

Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 22 November 2016

10 am

[Watch the meeting](#)

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

Evidence Session No. 20

Heard in Public

Questions 191 - 206

Witnesses

Professor Dame Sue Bailey DBE, Chair, Academy of Medical Royal Colleges; Ian Eardley, Vice President, Royal College of Surgeons; and Professor Jane Dacre, President, Royal College of Physicians.

Examination of witnesses

Professor Dame Sue Bailey DBE, Ian Eardley and Professor Jane Dacre.

Q191 **The Chairman:** Good morning and welcome. Thank you very much for coming today to assist us. I need to tell you some of the rules. We are being broadcast live and if you have private conversations they may be picked up. That applies also to the Committee members. During the inquiry, if issues come up about which you feel you would like to send more evidence, please feel free to do so after the session. You will be sent a transcript of the session; you are not allowed to change it but if there are gross inaccuracies please let us know. Would you please introduce yourselves and if you want to make an opening statement, please do so. Before we start, I declare that I am a fellow of several medical royal colleges—as you all know.

Professor Dame Sue Bailey: Good morning, everybody. I am Sue Bailey. I am privileged to be chair of the Academy of Medical Royal Colleges, which is a UK-wide organisation with 220,000 doctors. I was previously president of the Royal College of Psychiatrists. In my day job, with my concern about child mental health, I chair the Children and Young People's Mental Health Coalition.

As a headline statement I would say that in the short term we need urgently to ask that social care is properly funded, because healthcare is co-dependent on social care. We would be able to deliver better if the pressure was off social care. We need to be bold in helping the current workforce to adapt and the future workforce to work differently. We need to move from an illness to a wellness model. We need to start a national conversation with the public about what an open all hours service is for, what they can expect and how they can play their part in it. These are interesting times, with opportunities, but we need to attack with optimism rather than pessimism.

Ian Eardley: Good morning. I am Ian Eardley. I am a practising urological surgeon from St James's University Hospital, Leeds. I am also vice president of the Royal College of Surgeons. The Royal College of Surgeons represents around 20,000 surgeons and dentists in the UK and beyond. I have a background in surgical training; I was the chairman of our own specialty accreditation committee and have chaired the committee that oversees the whole of surgical training in the UK and Ireland. I am currently vice president of the college, with particular responsibility for workforce, for training and for the non-medical workforce as a means of support for surgical care. I would be very happy to expand on any of those issues.

Professor Jane Dacre: I am Jane Dacre. I am a physician rheumatologist working in north London. I have a long background in medical education, having been the director of UCL Medical School for many years. I am the president of the Royal College of Physicians.

My interest in this perhaps stems from my interest in education in the workforce. I have deep concerns about the morale of the workforce and the stress that is being put on the workforce by the gap that there appears to be between the aspirations of our wonderful health service and our ability to deliver that service.

- Q192 **The Chairman:** Thank you. We have heard a lot of evidence about different funding models for health and social care, but what we do not have is a cohesive argument that everybody accepts. You represent through the royal colleges a large workforce in the health service and social care. Do you have any views about future sustainability as far as funding is concerned for health and social care? In all of our questions we are looking long term, 2025 and beyond, and not at current problems.

Professor Dame Sue Bailey: First of all, there needs to be clarity in the identification of the funding and spend. There is lack of clarity at the moment. That is in the short term. Going forward, the academy supports the position that healthcare should be free at the point of use. There needs to be further investment and we need to argue the case for that when we have delivered productivity efficiency and we have a healthy workforce. Then it is for the public to have that conversation about how it might be funded; it is a democratic process.

The Chairman: Are there particular models that you would support?

Professor Jane Dacre: What is not in doubt is that the health service appears to those in the front line to be underfunded. When comparisons are made with other health economies there is much discussion about how we are relatively underfunded in terms of the amount of GDP that is spent on health. That is the first thing.

The second thing is that social care is in a worse position than healthcare. Even though I am sitting at the top of a medical royal college, I say that any funding model has to put social care first because of the difficulties that social care is experiencing and the effects on transfers of care around and out of our medical practice, either in primary care or in hospitals.

In terms of what could happen, I do not see, as head of a medical royal college, that it is my role to suggest how that should happen. That is a conversation that the Government of the day need to have with the electorate. Increasing taxes or cutting what we do or changing the way that the tax model happens are all ways to increase the funding for the health service. That is not the job of a medical royal college; that is the job of the Government of the day.

Ian Eardley: We agree broadly with what has been said, but with one or two caveats. I went to the launch of my own STP last week and in the discussions about social care and healthcare I was struck that the social care people clearly saw the healthcare budget as an opportunity to bail out their problems. This is within the context of an NHS which is in many ways cash strapped. There are funding issues. We have a triangle of

increasing demand, not quite enough money and workforce problems. I am sure we will talk later this morning about ways in which we could perhaps do things differently in order to make the service more efficient in the medium to long term. It is very difficult to see past a wider debate with the population and with the service about whether the whole of healthcare should remain free at the point of delivery. We believe that that is the right thing to do, but it is challenging to achieve, given the economic constraints we have.

The Chairman: Do you think there should be other models where there are co-payments?

Ian Eardley: We do not support co-payments. That is not what we view—but it is one of the options that people have to look at to achieve greater funding. If you look at it in ballpark terms, our funding of the NHS as a proportion of GDP is well below the European average. We would be supportive over a period of time, as the economic circumstances of the country allow, of an increase in healthcare spending to that sort of level.

The Chairman: I think that comment will interest Lord Warner—but we will hear from Lord Willis first.

Q193 **Lord Willis of Knaresborough:** I would like to take up and challenge Professor Dacre's comment that it did not seem to be anything to do with the royal colleges. If, as a royal college, you feel that you cannot improve healthcare in an abstract way without looking at health economics, I would challenge you and say that perhaps that is something you should look at. Working in different ways to deliver a quality of service should be led by the royal colleges; they should not simply trail along behind.

Professor Jane Dacre: I think perhaps there has been a misunderstanding. Changes in models of care, transforming the way that care should happen, driving for efficiencies in the health service are absolutely the role of the medical royal colleges. But we are doing all of that. We are committed to doing all of that but there remains what we see as a funding gap. So there is still a need for more investment in the system in which we work. Where that money comes from is something for political debate.

Lord Warner: If you look at the evidence we have been given and compare healthcare systems on a comparable basis, as OECD has done, we are not that much below the OECD average on what we spend on health and social care. Pleading poverty is not a very convincing argument from the evidence we have. If we cannot get you to look at the quantum, how about the way the money is distributed? You must have views on that. Is the system distributing money correctly with its very strong emphasis on the acute hospital?

Professor Jane Dacre: It has been recognised for some time that it would be better to distribute more funding into public health and primary care. I say that as the head of a medical royal college. However, I do not

think that the role for acute hospitals will necessarily diminish or go away. Whilst there should be more equitable distribution of resource, the reason there are problems with this is that, looking at the view from the coalface, from our fellows and members, there is not enough resource to do the things that we aspire to do.

The Chairman: If the model of redistribution is to give more money to primary care, do you think the current model of primary and community care needs to change or remain the same?

Professor Jane Dacre: The College of General Practitioners is not here.

The Chairman: They have been questioned but they need not be here. We would like to hear your view.

Professor Jane Dacre: My view is that we all need to change in the way that we deliver care.

The Chairman: We are particularly interested in whether the current model of primary care needs to change if more money is going to go to primary and community care for them, presumably, to provide more healthcare.

Professor Jane Dacre: The two models that were presented in the Five Year Forward View, PACS and MCPs, need to be given a chance to see whether they are going to work effectively. Those are changes in the way that primary care is delivered that we have not given enough time to evaluate.

The Chairman: You are being guarded, Jane, but there we are.

Q194 **Baroness Redfern:** Ian, you mentioned that you had talks regarding your STP. You quoted that healthcare was there to "bail them out of their problems".

Ian Eardley: That was the tone of the discussion. The social care services in my part of the country, which is Leeds and West Yorkshire, have had their funding cut substantially in the past few years as a consequence of economic problems. I perceived from their tone that they saw a merging of the healthcare budget with the social care budget as an opportunity for them.

Baroness Redfern: Do you?

Ian Eardley: It is a challenge. I am a surgeon and when I go in to do an operating list at 8 am I have an operating list to start. It rarely starts on time because the hospital is too full of patients. Each morning we have 70 more patients in the hospital than there are beds. At the same time we have 90 patients in the hospital who need to be in social care beds but who cannot get into social care beds. That is making me inefficient. So improving spending in social care would improve my efficiency and would improve the efficiency of elective surgery. So while the principle of merging the budgets and having a more streamlined, joined-up approach

to the spend makes enormous sense to me, I worry that simply transferring money from the healthcare budget to the social care budget on its own might not necessarily solve all the problems.

Baroness Redfern: So at this moment you would not want to see a change at all in the allocation of the budget?

Ian Eardley: I would like to see joined-up thinking.

Baroness Redfern: Thinking and putting into practice are different.

Ian Eardley: I would like to see the practice that goes with it, yes.

Q195 **Lord Bradley:** You have commented on the integration of health and social care. Do you see the integration of mental and physical health and a move to per capita funding in the long term as part of an efficiency and sustainability agenda?

Ian Eardley: I cannot claim to be much of an expert on mental health.

Professor Dame Sue Bailey: Yes, absolutely. There are two sides to this coin and the coin needs to get back together. Mental health funding has been chronically lagging behind and our patients suffer because of that. The other side of the coin is that the skills of mental health have a great deal to offer physical health services, given that 26% of patients in gastroenterology outpatient clinics are people who have psychological difficulties. That does not make them any the less ill; they just need a different sort of intervention. It is about time that we got back together properly, particularly when we start looking at prevention in the younger age range. We need to be brave enough. I am not here as the president of the Royal College of Psychiatrists but the concern on behalf of mental health is that we will have things taken away from us.

Part of the answer to A&E is to have more mental health teams helping that swarm of people who come to A&E who need psychological support and who can give proper help to those who are frail and elderly so that they can get through the system or do not have to come to A&E in the first place. Much of that is about how we integrate and look at the workforce. I welcome the nursing and social care associates who can deliver good, integrated care so that people can stay safely in their own homes and have meaning, sense, control and purpose in their lives. We should completely rebadge and shape how we look at healthcare.

Q196 **Lord Turnberg:** I express my interest as a fellow of Professor Dacre's college and a past president. I am also a fellow of the College of Surgeons, but no one has asked me to operate. My question relates to workforce and workforce planning. We know that the workforce is under tremendous pressure. We are trying to lift our heads above the parapet and think about the future. What sort of assessment of workforce planning are you making? Are we getting it right? How far into the future can you predict the future workforce's needs, remembering that we do have the smallest number of doctors per head of population of any OECD country—pace Lord Warner?

Professor Jane Dacre: I have always had a problem with the accuracy of workforce planning. Throughout my career I have never heard anybody say how marvellous workforce planning is at getting the answer right. It is an impossible thing to do. The reason for that is that the demographics of the workforce change. Next year for the first time there will be a majority of women in the workforce. Women want to work part-time but we do not know how often or when or which specialities those women will be in.

The other thing that changes is medicine itself. Twenty-five years ago, if you had an ulcer you had an operation. But today you have some antibiotics and do not need to go into hospital. Patterns of where care is delivered change. The trend is now for more care to be delivered in the community.

The complexity of workforce planning to me means that it becomes an increasingly inexact science. There may be a better way of looking at it, which is to say that if you employ the workforce that you have efficiently and flexibly, you should be able to move your healthcare workers around to where the service needs them. One of the difficulties we have is that we are locked into very long training programmes to highly specialist levels, which means that when you no longer need, for example, as many cardiothoracic surgeons—I am pulling that out of a hat—because a cardiologist can poke a stent through the hole, what do you do with all your cardiothoracic surgeons?

We need to increase training so that we have people who have a more flexible skill mix so that when the workforce needs change those people can change the work that they do. For that to work, we need a small oversupply of medical practitioners, because there is attrition. There is attrition because of pension, there is attrition because of family responsibilities, there is attrition because of all sorts of things including, currently, trying to work in Australia. If you have an undersupply you end up with a less flexible workforce because they can go and work wherever they like. So there are some fundamental principles that need to be changed in developing an effective and efficient workforce, which is about us being less focused on spending a long time to get that highly tuned specialist who is able to do only one thing at the end of the day.

Lord Turnberg: Are you changing your training programmes with that in mind?

Professor Jane Dacre: Yes, we are. The Shape of Training review has been quite controversial, but within physicianally practice we are working with our specialty societies to ensure that all physicianally trainees who come through have the capability to do more general medicine and so are trained to a higher level in less specialist activities. Not everybody agrees that that is the way forward, particularly people from some highly specialised areas. But what we would like to see is more people with a broader range of clinical capability.

The Chairman: It is suggested that currently the training programmes in

medicine are far too long, including for undergraduates. There are unnecessary steps and people who want to specialise, even if it is in general medicine, should be able to do so earlier on and shorten the programme. Would you comment on that?

Secondly, in answer to Lord Turnberg, you said you have new programmes starting. Do you have a timeline for that? When do these people start taking up their post? Jane, you also said that you need oversupply. What does oversupply mean? Does that mean they will be paid but have no job?

Professor Jane Dacre: No, it means that you have enough jobs to do the work. Maybe you need to take account of those people who, by attrition, are going to leave the system. Our workforce unit has worked out that you need to train 1.3 men and 1.5 women to achieve a fully committed workforce because of attrition for various reasons. That is what I mean by oversupply. Those people will not be unemployed; they will have walked away.

The Chairman: So if you train forward, you only need 1.3?

Professor Jane Dacre: Yes, 1.3.

Q197 **Lord Turnberg:** What is the impact of Brexit on all this? Have you calculated that?

Professor Jane Dacre: Up to 20% of our workforce are currently from the EU. We have not done the numbers with Brexit because it is still up in the air. Suffice to say, it is not good.

Ian Eardley: We are in a similar position. Some 40% of surgeons on the specialist register in this country trained overseas. Of those, half trained in Europe and the other half trained outside Europe. In recent years the number of people coming from outside Europe has been diminishing while the number coming from within Europe has been increasing. If that tap were to be turned off there is potentially a significant problem, certainly for surgery.

Q198 **Lord Kakkar:** I declare my interest as a fellow of the Royal College of Surgeons and a fellow of the Royal College of Physicians. I was a member of the Shape of Training review that has been mentioned. Professor Dacre, in terms of the structural organisation of developing a workforce, do you think that there are problems in the relationships between different organisations that have a locus in terms of developing the workforce? Could the relationships between those organisations be better co-ordinated to ensure that there is more flexibility, both in the creation of a generalist workforce and the development of the small number of highly specialist clinicians that are required?

Professor Jane Dacre: The short answer is yes.

Lord Kakkar: How would you go about addressing it?

Professor Jane Dacre: The first step towards addressing it is to recognise and identify that there has been a problem hitherto. The royal colleges and the arm's-length bodies within the NHS have, to a certain extent, been at loggerheads. We need to find a way to take the profession with the government initiatives—and that has not always worked very well. Our problem internally with the shortening of training requirements in the Shape of Training review has been about taking our fellows and members with us. There is a difference between coming up with an idea and saying it is all going to be great if we do it like this, and getting the people who are working as they currently are in the health service who we need, respect and value, to come closer to where that shining idea is. That piece of the management of change has been problematic.

Q199 **Baroness Blackstone:** I declare an interest as the chair of Great Ormond Street Hospital Foundation Trust Board and I am a member of the board of UCL Partners. On the question of length of training and greater flexibility, have the royal colleges done anything to put pressure on medical schools to provide four-year programmes for science graduates? I believe that there is a huge shortage of places on four-year programmes for them and it seems a waste of public money to insist that they start back at the beginning on a five-year programme.

Professor Jane Dacre: Yes, we have had those conversations. This area is fraught with regulation. There are regulations from the EU about the length of time that you need to spend on a programme in order to be trained as a doctor. There are also regulations within the universities about bringing undergraduates in for one course and wanting to transfer them over to another course for which they were not originally interviewed. The principle is there but it is fraught with difficult detail which often slows down progress.

Baroness Blackstone: I will put a bit of pressure on you. There are 14 medical schools that do have four-year programmes for graduates and have got round the EU regulations. Why can the rest not do so?

Professor Dame Sue Bailey: I would like to support you. We should challenge the regulations. We should have a different rethink when we take medical students in, whether they have already done science degrees, and be honest and open with them about the nature of the work they are going to do across their careers. We do not have that open, honest conversation. We ask for the brightest and the best but we should explain to them realistically the sorts of roles they will be taking. That does mean some radical changes in the way that medical schools run and think and the way we support them from beginning to end.

The Chairman: What Baroness Blackstone said is correct. There are 14 medical schools, mine being one of them, that do these courses over a shorter period. That also applies to postgraduate training. Both Lord Turnberg and I fought the battles over regulation some years ago. You can shorten the courses—but that is by the way.

Q200 Bishop of Carlisle: I would like to go back to the question of attrition. You said there are all sorts of reasons why attrition happens and it is difficult to retain people, so more people should be trained to cope with the numbers. What could be done to prevent some of that attrition? Are there measures that could be taken to keep people in this country rather than them going abroad?

Professor Jane Dacre: Absolutely. We are all focusing on that. Since the industrial action there is a huge problem with trainee morale. The brightest and the best having got into medicine as a profession are finding it is not as fulfilling a profession as they had hoped. The evidence is accruing that they are either trying to work elsewhere, they are going into other professions or they are giving up altogether. There is a big problem at the moment among trainee doctors which is beginning to filter down into medical students that maybe going into medicine is not as great a job as it should be. In the College of Physicians we have a programme of activities that are designed to investigate and improve the morale of our trainees. We are repeatedly trying to remind people why they wanted to be a doctor in the first place and to remind them that that magic is still there somewhere.

Bishop of Carlisle: In your view is the problem more to do with the pressures on people rather than levels of pay and that kind of thing?

Professor Jane Dacre: Yes.

Professor Dame Sue Bailey: We seem not to be able to deliver an enabling environment for a healthy workforce and yet we know what we need to do. We do not pay enough attention to generational difference. With respect, I guess most of us are baby boomers in this room. It is a different expectation. Doctors and other professions want to have portfolio careers. We need to understand that and go with them. This is not just about doctors, it is about the porter in the hospital, it is about the receptionist in a general practitioner's, it is across the whole of the workforce. This is the one thing we need to grasp. There are ways of doing that which are not complicated. I am working with Cary Cooper at Manchester University on this very thing at the moment. We can deliver this but it will take some time, some thought and some determination. Providers and employers have to be on board with this. This is the key thing we could do.

Q201 Baroness Blackstone: I know you think that workforce planning is very difficult because of all the uncertainties of demographic change and so on, but would you be able to say whether you think the current skills mix is right and whether that skills mix is going to be appropriate for the next 10 to 15 years?

Professor Dame Sue Bailey: No, it is not. We need more generalists and we need to think more carefully about what doctors do and whether other parts of the health workforce could do some of that work. As science progresses we are going to need upskilling super-specialists in certain areas. This needs looking at right across the board—for example,

physician associates or anaesthetists having more perioperative skills. This is at the core of how we do it. Doctors are not going to be unemployed.

The Chairman: Are the colleges addressing this issue?

Professor Dame Sue Bailey: Yes.

The Chairman: How?

Ian Eardley: I would agree completely with what Dame Sue has just said. There are two challenges. The first challenge is at the diagnostic and entry level, where we probably have too few people. Going to the high-level intervention level, for example specialised surgery, in some areas we do not have enough specialists. So we have to change the shape of our workforce. It is not just about doctors; it is about the non-medical workforce which can support and in some cases replace doctors.

We are currently doing a pilot programme of training with Health Education England which will begin in about 18 months' time that seeks to integrate a non-medical workforce within surgical training, thereby supporting the young surgeons and helping them to spend more time training and less time doing the unhelpful service stuff that in many ways is demoralising them. I would agree with the point about morale at the moment. The problem is that we train doctors to be doctors and in the first two or three years of clinical practice they are not acting as doctors, they are glorified administrators.

Baroness Blackstone: Could you give us some illustrations of where the medical workforce could be replaced by less highly trained and less expensive people in a variety of different ways?

Ian Eardley: I will give you two or three: how long have you got? We did a survey of foundation core trainees in surgery in three deaneries in this country, with 990 responses. We asked them what they did on their shift. They spent three to four hours doing administrative paperwork relating to discharge. It is not difficult to see that administrative support at a relatively low banding could support that. There are many examples around the country where physician associates, surgical care practitioners and advanced care practitioners are supporting and replacing junior doctors overnight to support care for overnight stay. If you go down to St George's at the moment, physician associates are doing that; they have advanced care practitioners that support the ENT and oral maxillofacial facial surgery service overnight. There are many aspects within surgery where a non-medical workforce could support and replace junior doctors.

Baroness Blackstone: Why is this not happening?

Ian Eardley: First, there is a workforce issue. There are not enough of them at the moment. To be fair to Health Education England, it has put a lot of money into training and increasing the number of physician associates. There is a regulatory issue with physician associates; they are not regulated and therefore cannot prescribe. They cannot prescribe

radiation, for example. So there are challenges along the way, but it is quite interesting. We have done a report, which you are very welcome to have, which looks at areas of good practice of this sort up and down the country where people have been using a non-medical workforce to support surgical services.

Professor Dame Sue Bailey: There is a further problem. You train advanced practitioners but when they go back to their provider organisation they are not always utilised for what they have been trained to do because they are pulled off into other things.

Lord Warner: Why are the royal colleges not driving an agenda of paraphysicians, parasurgeons and parapsychiatrists? If there is such a shortage of these professions, is it not in your interest, given that you all work in teams now, to grab this agenda and overcome the regulatory problems?

Professor Jane Dacre: The answer is that we are. We have set up the Faculty of Physician Associates. They have had their first CPD day. We welcomed them into our college and are looking forward to working with them towards the future. Physician associates are the only truly new group in the workforce that are not robbing Peter to pay Paul. We are welcoming them and supporting them. They have a member on our council. We support their council, we help them to run their exam and we are running their CPD programmes to do exactly as you suggest.

Ian Eardley: I would accept that the surgeons were a little bit late to the table but certainly for the past two years we have been committed to that and, indeed, I am going straight from this meeting to meet Health Education England to sit on a group whereby we are pushing for regulation of this different healthcare group to support services.

Professor Jane Dacre: There are not quite enough of them yet. They are exponentially increasing in number because they have to have three years of training before they go out into the service. So over the next two or three years their numbers will exponentially increase. We hope that that will be hugely helpful to the service.

Q202 **Lord McColl of Dulwich:** How far is burdensome regulation impairing healthcare? Many of my general practitioner friends are demoralised by the CQC inspections by people who do not know much about the subject. Why can local medical committees not do the same job?

Ian Eardley: We are supportive of the CQC, which was developed as a response to quite a significant healthcare issue in Mid-Staffs. As a means of regulating for quality we think it is fundamentally a good thing. Clearly it has to be value for money and there is more work that could be usefully done there. The difficulty for a medical committee to do it is the issue of externality; there needs to be an externality to any quality assurance process. As a principle and as a model we are supportive of it.

Lord McColl of Dulwich: I was thinking more about general practitioners. I know it was useful in the hospital service but it is in

general practice that it is destroying morale.

Ian Eardley: I am not equipped to comment on primary care.

Professor Jane Dacre: There is an issue of proportionality. There is no doubt that we, as a group of professionals, need to continue to polish all our apples and raise standards. There is no doubt that regulation is a very good way of doing that. But regulation becomes a problem when it is overly burdensome. In my trust we had training sessions to teach us how to handle the CQC when they came to visit. The sorts of investments that you need to put in to do well in your external regulation cannot do anything but remove focus from care of patients in the front line. It is a case of proportionality.

The Chairman: Does that not demonstrate the question that Lord McColl is posing—that there is a lot of bureaucracy for not very much benefit? You say externality is important but it is not focusing on outcome quality measures. It is counting empty ashtrays or whatever.

Professor Jane Dacre: We measure what we can rather than what we should.

Lord Willis of Knaresborough: Why do we not have one single regulator? The problem, as it seems to me, is that we are constantly duplicating, perhaps at the margins, the number of inspections. Why are you not fighting to have just one regulator? Or is that a silly idea?

Professor Dame Sue Bailey: I totally agree. There are nine regulators and I do not see why they cannot go down to two. In terms of CQC, we need to move to an inspection of a whole system of care and place-based health. I think that they are moving to that. There are a lot of myths and perceived obstacles in the world and we need to challenge those together.

Lord Kakkar: When you say there should be a single regulator, do you mean that the professional regulator and the systems regulator should all be in one?

Professor Dame Sue Bailey: We need a reduced number of professional regulators. For instance, if we are going to get physician associates up there and recognised, some of the big regulators need to decide who is going to do that. Inspections need to be separate but they need to work together better.

Q203 **Lord Kakkar:** I would like to turn to the question of planning in the health and social care systems. We have the sense that this is always done at a time of crisis and is therefore principally determined on planning for the very short term. Would you agree with the assertion that there is little by way of long-term planning? How does the variability of funding impact on system leaders to be able to plan for the longer term? If the Government and health systems themselves are consistently failing to be able to address long-term issues, who should be charged with ensuring that there is planning for a sustainable health service 20 years

hence?

Professor Jane Dacre: The answer is that, yes, there is a problem. We are blighted by short-term planning that goes along with the electoral cycle. The health service is a very big and very expensive organisation that does fantastically well. But it is frequently the victim of short-term political decisions that make it less efficient. Strategies for the health system, such as the Five Year Forward View, are admirable and perfectly deliverable but not over a five-year period. An increase in the length of time and less inference during the process of those reviews would be very welcome to those of us who work in the health system.

Lord Kakkar: Do you think there is sufficient planning with regard to the social care element of the health and social care continuum?

Professor Jane Dacre: I think the same thing; I do not think there is enough. The really big thing is public health, because public health interventions take an awfully long time to have a benefit. At the College of Physicians we first started campaigning about smoking in the 1960s and over the last few years we have just about got some pieces of legislation through that have made a significant difference to the number of people who smoke.

The Chairman: Lord Kakkar was also asking about social care planning.

Professor Jane Dacre: It is the same; I think long-term planning would be preferable.

Lord Kakkar: If we all agree that long-term planning would be sensible, who should be responsible for this long-term planning?

Professor Jane Dacre: I think the chief executive of the NHS has made a very good strategy for the NHS, but it should be rolled out over a longer period. Parallels in social care would be effective.

Lord Kakkar: How would the professions contribute to that? Do you feel that the royal colleges and professional bodies play an active enough role in contributing to long-term planning for health and social care? Do you think they have a role in that?

Professor Dame Sue Bailey: Yes, we absolutely have a role. The academy overall is looking at things such as choosing wisely, sustainability and disease prevention and we need to bed these things in. Over the years we have done that on big public health issues. We need to get behind public health and help that; it is the bridge across social care and healthcare.

Q204 **Lord Turnberg:** We know that the Royal College of Physicians has the Future Hospital plan. Would you like to tell us about that because that is your plan for the future?

Professor Jane Dacre: The Future Hospital plan came out of recognition that hospitals were going over a cliff. When it was written in 2013 they were just going over the cliff and now we feel as if they are in freefall. We

felt that the way that the health system was designed is no longer appropriate for the needs of its delivery. There were 40-something recommendations and along with those are some of the things we have been talking about today, including planning within hospitals to increase integration with primary and secondary care, increasing the flow through the hospital to try to improve the length of time that patients spend in hospital, increasing the focus on primary care and also on population health to try to prevent hospitals from becoming full, and talking about the skill mix of the workforce to increase generalism so that people are able to work across boundaries in a way they have not been able to do. We now have eight development sites that are piloting aspects of this. We are particularly interested in the chief registrar programme where we are training up medical registrars in leadership as well as management so that they work in the health service but also have an eye to developing their skills to try to change the system that they work in. That is a summary of what we are doing.

Q205 Baroness Redfern: Looking at health and social care in the next 15 to 20 years, what work is being done to progress real data sharing and having the confidence to do that?

Professor Jane Dacre: As people know, there has been a problem with the care.data initiative. However, within our college we are extremely supportive of developing data-sharing systems. We have a health informatics unit and today there is an announcement about a data-sharing system that is going to be used at the Royal Free Hospital in Hampstead which we very much support. We think that data sharing is essential.

Lord Warner: The Five Year Forward View is only looking at service delivery models and money. Where do you see the workforce fitting into a longer-term planning approach? Who should be doing it?

Professor Jane Dacre: The profession has very clear views about what the problems with the workforce are and reported those to us in our document that we called *Underfunded, Underdoctored, Overstretched*. We have very good data about the morale and the numbers of the workforce. We would very much like to be involved in some longer-term discussions about the workforce and the way the workforce needs to change.

The Chairman: The Committee can help you here but we need some specific answers from you as to how we can help. The question that Lord Warner is asking is, who should be made responsible for the workforce? That does not just apply to the medical workforce, it is the whole health and social care workforce.

Professor Jane Dacre: There is already an organisation that is responsible for the medical and clinical workforce, which is Health Education England. Should that include the social care workforce? I am afraid I do not know.

Lord Warner: From all the evidence we have heard, no one is in charge of this issue. Health Education England does not have a long-term horizon. It is not clear how the workforce is synchronised with the service delivery changes and the funding changes that people want to see. We are asking for help. We want some ideas to come from the professions because if we do not get those ideas the risk is that people will do things to you that you do not particularly want.

Ian Eardley: The nature of your question suggests to me that you know the answer.

Lord Warner: I wish it were so.

Ian Eardley: Health Education England currently does it and expects the main funder to be the people who do the planning. The problem is that they are constrained by the short-termism that was alluded to in the previous question. They are constrained by short-term political expedience. There needs to be a longer-term view and the colleges are very happy to provide advice on that.

The Chairman: Would it be all right for us to say in our evidence that nobody has any idea, nobody is responsible and that includes the colleges?

Ian Eardley: No, We have a view.

The Chairman: That does not mean planning. Lots of people have views.

Professor Jane Dacre: I gave my view earlier when I said that we need a few more than are required for the service and we need to allow them the flexibility to thrive. My workforce plan would be to stop trying to plan the workforce because it does not work; it would be to say that if we had enough doctors, if we had enough nurses, if we had enough physician associates, if we had enough social workers, if we had enough physiotherapists then we could get on with it and do it really well.

Lord Willis of Knaresborough: Could I try and help here, because that is my role on this Committee? It seems to me that Lord Warner is being extremely unfair. Health Education England, which has the task, also has a mandate to only do it short term. If it were given a longer-term mandate to say that its responsibility is to assist in the planning of the workforce until 2025 or 2030, would that be helpful?

Professor Dame Sue Bailey: I have to declare my conflict in that I am the senior advisor to Health Education England for mental health and learning disability. Having a mandate to look forward through a training cycle for 10 to 15 years would be extraordinary helpful. We have ideas about how to land that, and how the core to this is making everybody you train have more skills and adaptability and flexibility. The colleges would be very happy to work with HEE to deliver on that. This needs to be considered as being across health and social care.

Lord Kakkar: Does that mean that Health Education England should also

take on the planning for the social care workforce?

Professor Dame Sue Bailey: I think this has to be seen across the board. I am in difficulty here because I am employed by one part of this organisation—but we are already doing that. I will give you the example of mental health. We are doing the skills training for people working in social care and learning disability. De facto we are already doing it.

The Chairman: But they do not have a statutory responsibility.

Professor Dame Sue Bailey: No.

Professor Jane Dacre: Whether it should be Health Education England or whether it should be a new, wonderful organisation is difficult. The long-term planning of health and social care should be hand in glove. We would agree on that—but who would do it from what we have available currently is difficult to say. Health Education England has trouble with its mandate because it is constrained, and it would need to change.

Lord Lipsey: With all this emphasis on planning it sounds to me as if we are moving to a Gosplan economy in the height of the Soviet Union. Nobody has mentioned what is the primary motivator of the workforce, which is pay and morale. Pay is constrained appallingly by low budgets in social care; hospital trusts cannot pay people what they think they are worth and where they think more pay is needed. Should we not ask for more flexibility on pay as well as asking for a measure of planning?

Professor Jane Dacre: The better answer is with morale and people feeling they are worthwhile and are doing a job that is worthwhile. I spent many hours in dialogue with the junior doctors over the last 12 months. They may have had the dispute over pay, but that was not what was underlying that. That is the real change that is needed.

Q206 **Baroness Blackstone:** What is your key single suggestion for change that this Committee ought to recommend to support the long-term sustainability of the NHS? One sentence each.

Professor Dame Sue Bailey: We have to move from an illness model to a wellness model, get on with prevention, start early in schools and support social care. I live in Devo Manc and we have been given the opportunity to try and deliver on that.

Ian Eardley: I think this relates to the issue we have just been discussing, which is to take a longer-term view on workforce planning with a potentially increased role for a non-medical workforce to provide medical and social care.

Professor Jane Dacre: And we need realistic aspirations with a workforce where there are enough of them and they are capable of delivering it.

The Chairman: Do you think there is a cohesiveness in thinking amongst all the medical royal colleges and their faculties or do you think they

think in silos?

Professor Jane Dacre: It depends how much you divide up what we are talking about. Sue would be in a very good place because she is the chair of the Academy of Medical Royal Colleges.

The Chairman: I am sure you have looked at all the evidence that has been sent to us. Does it surprise you that there is so much diversion in the responses?

Professor Dame Sue Bailey: There will be diversion because they are focusing on different areas. I would have to say, as chair of the academy, that there is a core common purpose and we have a way forward if we can focus down on it. We will not always agree on everything, but no family ever does.

Professor Jane Dacre: I agree with Sue that we share a core set of common values. But, as you look into the detail, because I am a physician and Ian is a surgeon and Sue is a psychiatrist, that detail is a little different.

The Chairman: Do all the colleges of physicians agree on the training modules?

Professor Jane Dacre: We have the same broad outline, yes. We have been working towards it for the last three years and we have achieved diagram stability.

The Chairman: Thank you all very much for coming today; we appreciate it very much. As I said, you will get a transcript of this session. If there are any inaccuracies, please let us know—and if there is any extra material that you think is pertinent to the questions asked, please feel free to send it to us. Thank you.