



The Select Committee on NHS Sustainability

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

Tuesday 15 November 2016

10.05 am

Watch the meeting

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

Evidence Session No. 17

Heard in Public

Questions 171 - 177

Witnesses

I: Dame Julie Moore, Chief Executive, University Hospitals Birmingham NHS Foundation Trust; Sir Michael Deegan, Chief Executive, Central Manchester University Hospitals NHS Foundation Trust; and Sir Andrew Cash, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Sir Andrew Cash, Sir Michael Deegan and Dame Julie Moore.

Q171 **The Chairman:** Good morning, lady and sirs. Thank you for coming today. We are looking forward to your evidence because the future sustainability of the NHS is crucial to us.

There are two things I have to say to start with. First, we are broadcasting now, so any conversations you or Members have might be picked up. Secondly, if anything comes up that you want to submit as future evidence, feel free to send it to us later.

To start with, perhaps you could introduce yourselves, and if you want to make an opening statement, please do so—it might be very helpful—and then we will go straight on to questioning.

Sir Andrew Cash: I am Andrew Cash, chief executive at Sheffield Teaching Hospitals.

Sir Michael Deegan: Mike Deegan, chief executive, Central Manchester Foundation Trust, and current chair of the Shelford Group.

Dame Julie Moore: Julie Moore, chief executive, University Hospitals, Birmingham, and currently interim chief exec of Heart of England NHS Foundation Trust.

The Chairman: Thank you very much. Would you like to make an opening statement?

Sir Michael Deegan: Thank you, my Lord Chairman. We are really grateful for the opportunity to appear before the Committee on this crucially important subject. We are giving evidence this morning on behalf of our own organisations but also the Shelford Group. If I can speak briefly, my Lord Chairman, about the financial position of the NHS now and in the future, Dame Julie will address the workforce challenges and then Sir Andrew will outline some of the demand pressures.

First, I thought it may be helpful to outline the Shelford Group's position within the NHS. We represent 10 of the largest, and indeed the most successful, university hospital groups across the health service. In aggregate, we deliver services worth approximately £10 billion per annum, which is about 10% of the entire NHS, and a significantly higher proportion of highly specialised services. As biomedical research centres, we are hubs of research, education and innovation. We are sometimes referred to as the "backbone of the NHS" and, as such, we are as committed to its future as any other stakeholder group.

With that perspective, we see the NHS as approaching a crossroads. To be clear, our view is that the current path we are on is taking us rapidly towards an unsustainable position. However, we see no reason at all why

the NHS cannot be put back on a path to long-term sustainability, if there is a will to do it.

At a national level, the most fundamental concern is how much, as a country, we are willing to invest in health and social care. I think it has become abundantly clear that there is not enough resource for the service to meet the legitimate demands of the patients and communities we serve. Between 2010 and 2015, we have had to cope with the lowest levels of growth in the history of the NHS. Critically, that low growth is projected to continue for the next five years; so for the period up to 2020, average real-terms growth will be less than 1% per annum. That compares with a longer-term average of about 4% in the history of the NHS, which has enabled us to keep pace with demand, technology and patients' expectations. Even the 3% last year was barely enough to keep the show on the road and we are deeply concerned about the next three years, which, in our view, fundamentally threaten the sustainability of the NHS.

Clearly, there are important considerations about the percentage of GDP spent on health, and our position does seem relatively low by western European standards. But, my Lord Chairman, some of the debate around GDP and baselines leaves me a little cold because I think it obscures the realities of the impact of this on front-line service provision.

Moving to that, my Lord Chairman, we are aware that you will have heard descriptions when you have been sitting as a Committee, such as "year of plenty" and "feast and famine". As the Shelford Group, with over 150 years of collective experience as chief executives, we can absolutely assure you that on the front line it does not feel as if any of these years have been plentiful and there has certainly been no feast. The only question is how severe each year's famine is. The underlying deficit of the NHS provider sector at the end of last year was in excess of £3.5 billion. Now, when one or two trusts are in deficit, you can look to local issues and solutions. When eight out of 10 trusts and nearly the entire general hospital sector are in deficit, that points to a systemic underfunding issue. It does seem to us that we are creating a dependency culture in which even successful organisations can survive only on bail-outs or central funding, and that is utterly corrosive for good financial or clinical management.

Clearly, there are opportunities to improve efficiency, and I would be happy to talk them through with the Committee later.

The Chairman: We have a question about funding, so we will come back to it. I know that both Dame Julie and Sir Andrew are also going to make statements, so try and keep it succinct and then we will come back to the questions.

Dame Julie Moore: My Lord Chairman, thank you for the opportunity to talk today. In short, workload complexity has grown and, although the staffing numbers have grown, they have not grown to match the same level. We employ over 100,000 staff between us. I am very proud of the

way that the NHS staff rise to the challenges and the increase in work we have seen, but actually it is getting to a difficult point now. We have seen cuts in training budgets and national manpower planning has not reached what we need it to do, so there simply are not the staff there to employ any more. Some trusts are running with vacancies of about 10% to 15%. My own Trust does quite well around vacancies, but we still have nursing vacancies of about 6%. We are often told that we need to curb agency staff and employ them as full-time staff. The problem is that they are not real people; these are our own staff working in their days off, so we already employ them and, although they work an extra day or so a week, they are not there to be re-employed.

Also, we have traditionally looked to the international market to come, but Brexit has sent a bit of a shockwave through some of the staff we would have traditionally recruited. In fact, I have had some staff from the EU, southern Ireland, looking to go back. Of great concern to me are some of the incidents of racist abuse that my staff have suffered from patients following Brexit. If we wish to attract international staff over here, we are going to have to think very carefully about the messages that we give and how we treat our staff. It is not just that we want to use them as a workforce; I think the exchange of knowledge and research are vitally important to our NHS. We have benefited as a country greatly from international collaborations and I would hate to see that lost in all of this. At the moment, I would say that we do not have enough nurses, doctors, clinical professionals, managers—anybody, at the moment—and I am not confident that we are training enough to meet that demand.

The Chairman: Thank you very much. Sir Andrew.

Sir Andrew Cash: I think the reason that NHS finances and workforce are under such pressures is that demand has fast outstripped supply. Primary care is not delivered at scale and we still have a number of small practices of variable quality; therefore there is not an effective universal check on the demand for hospital services. In the first six months of the year, A&E attendances were up by approximately 6% nationally and non-electable, emergency admissions are up by 4% nationally, which, in turn, has put elective waiting-time targets under severe pressure. Bed occupancy is around 91% nationally in the first quarter of 2016 and we know that we need to keep it at around 85%, otherwise we get the risk of cross-infection. At the other end of the pathway in a hospital, it is difficult to safely and consistently discharge medically fit patients on some occasions because of the issues we are facing in social care.

Against that backdrop, it is no surprise that the hard-fought access targets that we have gone for over the last decade are suffering, which we see right the way across in A&E and the RTT of 18 weeks and so on, and cancer targets.

The response has been regulatory pressure. Front-line organisations now feel quite stifled about the burden of reporting and performance management, and the clinical leadership model—the clinical director model—within hospitals is also suffering; a number of people do not want

to be clinical directors. People who have been successful in the last decade have not suddenly become bad leaders or bad leadership teams, but it is more the systemic failures that we see that are affecting people.

As my colleagues have said, we feel we are at a crossroads. We do need either to invest more in health and care services to sustain their long-term future or accept some sort of degradation in the quality and the availability of those services. It is very difficult for people who have dedicated their entire professional lives to watch this go on.

Looking at the work of the Office for Budget Responsibility and others, we see no reason why a tax-funded, high-quality NHS should not be sustainable for the longer term, but we do feel that spending levels will have to return soon to their long-term average of closer to 4%.

Q172 The Chairman: Thank you for that introduction; it helps to set the scene in all the areas of questioning we have. Before we get down to the detail of the questions, we are looking at the long-term sustainability, beyond 2025 or 2030, as opposed to trying to solve today's problems, so we would like to hear your views on how we can make the NHS and social care sustainable in the long term.

Sir Michael, you have painted a picture of the financial situation, so let me ask you about that. What do you think might be the solution in the long term to make the NHS and social care sustainable financially?

Sir Michael Deegan: Longer term, the direction of travel that we are moving in, for example in Greater Manchester, around far greater integration between health and social care, is an absolute must for me, but that needs to be on the basis of properly funded health and social care arrangements. We need to be far clearer on the accountability, which again we are working through in Greater Manchester, and we need to make sure that our overall regulatory framework actually enhances and supports the levels of collaboration to have health and social care working together.

Lord Willis of Knaresborough: What does "properly funded" mean? It is just words. What does it mean, so that we have some idea as to what we should be recommending?

Sir Michael Deegan: As Sir Andrew touched on in his introductory comments, the OBR estimates seem to suggest that, if we were to return to a level of 4% growth per annum, which looks a sensible level to take on board the demand pressures in the NHS, the technology and the innovation, which is the historic level of the NHS going back to its inception, that will be appropriate.

Lord Willis of Knaresborough: That 4% will cover health and social care?

Sir Michael Deegan: I feel it is important that we do not look for differential settlements.

Lord Willis of Knaresborough: You have just said that you wanted integrated health and social care. I am asking you what the figure is.

Sir Michael Deegan: I think the OBR estimate of close to 4% is certainly at the correct level.

Lord Warner: I know the historical figure, but if your economy is not growing at 4% or anywhere near 4% per year, the only way you can sustain the NHS at that figure is by cutting other public services. Do you accept that?

Sir Michael Deegan: Given my accountabilities to another foundation trust in central Manchester, I look at the impact of the financial settlements at the moment and we will no longer be in a position—

Lord Warner: I am not talking about the financial settlements now. You are claiming that the NHS needs a 4% real-terms increase per year stretching into the future. That is what I am querying. Is that what you are really saying?

Sir Michael Deegan: I am really saying not—

Lord Warner: For ever?

Sir Michael Deegan: I do not think we can ever talk of for ever, but for the foreseeable future.

Lord Warner: Let us say 10 to 15 years; so your formal evidence to us is that we need to recommend an increase of 4% real-terms increase a year up until 2030? Is that what you are saying?

Sir Michael Deegan: I recognise the point behind your question as to the political difficulties of that, but when we look at the realities of front-line service provision, a level of growth at that level—

Lord Warner: That sounds to me like yes.

Sir Michael Deegan: I said yes at the outset, my Lord Chair.

The Chairman: We will move on to the next question and Lord Kakkar.

Q173 **Lord Kakkar:** Lord Chairman, if I may, I declare my interests as chairman of University College London Partners, a practising surgeon, professor of surgery at University College London, honorary consultant surgeon to University College London Hospitals NHS Foundation Trust, director of the Thrombosis Research Institute in London, business ambassador for healthcare and life sciences, a fellow of the Royal College of Surgeons and a fellow of the Royal College of Physicians.

I would like to turn, if I may, to the question of the sustainability and transformation plans that we are seeing emerging at the moment. There appears to be a view that these may offer the principal solution to challenges facing both health and social care in terms of financial problems, variations in care and outcomes and the changing needs of

populations. I would like you to address three issues, if you would be so kind. First, how confident are you that these STPs are going to achieve all those objectives? If you are confident that they will, how soon do you think we will be confident in seeing the evidence that they will provide some contribution to the long-term sustainability of the NHS? If not, what alternative solutions would you suggest are explored if the STPs will not be that bridge to long-term sustainability?

Sir Andrew Cash: First, on how confident, the 44 sustainability and transformation plans probably break down into three groups at the moment: those that are ready to go; those that need more work; and those that are in parts of the country where the systems have already broken down, there have been success regimes and they are now being switched into a sustainability and transformation plan. In terms of confidence, people in this service look at the three main aims of an STP. The first is about health inequalities—excellent; I think they are a great way to do that, but that is a slow burner. The second is to look at equality of access, things like all sorts of treatment—which is patchy, and different in different parts of the country. The third main aim of the STPs is about finance and efficiency.

To return to the evidence, first, health inequality is a slow burner. This is a 10 or 15-year piece and it will need backing because, as you produce a plan, the lifetime of a Government is, of course, five years and there will be difficult decisions to take on those things which then need supporting. Quite often the difficulty when you produce a plan is that it does not have local support because sometimes the plan you are producing is different, and we see that time and time again. It is excellent that we are connecting the sectors of health and social care first, and then, secondly, improving choice, opportunity, employment and education and those sorts of things. I think we can get to equality of access quickly across each of the 44.

On finance and efficiency, the issue is £22 billion. Lord Carter's excellent report said £5 billion, if that was absolutely put in. This is a huge ask, and the big difficulty about the STPs is that they will be moved into, "This is just a finance and efficiency issue", if we are not careful. The evidence, I think, is that they are longer term and they are a 10 or 15-year plan.

On alternative solutions, I think we will have to address the current regulatory framework, which is the 2012 Health and Social Care Act, which is essentially based on competition— to short-circuit that. We are trying to move to a system under STP which is effectively, at the moment, a coalition of the willing of a number of organisations coming together and agreeing things, and then edging towards a different sort of governance. In terms of a sustainable future, we are going to need to look at that regulatory framework.

Lord Kakkar: Just on that point about regulation, if I have understood you correctly, you would have a view that, unless we fully address the fundamental issues around the regulation of a health economy and the need to promote competition rather than work collectively in

organisations looking at a population and delivering needs on that basis, the STPs are unlikely to be that bridge to a sustainable long-term NHS?

Sir Andrew Cash: Correct; so in the top third of the organisation of STPs, the top 12 or 15, relationships are very good. They are normally more stable economies. We are trying to get away from a curative, hospital-based system and, down the track, integrated to a preventative, population- and capita-based system—but correct.

Lord Kakkar: With regard to the focus on social care, do you have evidence that the STPs have had a sufficiently rigorous focus on the social care element to address the concerns about the discharge of patients from the hospital environment? Is your view that the well-formed STPs have got that particular part of the relationship between health and social care properly integrated?

Sir Andrew Cash: Yes. I lead one of the 44 STPs and can only speak for my own, but we now have a plan about how we can do that over the five years of the plan. Financially, I have £727 million to make up, and I think about £154 million of that is social care issues. We are busily working now at the plan on how we do that. It is a huge ask to make up that sort of figure on a £3.3 billion budget.

The Chairman: There are some quick questions from some other Committee members, but would either Sir Michael or Dame Julie want to add anything to what Sir Andrew said?

Dame Julie Moore: I would like to add a bit about the competition issue. We took over management of Heart of England NHS Foundation Trust because it was in significant deficit, heading for between an £82 million to £100 million deficit last year. We curtailed that at £65 million and this year it will deliver a £13 million deficit, which is a big thing to ask. As we move towards trying to consolidate and become one organisation, the hurdles we have to overcome in competition are massive. Indeed, the fees alone are millions just to achieve that, so we are working hard, doing two jobs. Part of our STP is maintaining the standards we have as well as equality of access across Birmingham, but we have to do two jobs to do that in two separate organisations because of competition, and it is fiendishly difficult to pick your way through that minefield of competition law while you are trying to run two big organisations as well, as well as expensive.

Baroness Redfern: Chairman, first, I declare that I am vice-chairman of the Health Alliance. My question is to Sir Andrew regarding social care and emphasis on social care. I am from a local authority background. Do you think that STPs could work more collaboratively with local authorities in delivering a better social care system? It seems that decisions are taken without probably one of the main partners being fully involved.

Sir Andrew Cash: Yes, I think they could definitely work more collaboratively; and it varies, as I said, from STP to STP, and I can only speak for my own.

The Chairman: The question is whether it is workable, first, with the local authority.

Sir Andrew Cash: The answer to that is yes, they can. What we know is that people who are in social crisis end up in the health service and, therefore, the obvious first part for an STP is to bring health and care, ideally, together.

Baroness Redfern: So your plans are for more integrated working with local authorities? Is that correct?

Sir Andrew Cash: Absolutely, yes.

Lord Warner: What do you say to the chief executive of Birmingham who said that the STPs are much too NHS-centric?

Dame Julie Moore: We did have this discussion last night with the chief executive, who pointed out that he was talking about national and not local, where indeed he is the leader of our local STP. We have been working for the past few months together on how we do integrate and come together a lot more readily. There is a lot of duplication between health and social care; when we say that a patient is ready for discharge and have assessed the patient, then the social worker comes in and does the same assessment, so part of what we are doing in the STP is reducing that duplication to save money and, most importantly, time for the patient on both sides. On his behalf, I would clarify that we have been working very well together in Birmingham and his intention was to talk about the national picture. I would emphasise that in Birmingham we are working very closely together—the local authority, the health providers and the commissioners.

Lord Warner: So he may be right in national terms?

Dame Julie Moore: Probably in national terms. If you look back at it, it has taken a lot to get local authorities and the NHS to work together, and that has been a real step forward. I think there are still issues around how we do work together. We both have different regulatory frameworks, different everything, and their world is different from our world and vice versa, but we are learning about each other and working together quite well.

Lord Mawhinney: The STPs are obviously fundamentally linked to the 4% per year increase in funding that Sir Michael talked about. Can I just clarify one bit that was unclear? We have to produce a report. If we produce a report that mirrors your evidence and says, "We recommend 4% per year", the first question will be, "How much of that should be at the expense of other public services and how much of it should be through increased taxation?"—and your answer is?

Sir Michael Deegan: Actually, with the greatest respect, my Lord, that is not an issue for the Shelford Group, where the funding is sourced from. We are presenting evidence on what we feel health and social care requires to meet the legitimate expectations of our patients.

Lord Turnberg: I have to read out my interests. I am a retired physician from Salford Royal, professor of medicine at the University of Manchester, ex-president of the Royal College of Physicians, currently a trustee of the Medical Research Charities and scientific adviser to the Association of Medical Research Charities.

I want to ask Sir Michael about being first off with Devo-Manc and whether you have actually managed to succeed in merging the budgets, as they did in Salford Royal, for example, and whether this has produced some savings. Have you demonstrated that it actually is worth while?

Sir Michael Deegan: I feel, my Lord, that we are demonstrating that it is worth while. In Greater Manchester, we have spent the best part of the last two years establishing robust governance arrangements across health commissioners, health providers and local authorities, as providers and commissioners of social care, so we can address issues in localities, such as Salford, Manchester and Oldham, on an integrated basis. We are far from having concluded this journey, but we are aligning accountability for delivery with the accountability for planning. We are working through the regulatory issues which Sir Andrew mentioned earlier and our whole basis in GM is around collaboration, so we are having to match that with a regulatory framework that has a strong competitive element. Within our localities, places such as Salford and Manchester can point to benefits. Whether that would meet the test of evidence on a longer-term basis, I suspect we are not yet at that stage.

Lord Turnberg: How do they get round the competition story?

Sir Michael Deegan: For example, in the City of Manchester at the moment, we have developed a local care organisation that will pull together some local hospital services, out-of-hospital services, mental health, social care and parts of primary care. Our commissioners have developed a prospectus for those services which ultimately will be procured, so, as a group of providers, we would be part of a procurement process, bidding for that work on behalf of our organisations and our local communities. That gives an insight, I think, into the sort of work that Dame Julie talked of earlier.

Lord Turnberg: Expensive.

Q174 **Lord McColl of Dulwich:** Where are the greatest workforce pressures and what are your solutions to addressing those pressures? What changes do you want to see in the way the system plans for the workforce? Should providers have more control over workforce planning? Lastly, are unreasonable levels of bureaucracy still hindering patient care to which GPs would say yes?

Dame Julie Moore: In a very short answer, I would say yes to most of your questions, my Lord. The biggest, most problematic area of shortage at the moment is in the middle-grade doctors. In previous years, about two-thirds of doctors completing their foundation years went on to speciality training. It is now about half, so we have huge gaps in our

middle-grade rotas—the registrar grade of doctors that we used to have. Traditionally, we have filled those by a variety of roles, international recruitment and creating some speciality doctors. That is getting harder and harder to do. So what we are doing at the moment is creating doctors' assistants, physicians' assistants, associates, a variety of grades of staff to help doctors in their work, but there comes a point when you have to have a doctor. We talk about hands-on care, because you need the hands of the doctor to put on the patient. So we are, I think, facing difficulties.

Manpower planning is notoriously difficult because when you take medical students and you do not say, "What are you going to be when you finally finish?", you do not know. In the past, when I worked with the Future Forum, one of the things that shocked me greatly was that 20% of doctors who qualify do not ever practise medicine. I think manpower planning is really difficult. I am really pleased that we will try to train a lot more of our own doctors, but that is going to be a long time coming—10 to 13 years away. I would like more control and for the junior doctors to belong to us so that we own them and can look after them. Sometimes they pass through our organisations in as short as four or six months, so they do not really belong anywhere. Workforce is something that we need to nurture and care for for the future and not treat it as a commodity, which is why I do not like the term "human resources". They are not human resources, they are people. I would like to look after our own more, but when you get them for three months and they are gone, it is very difficult. I would like a lot more control.

Lord McColl of Dulwich: What would you do about the 20% who leave?

Dame Julie Moore: I think we need to find out why they want to leave. I think there is a lot of pressure on people academically sometimes to go in, but we need to look at how we offer careers to doctors. For a long time, I have been a believer that we should offer lifetime job plans and not expect somebody, when they become a consultant at 35, to have the same job plan and do the same levels of on-call when they are 65. I do not think that is sustainable. If you become a consultant at 30 or 35, it can be quite daunting to think that you are going to be doing exactly the same job for the next 40 years or so. They are onerous jobs. Of great concern to me is the accident and emergency department—they are very difficult jobs; they are not attractive to people coming out; there are lots of vacancies, and people can choose other places. We have to think about how we treat people, long-term job-planning and actually letting us do more of it than having it so centrally controlled.

The Chairman: We have heard that one aspect of tremendous pressure on the workforce is primary care. You, Sir Andrew, referred to the primary care model. Very briefly, is the current model of primary care the one that we should be pursuing in making sure that it is properly staffed, or is there a different model? You talked about integrating social care, working with local authorities.

Dame Julie Moore: Actually, we ask a lot of our GP colleagues and the model that we expect them to operate sometimes is no longer fit for this day and age. The demands placed on primary care are huge and demand is outstripping that. We need to look at new models of primary care and how we work more closely together in 24-hour services and actually relieve some of the pressure. We know that the current crops of GPs coming out, wanting jobs, want different working patterns, and we are not in a position where we can determine models without looking at what people themselves want as well, so we have to accommodate people who want part-time work, but I think we can only do that by working in bigger centres, working together and providing round-the-clock access that patients now need. I think we need to look again at the whole model of provision.

Lord Willis of Knaresborough: I would like to go back to this issue of retention—and I declared my interests earlier just to show that I have some. It staggers me that, in 2014-15, some 9.2% of all nurses left the profession. It staggers me that for every nurse we train and employ, within three years the equivalent number have left, so we are basically standing still. I would like to ask all three of you: how much attention are you giving, as the Shelford Group, to actually saying that unless we can retain more of the people, not within your organisation but within the NHS and other healthcare providers, we are absolutely stuffed and we just cannot have a sustainable healthcare system?

The Chairman: Dame Julie is an ex-nurse.

Dame Julie Moore: Yes, I am an ex-nurse.

Lord Willis of Knaresborough: I know, and we are very proud of her.

Dame Julie Moore: We are very concerned about retaining people. The pattern of turnover is different for our hospitals. In teaching hospitals, you expect some turnover, and the way it is measured is people moving within our system and locally within our hospitals, which is okay. Some of the hospitals which have been in trouble that we have helped have been in small towns, away from major cities, and their employment of nurses is their local population. When we helped the George Eliot Hospital a while back, we had to employ from the local population. It is really important that you grow your home-grown talent and try to retain that there because it is not likely that you are going to get a lot of people moving there, unless it is for lifestyle, a house there or whatever. We do exit interviews and we try to maintain all that, but actually young people now are pretty free to choose their jobs. Worldwide, there is a shortage of healthcare professionals. Some people want to take the equivalent of gap years and go and work abroad, and what we are trying to do is to have retaining schemes so that people can come back after a year and make sure they stay there. We have had years of restraint now on pay and one of the ways we managed in recent years around managing the budgetary pressures was by keeping a downward pressure on pay. When people can choose where they go to work, people are making those kinds of choices now.

Lord Willis of Knaresborough: But we are actually moving into a situation now where we are going to be charging nurses, to concentrate on them, £9,000 a year to train, yet I have not seen one single trust, including the Shelford Group, which has said, "We will actually pay for those fees and bring golden handcuffs in to retain you". If that is the case, it is much cheaper for you to spend £27,000 paying fees and giving them fee-free courses rather than, in fact, finding another nurse who costs you £75,000 to train. I do not understand the economics, yet it is not being done.

Dame Julie Moore: It is being considered. We are going through that at the moment and looking at how we could do that. Sometimes, we do support nurses through their training, particularly our own staff who started as healthcare assistants or auxiliaries, where we pay them while they go through their training.

One other scheme we are trying to do in Birmingham—sorry, Andrew, I know you are trying to get in; I can feel it—is to try to help people where we operate a learning hub where we take people who have been long-term unemployed and try to get them into careers in health by offering them interview preparation, CV preparation and on-the-job training. So far, we have managed to get 3,000 long-term unemployed people back into work mostly in the health service. That is not just to feed our workforce but because joblessness is a determinative of ill health as well, so it is part of our wider social responsibility.

Sir Andrew Cash: Perhaps I could address the primary care part of it. Of course, we have a Five-Year Forward View for general practice, and a number of the Shelford trusts have integrated community services with the hospital services. The model through the STP that we are looking at is to change that pyramid between the GP, the nurse and the healthcare assistant. So let us say that, typically in our local universities, 600 nurses qualify a year, we take maybe a fifth of those nurses and make them into advanced practitioners—the best ones. Similarly, about 150 therapists come out, so we take a fifth of those. Then, on the health inequality issue, we go into a kind of psychological contract with them that they will stay, by looking at the payment of doing additional courses that they may need to be advanced or whatever, and then to put them long-term into areas of higher deprivation. That is the typical scheme now. We are all looking at this; but to be frank with you, the day-to-day operational, annual budgetary pressures of keeping an organisation in budget and able to make those sorts of investments are the things we face day to day. So we are running two systems, trying to transform a system at the same time as still running it. Of course, you are responsible to your governors and board for keeping an organisation in shape at the same time as changing it. They are the practical issues that we face, but they are the sorts of things we could do.

Q175 **Lord Scriven:** I have declared my interests previously, but, seeing as Sir Andrew is in the room, I am actually a member of Sheffield City Council, so I think it is important that I do reiterate that.

I have listened to the issue regarding the 4% increase, but you have said nothing about productivity and variance. We have had lots of evidence previously, including the fact that the NHS over the last three years has had a 0.96% decrease in productivity. There is huge variation. Right Care, for example, says that there is £15 billion-worth of funding that could be released from low-value care to high-value care. What is stopping productivity gains in the NHS, in particular in your sector? What is going to have to change, be it either at local level or national level, for a sustainable NHS to unlock the levers of productivity which, clearly, are not being used at the moment?

Sir Michael Deegan: There is lots of work across the Shelford Group; for example, on the procurement—how we can develop a far more powerful presence. In one of our projects, which Dame Julie or Sir Andrew may wish to talk to, we are looking at a £200 million saving through procurement by punching our weight far more effectively. Our chief pharmacists are currently coming together in a similar vein, so there is lots of work at the Shelford Group level and, again, at a Greater Manchester level. We are not addressing the Carter savings as individual institutions, but looking at how we can address them across the whole of Greater Manchester, so there is a significant amount of work. At a high level, on Patrick Carter's estimates, that generates about £5 billion of the £22 billion, so there is still a step beyond that.

I would come back to the earlier comments from Sir Andrew on the nature of the regulatory framework—that if we can operate some of these issues on a far greater collaborative footprint, that offers more utility.

Lord Scriven: What is stopping that? You do not need legislation to work collaboratively. What needs to happen to make this collaboration work, because it starts at your level? What is stopping this?

Sir Michael Deegan: In Greater Manchester, it is starting to happen.

Lord Scriven: Let us forget where it is working. We are really interested in where it might not be working as well. What needs to change?

Sir Michael Deegan: There is a disjoint between the accountability for planning and the accountability for delivery. For example, if you are part of a collective set of arrangements and the benefit may accrue elsewhere, if you are a single statutory body, you do not derive any of that benefit. Part of this is creating that broader common purpose. I think that needs to be place-based as we develop this.

Lord Scriven: If we are making a recommendation to the Government on that, what recommendation would you say would actually help that to happen?

Sir Andrew Cash: Three things are stopping it: capacity, capability and leadership. On the last issue, there is a growing leadership issue within the NHS where a large number of chief executive positions and executive director positions, for instance, are held by interims at the moment and people are running worried of these very challenging jobs.

In terms of what has to change, what would be very useful is if the guns of the NHS in terms of our marching orders were to change some of the targets, if I can put it that way, to working with, for instance, the most vulnerable in our society. You might look at people in care homes to make sure they all had a co-ordinated plan between all the agencies and you might look at people with multiple long-term conditions, given the high numbers of people living longer over 65 and over 85, away from access targets—which are now in a pretty good shape, but the entire NHS is concentrating on those. So we have to get up front. That then leads you into a capita-based solution for the allocation of funding based on a place, a neighbourhood within a city, and you begin then to concentrate on primary care, the model and the integration, and connect the pathways of primary care, community services and hospital together, that sort of thing.

Lord Warner: Are you saying, Andrew, that payment by results has outlived its usefulness?

Sir Andrew Cash: Yes, I am. We have different incentives in the system and the STP, as a system, plays against payment by results. My own view is that you need to incentivise hospitals in a different way.

The Chairman: Would Sir Michael and Dame Julie agree with that?

Sir Michael Deegan: Ultimately, I think we need to move to a capitation-funded system. Whilst we have PbR, we need to make sure that the costs are reflected in the tariffs, but we need to move to a capitation-funded system.

Dame Julie Moore: Could I return to productivity? I think that the NHS has become more productive in many areas. When we moved into our new building, we moved from 24 day-case beds to 95 and we have had to open up another day-case unit, so we are doing far more work as day cases. However, we are now seeing 7% more patients coming in through A&E and we have more people we are unable to discharge for all the reasons we have talked about. Currently, in my hospital, 100 beds are occupied by people who previously would not have been there. Whereas length of stay was coming down quite considerably, it is now starting to rise again, with these problems. It is not just social care; it is delayed transfers of care. As the surrounding hospitals become full, we are unable to discharge people back who we have done the specialised care for, and when they are going back for the secondary care, we cannot get patients back to those hospitals as well. It is starting to silt up.

In terms of how you measure productivity—I think there is someone over here who is probably better qualified to answer this—I think it is notoriously difficult. When you look at the new techniques we introduce, such as split liver transplants—in the past, you used to take a liver and put it in the patient, but now you cut it in half and put it in two people—it is constantly increasing the complexity of what we do.

Another point I keep returning to is that the NHS has been successful. The problems we are facing are due to the fact that more people are living now into older age with more complex conditions, and actually I think there is a price for us all to pay for that. That is not for me to say; it is clearly a political decision for the Government. But if I were to say to my parents, "You've got an extra 10 years of life over what your parents had", I do not think they would ever think of it in that way, but it is right.

The Chairman: That is a good point at which to move on to the Lord Bishop of Carlisle's question.

Q176 **Bishop of Carlisle:** I want to declare some interests as well, as lead bishop for health and social care, patron of Eden Valley Hospice, Hospice at Home North Lakeland and Burrswood, and I am an associate of the Faculty of Public Health.

I would like to return, if I may, to this whole business of the integration of the NHS and social care, which has been mentioned frequently in our discussion. Sir Michael, you started off by saying that you felt that the integration of the two was essential for the future sustainability of the NHS; and Dame Julie, you talked about the duplication that there is at the moment. A number of our witnesses have indicated that, even if the two were integrated properly, it might improve quality, and almost certainly would, but would not do much for finance; in other words, it would not be any cheaper. I would be grateful for your comments on that.

I have another question about how some of the existing obstacles in the way of integrating health and social care can best be overcome, and you have already given some indications of that in terms of what you are doing at the moment.

Dame Julie Moore: Perhaps, my Lord, I could give a concrete example of when I first became interested. It was some years ago when my aunt was dying at home. I watched as the social care person was in her home, feeding her, making food and giving her that, and the community nurse was stood waiting for her to finish, which was dead time. I thought then that this is huge duplication. I think quality will improve and that it will become less costly to provide a service in that form of integration, which is what we are talking about in Birmingham, to remove the two people visiting, one from community services and one from social care.

Actually, there is a lot to be said as well for multi-skilling people. A very good scheme we operate in Birmingham for the Royal Orthopaedic Hospital, for example, is that nurses can do the physio following patients having joint replacements and the physios can do the wound care and you have one person visiting instead of three or four, which happens elsewhere. That is a very simple example.

Do I think it will solve all the problems? No, because we have an increasingly ageing population. We need to find ways. One of the things that gives me great hope in the STP is that it is not just about social care and health coming together but about the wider public sector. In one part

of our STP, for example, where the fire brigade go in to fit smoke alarms, they are also looking for other signs of ill health and feeding that back in. We are having good discussions with the police and a whole range of other agencies about how we pool our intelligence, the information we get, and work together in a better way. That is the first time that has happened, so I am really pleased.

However, a growing population with chronic diseases are going at some point to require care. We extend life expectancy—we do not save lives, we prolong them. So actually, at some point, people are going to require care. We all know that the last years of someone's life are the most expensive part of it. I do not think that we, as a society, can avoid that.

Sir Michael Deegan: I would support entirely what Dame Julie has said. In terms of the cost in our Manchester locality plan, we are viewing any inappropriate hospital admission as a fault of the system. We operate from a new PFI-funded hospital which is expensive in terms of bed days, but it is, I think, both more clinically effective and cost effective and better meets the needs of patients for care in either a home, hospice or care setting. We are currently in the stage through the STPs, in initiatives such as GM devolution, of working through the cost-benefits at this stage.

Bishop of Carlisle: That is very helpful, thank you. The obstacles that are preventing people in the NHS from working more closely with social care, are they simply structural?

Dame Julie Moore: I think it is history and habit. Some of it is structural, but now that we have started to get over that, it is starting to break down a lot. Also, when times are hard, people start arguing over whose fault and responsibility it is, which has happened quite a lot. Social care sees us, the NHS, as placing demands on it by having all these patients ready for discharge. We see social care placing demands on the NHS. But actually it is nobody's fault; it is nobody's responsibility; we need to work together to try and find the best way of doing it. We will make things better, but I do not think we will make them perfect.

The Chairman: The Care Quality Commission report suggested that there needs to be a new look at how social care is delivered. What is your answer to that?

Sir Andrew Cash: The obvious point, which has been around for many years and is probably the biggest in terms of productivity gain, is that, if you look at any hospital, there will be people who probably do not need to be there. The issue is how you solve that. The hospital should be the last port of call, but it is an incredibly fragile system that we live in. The care home issue is about to break and is breaking all the time, and the last port of call, of course, will be hospitals, so we have to change this system somehow, and one of the obvious ways to do it is to integrate social care and healthcare. Under one organisation, there is a chance that you can begin to keep people in their own homes, supported by assistive technology, et cetera, for longer periods of time.

Dame Julie Moore: In recent months, we have seen a third of the nursing care homes with the most complex patients close in Birmingham. I think you are entirely right, my Lord, that actually the social care model in terms of particularly private care and nursing care homes is not working at the moment and we are seeing lots of homes go out of business. That is a huge problem.

Lord Bradley: I have previously declared my interests, but I have additional interests as an ageing resident of the City of Manchester.

Within the financial context you have described, Sir Michael, are you confident that the devolved budgets, which I am a supporter of, actually allow you, through the £450 million Transformation Fund, to address the underlying deficits which you have rightly identified? Do you believe that not only the integration of health and social care—where, for example, in the current spending round, there is a £27 million shortfall just in the City of Manchester in social care, with the expectation that that will be down to the NHS to fund—but the further integration of physical and mental health is another efficiency that could be delivered within your STP and locality plans?

Sir Michael Deegan: My Lord, the GM devolution settlement is the most exciting initiative I have been involved in in my entire career in the NHS. I think it affords us the best chance we have to address some of the underlying issues through a process of connectivity and collaboration across Greater Manchester. Whether it will fully address all the financial problems, I am unsure, but I think that, at its heart, it is about how we develop a place-based approach as opposed to an institution-based approach. I think that gives us maximum mileage moving forward. You rightly draw attention to the critical role of mental health integration in this, and again, my Lord, as you are aware, in GM we have all the different partner organisations coming together under GM devolution.

Lord Scriven: We have been talking about integration for 30 or 40 years. In terms of going forward to make this real, could you make one recommendation on what would have to happen with budgets and with structure? Sir Andrew, you mentioned one organisation. What would have to happen with targets and behaviour? What needs to change to make it happen?

Dame Julie Moore: I think that you could not take away from local authorities the responsibility for long-term care and nursing and residential home care. I think the grey area in the middle is over care in homes. We should integrate that and have one budget and I would like, as a health person, to take control of that—but then people would say I am a control freak, which is fine; you would not like anybody in my job not to be, really. I would like that bit of integration to take place. I do not know what the others think about that, but I think we would save money as well as drive up quality in that regard.

Sir Michael Deegan: Budgetary integration and again align the accountability for planning with the accountability for delivery. Currently, it is disparate and separate. All that needs to be drawn together.

Sir Andrew Cash: I would say that, at the highest level, having the budgets devolved in the way that it is happening in Manchester and Sheffield—not including health, but in due course possibly including health—is the best way to bring about the wider public sector reform. That is really important. For me, the most important change in my NHS career has been foundation trusts. Why? Because it gave you local responsibility. In a similar sort of way, we now have to get local system responsibility in all this. It is no criticism of central regulation, but, if you stack everything to the middle, you lose the power of doing things for your local people. For me, local responsibility through integrated budgets in the way that Manchester is doing is very good.

Q177 **The Chairman:** Listening to today's evidence, if the Secretary of State were listening to it and if I were to say to him that the NHS and social care are not sustainable in the long term, he could just point me to the evidence you have given—which suggests that although there are difficulties, there are structural changes in place; you are making changes to social care and integration; and things will therefore be sustainable.

Dame Julie Moore: I think they will be better, but not sustainable. I think that the growth is part of our success and we need to recognise that and actually say that how a society cares for its older and sicker people is a mark of that society. We need to make sure that we do that and we actually care for our older and sicker people appropriately. We are making things better, but we are not making them perfect. I do not think it is sustainable with the current growth in demand.

The Chairman: So what one recommendation, Dame Julie, do you think we should make?

Dame Julie Moore: I would not like to see any change to the way the NHS is funded but we need a public debate about what the NHS is now coping with—the increasing complexity, the increased demand—and to ask, as a society, what we are willing to pay for. If you actually said to people, "You are paying for an extra 10 years of life", most people would say, "Well, that sounds reasonable".

Sir Michael Deegan: My Lord Chairman, I do not think it is the funding model, it is the funding level.

Sir Andrew Cash: There is a strong argument for social care and healthcare to be brought together up to but not including means-tested social care. In parts of the country, this is happening, but we now need to bring these social care staff, where they are provided by a local authority, into the health service.

Lord Mawhinney: It is not the funding model, it is the funding level, Sir Michael said, yet this morning's news carries the story that, of the £250

million that was set aside for mental health, only £75 million of it was used to address mental health issues and the rest was sucked in by hospitals to cover gaps in other parts. It sounds to me that the funding system is a problem, not just the funding levels.

Sir Michael Deegan: Sorry, my Lord, I am not aware of the particular news report you are talking about, but I would say it is around how you align governance in a locality. For example, in the GM setting, that is how we ensure that mental health budgets, acute budgets and social care budgets are all cohered and managed as one. I think that addresses that issue. It is not one, for me, of the overall funding model.

The Chairman: Thank you very much for your evidence; it has been most useful. If, on reflection, you think that there might be some other material that you would like to send in to back up your arguments, please feel free to do so. We are very grateful to you for today's session.