourselves



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about where we really are. I thought you, absolutely, as a Committee pointed out quite correctly that it is not £10 billion actually; it is £4.5 billion. I have already pointed out that the provider sector deficit is not £2.45 billion; it is £3.7 billion. We all know that the social care system is in a rather worse state than people are pretending and that the spending review settlement is too little too late. We know that. The supposed £22 billion to offset against the 8 is simply not going to work. We all know that we have only just squeaked through in the last two years in terms of the Department of Health meeting its budget by effectively doing some things that Sir Amyas has described as completely unsustainable. We are in danger of living in a bit of a fantasy world here in not being prepared to recognise where we really are, and my observation would be that we have to find some ways of getting that truth out there.

One observation, again, if I am allowed to make it, is that one good thing that has occurred over the last five or six years—it is not a party political point—is that the Office for Budget Responsibility has put out a level of information about public spending that enables those who wish to do so to have a proper conversation about what future trends look like. It has been incredibly useful. I cannot help feeling that, with some kind of organisation that is capable of putting out that kind of information and really looking at what is going on in the health service in an objective way, we can start to have a proper debate. My observation at the moment is that we do not seem to be able to say honestly where we really are as a health service, partly because—and, again, it is not a criticism of the current Secretary of State because I think whoever or whatever colour the Secretary of State is would be under these pressures—I do not think we seem to be able to have that debate. That is certainly what our members feel.

Julie Wood: I would add that we also need to get serious about the lifestyle burden—the cost on the NHS. If you think about obesity and diabetes, the amount of money that we spend, if we do not really get serious and start vocalising the impact that that is having on the NHS today, tomorrow and in years to come, we will not have a sustainable NHS. Prevention, self-care and patient activation are all really important in delivering a transformed health service and we all have a part to play in helping to get that out there as well.

Stephen Dorrell: The concluding thought, if I may, building on what Chris said, is that Chris's last contribution focused very much again on money, and the value add that we are delivering here is better outcomes. If we could show trends of better outcomes, at the same time challenging ourselves to match the outcomes we achieve in London, Birmingham or in Manchester with outcomes achieved in Chicago, Hamburg—if we are still allowed to talk about these places—and Madrid, so that we can actually demonstrate to British citizens that the part of our economy that delivers these services, first, delivers a trend improvement in the quality of life in the United Kingdom and, secondly, matches itself against equivalent sectors in other countries in the world—



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Q45 Mr Bradshaw: But in Hamburg and Chicago they spend twice the proportion of their GDP on healthcare than we do. Is it not your responsibility collectively to point that out to the Government as well? If we want to live in a society that has Scandinavian-quality healthcare but we are only prepared to pay American-level taxes, it does not add up.

Chris Hopson: I completely agree. Stephen and I both had the privilege of meeting the German Hospital Association last week and this was exactly the conversation we were having, which is that you cannot expect the NHS to deliver German-style health outcomes on 7.5% of GDP when the Germans are spending 11%. We do remarkably well in the NHS in terms of—

Q46 Chair: It is very efficient.

Chris Hopson: We are remarkably efficient, but it is not entirely surprising if you basically believe you get what you pay for, and I think Sir Amyas Morse was absolutely saying that, 7.5%—

Stephen Dorrell: We could get more for what we spend but if we spent more we would get more.

Chris Hopson: Yes, exactly—nicely summed up, Stephen.

Q47 Maggie Throup: Coming back to the pounds and pence rather than the outcomes and prevention, which I should think are really important as well, Chris, you mentioned that the end of quarter 1 is looking pretty good for the financial reset. Taking that into consideration, and the NHS operational planning guidance for 2017, 2018 and 2019, is that a credible way forward? Can you see that balancing?

Chris Hopson: Might I draw a distinction between short term and medium term? There is a good short-term plan in place thanks to the £1.8 billion extra investment funded by the year of plenty to get us to a place where I think probably next year, if everything stays on course, we will be able to eliminate the provider-sector deficit, thanks to a lot of very hard work. Can I make the point that we have provided a more than pound-for-pound return on that investment? In other words, the deficit is coming down more than the STF has been put into, so the NHS is in that sense an investable proposition.

However—a very important “however”—as to the medium term, is there a credible strategy to get the NHS through to 2020-21 with this plus 3.7%, plus 1.3%, plus 0.3%, plus 0.7%? I am very clear that the answer is no. There is not a credible strategy in place and that feels to us to be a huge gap. So in the short term it is half a tick, or three quarters of a tick, but as to the medium term there is a real question.

I have one more tiny thing, which is just to make the observation that the incentives this year have been reversed, and in order for our members to receive their share of the £1.8 billion sustainability and transformation funding money they have to demonstrate they are on



track in quarters 1, 2 and 3 to receive that money. We all know that accounting is an art as opposed to a science, so clearly there must be some risk that effectively a gap might open up in quarter 4. We hope it will not. We are all doing everything we possibly can to reach that minus £580 million, which is the figure we have agreed, but please be under no illusions about how difficult this is particularly, even though it is in the year of plenty.

Q48 Maggie Throup: Taking into account the fact that you are quite happy until 2019 and the STPs come in place, do you think that will—

Chris Hopson: That is the \$6 million question: can the STPs produce a credible plan to get us to 2020-21? You can tell from what I have been saying about the STPs that at the moment I have not come across an STP yet that believes it has a genuinely deliverable plan to cover that gap. Virtually all of them are saying to us that this is simply too big a gap. That is why they are saying they can get a third of the way, half of the way or two thirds of the way there—and I know I am concentrating on the money again—but nobody has said to us that they genuinely have a believable plan to cover the whole distance.

Stephen Dorrell: Can I pick up also one point Sir Amyas made earlier—I think it was you who asked him—on where he would put the money? He said the immediate pressures are in the acute sector and therefore he would put it in the acute sector to stabilise it, and I quoted the figures that suggested that had happened once or twice before.

The point I would make in response to his point, which is a perfectly legitimate one, is that if the acute sector is in certain parts facing extreme difficulty—and it undoubtedly is—so is social care. It is a very close run thing as to which of those two systems is more unstable on current funding levels, and if social care were to find itself facing a serious risk of significant capacity reduction, that would feed straight back into the national health service and would significantly further destabilise it. So I think there are risks to stability in the system—in the acute sector in certain parts of it for sure, but elsewhere as well, including in social care and including, I would also say, in parts of primary care.

Chris Hopson: Certainly in our autumn statement submission—and you might be quite surprised by this—we are arguing for three particular areas where, if we were to get extra support, we would like to see it in the following: first, in social care; secondly, in increasing primary care capacity; thirdly, could we, please, have more help and support to realise the efficiencies that we know we need to realise? Interestingly, we are not in the same place, in a sense, as where Sir Amyas was. We think that if you look at where the pressure is greatest in the system at the moment, and therefore is knocking on to our members, it is social care and primary care. We recognise there is more to go at in terms of efficiencies, but we simply do not have the capacity and capability at the moment to do that because we are so busy keeping this very wobbly



day-to-day system upright and we need more capacity in terms of analytical capacity, project management capacity and change management capacity to get to this more complex efficiency and elimination of variation that we simply do not have enough capacity and capability to get to at the moment. If there was more money being spent, that is where we say it should be spent.

Julie Wood: We would echo that. It goes back to my answer to Helen's question about what additional support we need at an STP level. It is very much that. The other thing on the variation I would argue is that we need some support to be able to rapidly translate the analysis and synthesis into delivery across the system quickly. If we have to replicate things a number of times, then it will be sluggish and slow, and we will not realise the actual elimination of variation that we need to do to realise the funding.

Q49 **Dr Davies:** Chris Hopson, in your letter to us on behalf of NHS Providers you told us that one way of tackling the challenges that are being seen financially was to reduce the number of national strategic priorities. Which of the strategic priorities would you not follow?

Stephen Dorrell: You are on your own.

Chris Hopson: I think our members, were they here, would argue, in a slightly weaselly way, that they work within the strategic national framework and effectively it is up to central system leaders to set that framework. The observation they would make is they cannot see how it can work, if they are already struggling to meet the existing demand of 4% a year and cost increases much less than that, when you add on the mental health, maternity and cancer taskforces, extra outcomes that involve significant amounts of expenditure, and when you add seven-day services on, and so on. One thing we feel that is slightly lost under the old system is this. If you go back to the days pre the 2012 Act, our argument would be that the Department of Health acted as a rather more effective gatekeeper and filter, and nobody was allowed to add an extra priority until it was very clear how much cost it was going to add and how much extra bandwidth at the local level it was going to take. That filter and that gate have now been completely lost, so what you have is duh-duh-duh-duh, duh-duh, duh. Genuinely, our members would say it is not really for them to answer exactly. All we can say is it is just impossible to deliver what we are currently being asked to deliver.

Julie Wood: Welcome to the world of the commissioner. That is the job that commissioners face day in day out, where you are trying to do all the things you would want to for mental health, primary care and cancer, but when you stack them alongside each other with the resources and nothing else gives, they cannot all be delivered. We need to have some conversations about, "Well, then, what does give?" It may be about the pace at which we implement all the plans in terms of the better birth, maternity, cancer and mental health care. We may not be able to do absolutely everything of all of those at the same time. We may have to



be reasonable. It was indeed, as we all know, one of Simon Stevens's five tests, in terms of the SR settlement, saying that new asks needed to be consistent with the phasing of new investment, and when we have the investment not playing through in the middle of the SR period to the tune that he expected and the service needs, then something has to give somewhere.

Stephen Dorrell: The more serious answer to my provocation to Chris is to say it is an old truth, is it not, that "When everything is a priority, nothing is a priority"? We have to prioritise. That takes us, in my view, straight back into the STP process. It is about determining what is right for a local community, which depends on outcomes, quality locally and opportunities locally. Our ask from the Confederation would be to recognise, from a national political level, that you can only deliver the objectives of good-value, high-quality healthcare if you enable local people to make the local decisions that work for them and that trying to over-micromanage a series of national silos cuts straight across the objective of efficiency and local accountability, staff engagement and a whole series of other objectives as well.

Chris Hopson: There is also something, if I may say, about the correlation between efficiency and the pressure the system is under. I had a fascinating conversation with the German Hospital Association where I was effectively talking about capacity levels in our hospitals. In the last one I visited, genuinely—this genuinely was the case and I was really very surprised in one sense—I was having an interesting debate with a theatre manager, who was making a real-time decision about whether to allow somebody to go into theatre for an hour's operation based on whether they were absolutely certain there was going to be a critical care bed available at the other end. You could see the entire system was literally geared around, "Can we find a way of shoehorning this extra person into a critical care bed?" It is an incredibly inefficient way to run a hospital. The Germans were basically saying, "Tell us about your capacity levels." While I was explaining that we were running bed capacity very regularly these days at 96%, 97% and 98%, they were saying they would never ever allow their hospitals to run on a regular basis at more than 80% to 85% simply because you start becoming incredibly inefficient. So there is, it seems to us, a real issue here about how you make sure that we try to have an appropriate margin, be it on the money for the Department at the end of the year so that you can cope with a demand spike, or be it actually in the hospital. We are running our NHS at a level of hotness on a consistent basis that is unfair to the staff, because the burden gets put on them, and that, it seems to us, is one of the big reasons for the junior doctors' dispute, but also in terms of it being a very inefficient way to run a system.

Q50 **Dr Davies:** Ultimately, we need more capacity and more funding and it is very difficult to identify anything that is proposed nationally that is superfluous, although you do feel that some greater decision making at the local level would be one way around it.



Stephen Dorrell: It is both decision making and the willingness and ability to look across the different services locally in order to use a Manchester pound, a Bristol pound or a Birmingham pound to deliver services to the people of that locality.

- Q51 **Chair:** In trying to wrap up this session, clearly there is quite a lot of agreement on the panel that the NHS needs to have more funding, but we heard today again in Health questions the use of the £10 billion figure rather than the more real and accurate £4.5 billion figure. Given that it looks unlikely that there would be extra funding for the NHS in the spending review, and, as you have stated very clearly, that if there were extra money you feel it should go into social care rather than the NHS at this point, are there any points where you feel you would like to see the Committee making recommendations, if that is the settlement for the NHS, as to what we should be recommending happens next to allow the NHS to live within its means? What would be your priorities for that?

Stephen Dorrell: If I can go first, at whatever level of funding for public services, health and care—the NHS, as a cascade—if the services are to deliver the objectives of high-quality service to the citizen and good value to the taxpayer, we have to learn a new political dialogue at both local and national level that allows decisions to be made that break down national silos. It is the point—I am sorry if it is repetitive—that is at the heart of the next stage of policy making, to recognise that, if we think the NHS, as I quite often refer to it, is a city on the hill, we make it impossible for it to deliver good-value, high-quality services. It has to be part of the range of local public services, and that requires a different way of making decisions about it, both at national and local level. If we could start to develop that narrative, I think even in the context of very scarce resource we will get better value and better quality for the resource that is available.

Chris Hopson: Where I would go is to say, rather than give us an absolute specific answer of, “Do this, do that”, the Committee, it seems to us, has a very important role, which is already played very effectively in relation to the £4.5 billion, to ensure that it is called as it is and that we stop pretending.

Let me give you two other bits of pretending. One is the idea that we can carry on adding extra demands on the service, as to which seven-day services is a very obvious one, but one thing we have not talked about at all today is that it seems to us it is really difficult to see how we can afford the extra levels of staffing that are currently being talked about in terms of the Department, and which the Department, for perfectly understandable reasons, and I can see, says, “We are going to add X thousand doctors and nurses.” If you look at the current figures, 70% of an average trust’s budget is spent on its workforce. We cannot see how we can afford the extra levels of staffing that are being talked about over the next three or four years. There, for us, is a very good example of the need for an honest and realistic debate about what can be afforded within



the funding envelope that we have. There are very few sources—independent, in a sense—basically telling our system leaders to be honest and realistic about what can be achieved for the funding envelope available, and it seems to us that this Committee is in a uniquely powerful position to say let us do that and let us stop pretending that we can do things like add extra staff and add extra demands on the NHS when we are struggling to just afford what we currently provide.

Q52 Chair: Indeed, another example most recently has been the announcement of the 25% increase in the number of medical student places coming at a time when the HE budget is being cut. You would like to see much more realism about what can be achieved.

Chris Hopson: Yes, absolutely.

Julie Wood: I echo that and ask for realism about the pressures on the system. We have seen things like funded nursing care come out from left field that has significant financial impact on the commissioning side of the system. Recognising that and the consequences is really important. It is this honesty in calling it as it is about the choices that now do have to be made both locally and nationally, about how we spend the care pound and what some of the consequences of that are, and some of it will be taking decisions about things that have never been broached before. Getting some honesty and realism about that would be helpful.

Q53 Chair: One area that we have not touched on very much this afternoon has been the issue of prevention and the public health agenda. That has also been part of the unfinished business as part of the Five Year Forward View. Are there any points any of you would like to make on that as to which you would like to see recommendations made by this Committee?

Stephen Dorrell: Absolutely, if I may, because it is very important that prevention is not seen as being something that is handled just by public health doctors or antismoking campaigns. The example I quoted and then drew back from in our application of air-conditioning units in low-income households in New York was preventive spending. When Sir Amyas was saying earlier that he is concerned about the evidence to support the case for social care measured by hospital admissions or hospital discharges, it rather misses the point, or is in danger of missing the point—

Q54 Chair: Yes, he talked about discharges.

Stephen Dorrell: This is about the range of public services, the vast majority of which have the effect of preventing the development of acute disease and therefore preventing demand on NHS acute services. The wide range of public services, including drug and alcohol services, mental health services in schools, housing adaptations and supported housing arrangements, support for carers, are preventive health expenditures. They are investments in health rather than funding the treatment of disease.



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Julie Wood: When you think the lifestyle challenges are costing the NHS £11 billion, we have to face up to that, what the consequences are and do something about it. As well as the wider issues that Stephen mentioned, it is still thinking about obesity, smoking and alcohol-related misuse because it is costing the NHS an awful lot of money that we need to do something about.

Chris Hopson: If Helen was still here, one comment I would make to her is that, effectively, one thing I think is a very obvious gap in STPs at the moment is that they have not had the time to think through properly that kind of prevention and health and wellbeing agenda. There is a unique opportunity, by bringing local government and health together, to really promote that agenda, but at the moment all people have had time to do effectively is to say, "Okay, so how might we reconfigure acute services? We might just about be able to think about out of hospital," but actually people have not had time to say, "Okay, if we were going to make a real big deal of prevention and public health, how would we do it?" Again, for the first time, we have the players in the room together but they have not had the time so far to do it.

Q55 **Chair:** Do you feel there is more the Government could or should be doing in terms of giving local government the levers to make a difference—for example, planning, and health being a material objection in planning and so forth, and a more effective childhood obesity strategy?

Chris Hopson: Yes.

Stephen Dorrell: There is a real appetite in the world of local government to engage with these issues. It was referred to me recently at a meeting with local government representatives that talking to the NHS in the STP world is like talking to an ice wall. It is like trying to climb an ice wall; that would probably be a better metaphor. In bringing local government into the concept of health policy as distinct from the treatment of illness policy, there is a real appetite in local government for that and that is a real public policy opportunity.

Chris Hopson: This Committee, to be frank, is one of the very few places that has really focused on that in terms of the work you have done on prevention, on childhood obesity and a bunch of issues in that space. You are one of the very few voices out there making a very coherent and effective case for doing work on this.

Q56 **Chair:** Thank you. Are there any points that you have not felt you have been given the opportunity to comment on this afternoon that you would like to mention?

Julie Wood: Not for me, thank you.

Stephen Dorrell: I suspect, from experience, you have tested the patience of your colleagues. Thank you very much for the opportunity.

Chris Hopson: Thank you very much.



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Chair: Thank you for your evidence this afternoon.