



The Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 22 November 2016

11.05 am

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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. 21

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Questions 207 - 215

Witnesses

I: Dr Helen Stokes-Lampard, Chair, Royal College of General Practitioners; Janet Davies, Chief Executive & General Secretary, Royal College of Nursing; and Professor Cathy Warwick, Chief Executive, Royal College of Midwives.

Examination of witnesses

Dr Stokes-Lampard, Janet Davies and Professor Cathy Warwick.

Q207 **The Chairman:** Can I welcome our next witnesses? Thank you for coming to help us with this inquiry. I will repeat what I said. You are now in the privileged position that you have heard some of the previous session, so that will pre-arm you. We are on broadcast and, to start with, if each one of you would introduce yourselves and who you represent, and if you want to make an opening statement feel free to do so. Can I, before I start, first of all welcome all of you, but particularly Professor Helen Stokes-Lampard as the new chairman of the council of the Royal College of General Practitioners? I declare an interest: I am a fellow of your college. I was trained by many midwives, and I will declare that interest too, Professor Warwick. Can I start with you?

Professor Cathy Warwick: Thank you. My name is Professor Cathy Warwick and I am the chief executive of the Royal College of Midwives. I would like to say that I speak on behalf of midwives but I also very much collaborate with other members of the professions who deliver maternity care, and I am very focused on the needs of women.

The Chairman: Not only when you choose to do so but all the time.

Professor Cathy Warwick: Yes, and I would like to welcome the opportunity to speak to this Committee and to welcome an inquiry that is focusing on the long term rather than the short term.

Janet Davies: I am Janet Davies. I am the chief executive and general secretary of the Royal College of Nursing. We have 450,000 members from all specialties of nursing, including healthcare assistants. One of our big concerns, and where we think we need to move to, is far more integration for sustainability and less working in segmented silos, so as to see the full picture of health around the individual. That would obviously lead to workforce planning that met that need, rather than the current model.

Dr Helen Stokes-Lampard: I am Professor Helen Stokes-Lampard. I am a GP in Lichfield in Staffordshire. That is my first and foremost role. I am the relatively newly-elected chair of the Royal College of GPs and I am chair of general practice at Birmingham Medical School. Like my colleagues, I am very grateful to be here to discuss the long-term future of our NHS because I, my college, and I know the other colleges believe passionately that the NHS is sustainable in the long term. It can be done but we all have to work together to make it so. I am delighted to hear that health and social care are being considered together because, from our point of view, this is absolutely integral. As general practitioners, our job is whole-person care, not merely the physical disease elements of care.

My opening pitch to you is that general practice and the whole of primary care underpins the entire NHS, and the NHS can only be sustainable if

general practice is sustainable and thriving, and if we have the workforce and resource to do that. If we can do that well, we can allow secondary care to thrive and survive too. Thank you.

Q208 **The Chairman:** My question is: what do you think future sustainable healthcare in 2030 and beyond will look like, and can you also say what we should prioritise now, and begin to prioritise in a timeline that will get us there?

Professor Cathy Warwick: We certainly think there should be far more integration of health care and social care, with local government being brought into the picture, and the aim of that integration would be to have far more focus on population groups, their needs, and public health in particular. It would be our view that most of the issues that end up using a huge amount of resource in my area, maternity services, could be prevented by a stronger focus on the social needs of women and on population groups. We tend to focus very strongly on clinical outcomes as opposed to developing services which meet the social needs of women. Long term, we would pull things round to be delivered far more locally, in a far more integrated fashion. We would have far more children's centres, for example, and far more community hubs where people could get together, work together collaboratively and focus on prevention.

The Chairman: What does that mean in practical terms? What do we have to do and who is to do it?

Professor Cathy Warwick: In practical terms, I think the "Better Births" maternity review, which has relatively recently been published in England, describes a model where care starts in the community, where the women are, as opposed to women having to come into the acute services. We have to make sure that there are facilities. That does not mean building a lot of new facilities; it means using the services that already exist, such as big GP centres, small midwifery units, the children's centres that are left—they have been decimated, but the ones that are left—bringing professionals together to work in those services, bringing professionals out of the hospital system to work in those local services, and only referring women into the acute services when that is necessary.

What is needed to make that happen I believe is some interim funding. The difficulty at the moment is that we have a model that is the total opposite of what I am proposing, and to get from where we are now into the future we have to fund the transition. It will not happen in a situation where everyone is run ragged and carries on doing the same old same old. Ultimately, I think we could pull costs out of the system by a far more community-based, public health-oriented approach.

Janet Davies: I guess there is quite a lot of consensus between ourselves and the midwives. There is something about seeing the whole of being healthy as opposed to the segments when we may be unwell. That means working with health and social care, local authority and healthcare so as to look further into the future. We will not see the

benefit of investment in community nursing, health visitors, and school nursing for quite a number of years. That is where we fall down at the moment, because as long as we are looking at the short term we do not invest in long-term health. There is also something about maintaining people well, keeping people well, and that should be in the community and closer to home. There is definitely a need—I agree with Cathy—to move away from everything focusing on that acute crisis episode and focusing our attention on the whole person. That means working less in silos.

At the moment some really contradictory things are happening. There is a hospital somewhere with real problems with their A&E, they cannot get people out into the community, people are coming in because there is no community support, and we can see that in that particular area they are cutting the number of district nurses because of the budget. It does not make any sense because each of the budgets is in a very separate area, some with local authorities, some within the CCGs, some come in different ways, and as long as we are working in that way, we cannot see that trajectory that will take us to 15, 20 and I would say probably 50 years' time, when the children who are being born now will be starting to clog up our A&Es with their coronary heart disease.

Dr Helen Stokes-Lampard: Thank you. I have a lot of affinity with my colleagues, so I will not repeat what they have said, other than that I have not disagreed with anything they have said. To be clear, I fully support the integration of health and social care, the whole spectrum.

Multimorbidity, that is the multiple long-term conditions that people have, is increasing exponentially. By 2030, which we are talking about, there will be at least another 1 million people added to the list of those with multiple chronic conditions that need managing, supporting, and treating, recognising that, with an ageing population—and our ageing population is a huge success of our health and social care so far; let us not make any mistake about it—the inevitable consequence is an increasing burden on the NHS and on social care. As the burden increases, you will need that joined-up thinking across the community, and I think we need to embrace a wider range of healthcare professionals providing that. It should not just be the specialists we have here today, but the whole range of professionals, supporting us to enable us to do our jobs effectively and efficiently, so that people are seeing the most cost-effective person to help them with their needs; those people helping to navigate all the resources that are already there but are not joined up; the IT to underpin it, so that we can all communicate with each other; and the right care for the right person in the right place for them, which is likely to be closer to home where possible.

The Chairman: You are all making a case for more of the care, including social care in the community, to be delivered by health professionals who work in the community, and the scenario is a centre where there is midwifery care, physiotherapists, general practitioners, optometrists and any other health professionals?

Dr Helen Stokes-Lampard: Yes.

The Chairman: How can this happen? Who is responsible? Who runs the show?

Dr Helen Stokes-Lampard: I would argue that community-based services are probably best led locally by the expert medical generalists, the GPs, who can see the various things that need to happen.

The Chairman: It is the GP who co-ordinates the whole thing, decides how many of each staff you need, et cetera. Would the others agree with that?

Professor Cathy Warwick: I do not really mind who leads it. It is a question of how you lead, is it not? Anyone can be in charge, but I think there has to be a method of leadership out there which acknowledges and respects the different roles of everyone involved, and which manages the system through some degree of consensus. That is the leadership model that tends to work. At the moment, particularly within our acute health services, we still have an incredibly bureaucratic, managerial system of leadership, and that demoralises professionals, it does not get the best out of your local workforce, and I think we have evidence that when people work in systems where they feel ownership of the people they are looking after, or they can build relationships with them and they can feel responsibility for the outcomes, we get better care. The leadership model needs to be inclusive and respectful.

The Chairman: Helen, does the current contractual model of GP allow this to happen?

Dr Helen Stokes-Lampard: Yes, it does to a certain extent, and there are lots of really innovative ways of working that are happening. We have some fantastic examples of integrated care across the UK, but they have tended to be born out of crisis, where people have been forced to work in new ways. Of course, anything born out of crisis might be creative and innovative, but that is hard to roll out across the UK, so what we are trying to do is share good practice.

The Chairman: The question is about whether the current contractual model of GPs allows this to happen.

Dr Helen Stokes-Lampard: Yes, it does. There is a surprising amount of flexibility within it. We would argue for a change in the future, yes, of course, but we can do a huge amount with what we have. I would not want to be bogged down with contractual change at this point.

The Chairman: You have obviously excited quite a few of the Committee members—Lord Kakkar, Lord Willis, Lord Turnbull, Baroness Redfern.

Q209 **Lord Kakkar:** If I may pick up on this emphasis on local delivery and localism, are you therefore suggesting that we should move away from a nationally driven strategy for healthcare and have it more locally driven, with accountability through local government, and mobilisation of

resources at a local level, with a population capitation vote for the funding for each locality?

Professor Cathy Warwick: Personally, I believe it should be a mixture. I feel in my own career, in maternity services in a lot of different roles, I have seen a very centralist kind of approach under certain governments, and I have seen a shift to an approach where it is much more down to local need. I think a mixture is needed. There are some issues that need quite strong national direction. For example, we have national direction at the moment in maternity services, saying that we must reduce our stillbirth rates, and that is absolutely right. On the other hand, I think there will be local issues. For example, there are some areas where women who are asylum seekers and refugees have particularly poor outcomes and may need a particular focus. Personally, I think it is a balance between some kind of national framework and some absolutely must-do national targets, if you want to use that word, but with some flexibility locally to build a score system around perhaps 10 key targets—a mix.

Lord Kakkar: Do you think there should be sufficient flexibility to allow an individual health economy to deliver healthcare, accepting there are certain standards to be met and delivered, as it wishes to do, not constrained by excessive national regulation or a nationally defined structure for the delivery of healthcare?

Professor Cathy Warwick: I certainly think the national structure should be light touch in both the framework and the regulation and, yes, there should be a lot of local autonomy in the practicality of how it organises that.

Janet Davies: There is also something about what is enabling and what is delivery, and that central function should be to enable good health and social care to be delivered, by the funding, probably by the policies, by the good use of the evidence, by probably commissioning research and evidence, but the delivery is very much focused on individuals, which are local. It will be fascinating to see what happens in Devo Manc, because they are attempting to do that. However, they are still attempting to do it in a very bureaucratic diverse situation. They still have the CQC coming in and doing all the inspections. We should really move to care built on evidence and around those population needs.

Lord Willis of Knaresborough: I was fascinated, Helen, when you made your remarks, that you automatically assumed that it would be GP-led primary care or community care, and I would like to challenge that, and challenge your college's view of that. Last night Janet and I were at an event, and we heard the most remarkable exposé of a nurse-led GP surgery in Ealing, the Cuckoo Lane Surgery, led by two inspirational nurses, which is one of only 3% of GP surgeries that have an excellent CQC rating. Is that not the way to go forward: not in fact to keep to the rigid silos that we currently have but to look for new ways of delivering inspirational care, simply by inspirational people?

Dr Helen Stokes-Lampard: I really like the challenge. I was answering a very specific question about delivering primary care services locally from the point we are now, looking at 2030. To achieve change takes a lot of time. I love leadership that is the right leadership for the right environment. What we currently have is primary care leadership that is generally primary care focused, and general practitioners have embraced that and are generally very well-connected and equipped to provide that. I would not suggest for a moment that is the only way of doing it, and doing it well. Certainly, in my own locality we have some nurse partners in local practices who do an admirable job. I want to be clear about this. This is not a protectionist view at all. This is a pragmatic view. The reason we use the GPs as likely leaders in the community is because they are the generalists, the ones with the widest ranging view. We are the ones with the mandate to look at the whole person, the physical, social and psychological care. It is a very good starting point. That would be my riposte to the challenge.

Lord Willis of Knaresborough: The Chairman asked about the contractual arrangements, and to bid for a contract for primary care is exceptionally difficult unless you are a doctor, a medic.

Dr Helen Stokes-Lampard: You can be a partner without being a doctor.

Lord Willis of Knaresborough: No, but you can lead that without being a medic; you do not have to be a medic.

Dr Helen Stokes-Lampard: Yes, there are quite a lot of contracts that are not being won by GPs; they are being won privately.

Lord Willis of Knaresborough: I wonder whether you welcome that.

Professor Helen Stokes-Lampard: What I welcome is necessary and pragmatic solutions for the difficult problems we face. We all have to be realistic about what the future holds, and, whilst personally I love the partnership-led model of general practice, I know it is not likely to be fit for the long-term future and that we have to have local solutions for local problems.

Coming back to the other challenges that have been mentioned, about whether there should be top-down or bottom-up approaches, we definitely need a combination, because you have to have some high-level aims and standards that we all aspire to, but we are such a diverse nation that it is completely unthinkable that what will work for inner-city London or Birmingham would be the right solution for remote Lancashire. There might be half a dozen models that will work, but we have to embrace all that, and we have to have the flexibility, and that flexibility will allow for leadership, which may come from primary care, secondary care, nursing, midwifery, or psychiatry. I do not mind where the leadership comes from. We should not dictate it, but there are some obvious sensible starting points that we should embrace and work with. There is a lot of enthusiasm and passion that is there to be tapped.

Q210 Lord Turnberg: I enjoyed hearing about your aspirations, which I think are excellent. The question is how we get there. Last night I met a young doctor who was working in the accident and emergency department at the Royal Free Hospital. He said they had to stay on duty for 10 hours to deal with the load overnight. They could not get through them all. I asked him how many of them should have been seen in A&E, and he said 90% should have been seen outside by their GPs. We have a situation in which we have a mountain to climb to get to the aspiration you describe. How do we get there?

Dr Helen Stokes-Lampard: Workforce is an obvious one. You touched on workforce earlier. Workforce is a serious problem at the moment, not just the number of general practitioners but the entire myriad of practitioners in the community. We have a massive problem with mental health care workers, and under-provision of mental health care services across the board. There is nursing, district nursing, and all manner of services, but there are a lot of social care services which are necessary. Yesterday in my consulting room I saw several patients who needed a social worker, a care navigator to act as a charity service, a counsellor—they did not need the skills I could offer them as an expert medical generalist, but I was the only person they could turn to. I was the only person who did not have a “We are full” sign at the door, so they came in because we would see them when there was no one else for them. That is the harsh reality of it but, as we fall over and my colleagues’ surgeries close, the push inevitably goes to secondary care, which does not help anybody.

Lord Turnberg: There are not enough GPs?

Dr Helen Stokes-Lampard: Not enough GPs, not enough community nurses, and not enough physician associates, the whole spectrum. Unfortunately, it is a big problem. There are a lot of things we could do about it, there are a lot of things being done about it, and the General Practice Forward View in parallel with the Five-Year Forward View has some excellent aspirations. We need to make them happen—not that I am impatient or anything.

Baroness Redfern: Very quickly on that point, if I may: do you think there should be closer working relationships with the local authorities and their social workers?

Dr Helen Stokes-Lampard: Definitely.

Baroness Redfern: In my area we have community hubs, and it is about helping to keep people in their own home for much longer, and keeping them well, because we want well people living longer.

Dr Helen Stokes-Lampard: Yes.

Baroness Redfern: So you think there is more emphasis on that approach and therefore helping the acute sector, and that more budget should be spent on health and social care and less on the acute sector?

Dr Helen Stokes-Lampard: I do.

Baroness Redfern: Sorry to put you on the spot.

Professor Helen Stokes-Lampard: No, I think primary and secondary care have to accept that if social care is not in the best place, the rest of us cannot do our jobs either, so, yes, inevitably it has to come back to health and social care, and a slight shift there. Much as I would not want to argue for less resource anywhere, the reality is if our health and social care is not right it is making general practice crack, and it is making secondary care crack.

The Chairman: Are you advocating shifting of funds?

Dr Helen Stokes-Lampard: That is the decision you guys have to make but I would say it is probably the inevitable consequence, yes.

Baroness Redfern: Mental health issues come into that, so that is all in that role as well.

Dr Helen Stokes-Lampard: Yes.

Janet Davies: We have nurses working across the two, and we have nurses working in social care, because obviously local authorities employ nurses, and there is a real issue of that gap between health and social care, being able to see the person as a whole. It is either duplication of care, which is a terrible waste, or no care at all, and there is something about seeing the population as a whole and their needs, whether it be health or social care, and which is health and which is social care is so difficult to define, particularly when you are talking about nursing. It is a really false divide. Some people get funding, some people do not, and that is the sort of thing that has to be tackled. Of course, when that falls down, that is when people have nowhere else to go but to an A&E department, which is the very worst place for someone with mental health problems, long-term conditions or frailty, because it makes them worse.

Q211 **Lord Warner:** We might go on to the issue of primary care, but can I bring us back to the day-to-day reality of managing services? At the moment, in hospitals you have a system where you have a hospital board which can exercise governance arrangements, good or bad, in relation to its job. There is a local authority which can do the same thing. In the middle of all this you have a rather strange business partnership called primary care, which may or may not have attached to it nurses and all these other people. I think this is a question for all of you: if you all want to have these services run from the community, how do we get from where we are, with this partnership model of primary care, into a robust governance model for managing these services? It is not just about the GPs; it is also about community nurses. Nurses like having contracts of employment with hospitals; we do not see many of them wanting contracts of employment to work in the community. The number of community nurses growing is not very good.

Janet Davies: We know the reason for that.

Lord Warner: Can we deal with the governance issue? How do we make robust governance for primary care that would work?

Janet Davies: I think we have clinical commissioning groups as well, which were meant to do just this.

Lord Warner: They are commissioners, not providers.

Janet Davies: They are commissioners but they determine what the landscape will look like by what they commission. Community services are now almost entirely governed by the contract placed by the CCGs, so there will be a contract specification, which the CCGs will put together, which then goes out for tender, and then people put in a tender for that service. It has totally changed the way community services are working at the moment.

We have talked to district nurses whose badges have changed three or four times in the period of the last six or seven years because the contracts are changing. It is the CCGs who are currently determining what that will look like, and they will work with the local authorities, but at the moment it is not working well because the majority are going for lowest cost, the lowest price, which does not necessarily meet those needs. Things fall through the gap, and that is what I was saying before: is it social care, is it healthcare? There are certain things in the middle that are then forgotten about or left because nobody wants to take responsibility. There is something about the model that has been determined to do this, but is it working or not? Is setting those contracts the right way of doing it, or do we need to look much more at population health? They also, of course, commission hospital services. If that was to work well it would be that local model, but we are still left with these silos, and I do not know why those CCGs have not managed to get it to that next stage. It was obviously the intention of them in the first place.

Lord Warner: You are agreeing with me that it is not working?

Janet Davies: It is not working.

Lord Warner: What I am trying to get at is the model that would work.

Professor Cathy Warwick: Talking of maternity services, we have certainly agonised over this for a long time, and come up with the concept that there has to be what we are now calling a local maternity system, on which everybody with any responsibility for providing high-quality maternity services sits. I do not see why that kind of model cannot translate into the wider health service so it is a far more collaborative, non-competitive kind of model. Commissioners sit together with providers from each bit of the system—social care, local government, healthcare—and work out what the local population needs. I think the question is what size this governance system should be—the right population numbers to go into this system. Effectively, we need to

move away from what has been a very competitive model to a collaborative model.

Dr Helen Stokes-Lampard: Can I pick up on the point about nurses and contracts in primary care? I am a little dismayed by that, and it is not something I recognise. Nurses who are employed by general practices have a very robust contract. They are in the NHS pension scheme, on similar, almost identical terms and conditions generally to the NHS. It is not something I really recognise. We can provide a very interesting and stimulating career structure for nurses, and we know a lot of nurses who find the shift working patterns in secondary care very restrictive—who, particularly when they have childcare or carer responsibilities, shift to primary care and have extremely rewarding and vibrant careers. I would be horrified if people were not contemplating primary care nursing as an option because of contractual issues. That would be very unhelpful.

Janet Davies: Community nursing numbers have dropped by 14% since 2010, which is atrocious, and that is because the funding has not been there and there have been no training places. There are lots of nurses who want to go into community nursing who are unable to do so. The budget for next year for continuing development for nursing staff is being cut by 50%, so it looks as if there will not be much opportunity with that either. We have to take seriously investment in the education of nurses for the community, including their placements during their education, but we also need to make sure that we have those posts there. This is a product really of the constant look at the cost of community nursing, the cost of the contracts, and cutting those numbers. That is a very large number. We are cutting the number of school nurses, when we did not have enough anyway, by 13%.

Lord Warner: Can I stop you a minute?

Janet Davies: That is what is causing it.

Lord Warner: We keep deviating away from the issue. The issue is how you construct a community system which is robust enough to run these integrated services that we all want to see, and sustain it against the forces of putting more and more money proportionally into acute hospitals. You are all saying that clinical commissioning groups cannot deliver this. That is what you are saying.

Dr Helen Stokes-Lampard: I would strongly advise against another wholesale restructure. That would not be helpful to anybody. I think we need to work with what we have. We have CCGs; they are still forming—unfortunately, new bodies take a long time and some of them are still forming at this stage. However, they are doing their best. The reality is that they are in a very resource-constrained environment and are struggling. If they were resourced and supported, they could do a far better job, and I think that would be embraced. The STPs, however, have to be the way forward. We have the STPs, which are aiming to look to the medium to long-term future but, again, they are being distracted by shoring up the acute sector deficit, which is a real distraction from what

they really need to be doing, which is fulfilling the aims of planning for the future. We need to accept the situation that when you have cut away all the fat in any system, all you can cut is the meat, and when the meat goes, the system is weaker. That is unfortunately underpinning a lot of these challenges.

Baroness Redfern: I think many countries are moving away from the bureaucratic system that we have. Listening to Lord Warner, we appear to have too many CCGs with small populations so they do not have the flexibility. We have STPs that are not coterminous with local authorities. CCGs are following their contracts and therefore want staff to fulfil those contracts. I think they are being hampered to a great extent and I wondered what you thought about that.

The Chairman: Lord Bradley, did you want to come in?

Lord Bradley: Yes. Helen mentioned that the drivers for the change that is expected, picking up Lord Turnberg's point, are the STPs. Have you, from your different perspectives, been involved in the development of those STPs? How much of that input has been about transformation rather than sustainability?

Dr Helen Stokes-Lampard: Yes, we have very much tried to be involved in the STPs. The Royal College of General Practitioners has invested members' money in producing an ambassador for every STP, to help the STPs understand the whole context and to provide a channel of communication of information, because we recognise the vital importance of the role they play in the future landscape. We want to help them to get it right because it is in all our interests for them to do so. Yes, we have been there, and what we have seen is a huge variety of engagement, certainly with primary care and secondary care. We have seen a huge variety in the involvement of local government and social care. Some of them seem to be getting the wholesale picture and embracing that, and seeing this as a phenomenal opportunity, which we welcome. Others seem to be so focused on solving the acute sector deficits that they were inheriting that they are completely blinkered and unable to see beyond that. That is a tragedy, and we are trying to help them where we can, and if there is anything we can do further to help we will do it, because we know we have to support the only horse in this race.

Q212 **Lord Willis of Knaresborough:** I think this whole issue of governance is clearly of fundamental importance to move forward in the long term. My particular interest on this Committee—and I declare an interest as an honorary fellow of the RCN, which I have done before—is in the workforce and the skills mix. It seems to me that, looking forward now, not resolving today's problems, we cannot have the same silos of workforce in 10 or 15 years that we have today. I wonder if each of you could say what workforce issues you think are the greatest threat to us transforming the NHS and social care system moving forward, what changes you think need to happen, and in particular could you address this fundamental issue of how on earth we retain the staff already in the NHS so they continue to work a full career rather than bailing out at very

short notice?

Professor Cathy Warwick: From my point of view, the greatest threat to maternity services is not having enough midwives. We now know from global research that if you are going to maintain the health and well-being of women and babies, they need midwifery input, and that is best delivered by midwives. It is not protectionism. The fact is that investing in midwives leads to higher-quality care.

However, I would add that those midwives need to be well supported by highly qualified, well-trained, competent maternity support workers, and we need to focus on that workforce as well and help them reach the required standard. We also need to ensure that our maternity services have sufficient clerical support. Midwives are currently spending up to 50% of their time doing non-clinical duties, and that is absolutely shocking. I think the greatest threat to high-quality care is lack of midwives.

Lord Willis of Knaresborough: Can I stop you there, Cathy? You are describing more of the same silo, and that is what worries me, in that when I look at midwives and the interface they have with some of the poorest as well as the wealthiest communities, every community in Britain is interfaced with a midwife, yet you are describing a very narrow role for them. I want you to look beyond that to ask: what are the midwives of the future going to do?

Professor Cathy Warwick: They are going to be doing public health.

Lord Willis of Knaresborough: They could not even look after my daughter when she was ill.

Professor Cathy Warwick: I do not know what was wrong with her.

Lord Willis of Knaresborough: I am not going to tell you because it is very personal.

Professor Cathy Warwick: The bottom line is, I guess, that midwives need to work collaboratively with loads of other people: they need to work with smoking cessation co-ordinators, they need to work in public health, and they need to work with mental health specialists. I am not saying they should not work collaboratively, and they certainly should fulfil all aspects of the role, but if they are going to do that you need to have enough of them.

The Chairman: That is still, as Lord Willis is saying, silo thinking. I appreciate the importance of midwives. Why would I not? I totally appreciate them, but the question is how you take midwives, and anybody else working in the community and primary care, to think about the totality of the service.

Professor Cathy Warwick: I think what I am saying is that midwives would be looking at the totality of the service. We have done a very big project in the Royal College of Midwives looking at the role of midwives in

public health, and there is a huge amount of work we have described that midwives should be doing—not on their own though; they need to work with specialists in this area. They need to work collaboratively with GPs, for example.

The Chairman: Maybe even with obstetricians.

Professor Cathy Warwick: You know we work with obstetricians all the time. No, I am not saying midwives do not work with other people, but I am saying it is incredibly important that you have enough midwives to carry out the full extent of their role.

Janet Davies: There is something as well about how we plan for our workforce. At the moment we plan it in a poor way. We should be looking at health needs and the demand on health services, and what we currently do is think how many people we want and then how much we can afford, which is why we are in the state we are in, I believe. We need a smarter way of looking at it—not necessarily in silos, I would hate to see that, but there are certain numbers of doctors and nurses we need as a basis before we start looking at probably some sort of way of moving between disciplines and working at the top of people's ability. There is something about population need and population health and we should be a bit more radical with how we plan our workforce.

We know some countries look at their population, so you will have so many doctors per head of population, which gives you much more flexibility than how many nurses you need for this hospital and how many doctors you need for this surgery. As we move into the future we would perhaps have a bit more ability.

I do not think we are in such a bad place as it might seem. I think we have moved amazingly. Last night we saw a nurse managing a practice and employing GPs in a surgery which is giving excellent care. One of the things the college has done is to have emergency care practitioners: it does not matter whether they are a nurse, doctor or paramedic; they have exactly the same competencies and the same postgraduate training programme to fulfil that need. That is quite revolutionary. We have co-badged it. That is moving away from silos, but we need to make sure that is what we look at. I worry about some of the assistant and associate roles if they end up being stuck, so whatever associate roles we build, I think it needs to be across professions, not building yet more silos, all with different associates.

There is a bit of a push, I know, from one of your colleagues in the Lords to stop calling them nurse associates but to call them associates, so they can move across and cover that rather than have yet more silos. They need somewhere to go at the end of it—so keeping our current workforce, giving them lots of continuing professional development, which we know is what people like most, and enabling them to develop their practice. All these new roles that are created need to have somewhere to go. Talking to some of the physician associates—which is of course not our topic—they have nowhere to go at the end of it. A

career for young people now is 20 or 30 years of not necessarily doing the same thing. We need to build that flexibility in.

- Q213 **Baroness Redfern:** We have heard evidence on the significant and unwarranted levels of variation in both care and outcomes which persist across the country. Why do you think such little progress has been made in tackling variations? What do you think of the role of technology in tackling those variations in health, and why has there not been a greater uptake in the use of technology in the NHS to date?

Professor Helen Stokes-Lampard: The inverse care law applied many decades ago, and still applies today, in that the health of populations is least well served by those who most need it. I think we have all established that. There have been huge advances in improving variation in care in the Quality and Outcomes Framework in general practice, which brought national standards, which brought the level up, so that at the very least care that was happening was being measured in a way that had never been done before, starting in 2004. We know that there is a correlation between the number of healthcare professionals per head of population and the standard of care received. There is a 20% variation throughout the UK, and the Centre for Workforce Intelligence has shown a 20% variation in the number of GPs per head of population in the most deprived parts of the country and the most affluent parts of the country, so there are things that we can identify.

Baroness Redfern: There is a shortage of GPs in certain areas.

Dr Helen Stokes-Lampard: Absolutely, in the areas that need them most, the most deprived areas generally.

Variation in provision of care is matched by variation in demand. We can identify the problems; we can see where there is clinical quality. We have heard about the CQC earlier and have mentioned the Quality and Outcomes Framework, which have helped. However, looking to the future, it is back to the integration of health and social care, and recognising that the needs of local populations will be served by local solutions and flexibility in delivering that care.

Janet's point about numbers of clinicians per head of population is helpful. The King's Fund and Nuffield have done a lot of work internationally looking at this, which provides a sensible basis to go forward. The problem we have is that we are not even meeting the minimum level starting point. We need a minimum starting point and creativity in the ways we work together. Yes, definitely, let us get out of our silos; I think we are all keen to embrace that and move forward. There is a lot of passion for this out there, but somebody needs to let the reins go, and unfortunately it needs a big cash and resource injection to get it started. That is the hardest problem in the current climate.

May I say something about IT, information technology? We desperately need to embrace technology. Healthcare professionals love technology generally; it is just getting standardised, joined-up systems that we can

use across the board. We want to be able to communicate with each other efficiently and effectively. It needs resource to do that, because IT will help us enormously with our jobs. When I hear that midwives are spending 50% of their time on admin tasks, we know that if we had better IT systems that could be reduced massively. Certainly it is true in primary care and certainly it is true through secondary care. Massive investment in IT would be helpful but it has to be designed with the patient at the heart of it. The problem is it is sometimes designed by somebody who has a novel idea in a silo. There has to be a cross-system approach to it. That is a very bold, radical move, starting with IT from the patient working backwards, not from the computer, the database, working forward.

Janet Davies: The other thing with IT is that it is often seen as a project, and it is not a project; it does not start and finish; it needs to be a level of investment that continues, because we are developing IT systems all the time. Having a whole segment of the budget for IT, as most big companies do, is essential for healthcare.

Professor Cathy Warwick: The only other thing I would add on variation—I agree with everything that has been said—is that there is some really good evidence emerging now around clinical variation and the disparity of outcomes. It links back to Lord Willis’s question about morale and how we keep people in work. There is no time in the current system for groups of clinicians to get together and address some of these really good pieces of information that are emerging. Somehow or other in the future we have to rebuild into the workforce time for clinicians of all varieties to get together and talk about how we improve care. I am not sure how we do that, but the first step would be to at least acknowledge that unless teams can work together and talk about outcomes it will never change. That is what I would plead for as we try to eliminate variation.

Q214 **Bishop of Carlisle:** Can I return to the purpose of this Committee, and the theme that has lain beneath our discussion so far? I think all of you in your answers have helpfully suggested that long-term planning is tremendously important, and you will have heard us ask previous witnesses who they thought should be responsible for that long-term planning, given that most of it does not seem to be happening at the moment. Can I ask what your answer to that would be? Who should take charge of long-term planning, including integration with social care, numbers and skill base of workforce, and all the other things we have been talking about?

Janet Davies: I think the knack is to focus away from delivery. I think as long as we look at delivery it becomes very confusing. Really, there is something about the funding and the sustainability and looking at what might happen in 20 or 30 years which is very problematic when it is a service that is so politically driven, because obviously those effects are not going to be felt till about three, four or five parliaments later, but there needs to be some sort of central oversight with health and social care. Whether that is bringing health and social care together at

government level, with a stronger Department of Health which can deal with the population needs, or whether we need something different, it cannot be the NHS as such, because not all care is provided in the NHS, and that is why we have that provider model. For instance, in the Royal College of Nursing a third of our members do not work in the NHS; they work in the independent sector, they work in charitable sectors, and they work in social care, and that is the way we need to see our population's health. By putting it into these segments we are missing a whole raft of services that are provided for people which might make the biggest difference. In the current system there is nowhere obvious it would sit.

Bishop of Carlisle: Do you think the NHS should therefore be redefined in some way?

Dr Helen Stokes-Lampard: I do not think the NHS needs to be redefined, and we certainly do not need to shake it up, but I agree we need a department for health and social care that is all-embracing and recognises the intimate relationship between health, social care and public health. Having them split up is destructive and wasteful, I would suggest. Within that—so that is the top end—at the bottom end, at the patient-facing end, we need services that are responsive to what patients need, delivered close to home, in efficient ways, with teams of multiple healthcare professionals and other professionals working together to deliver patient-centred care. Collaborative care planning would be the patient-facing end of it, and I am sure there is a way to get through that, but it will be a very courageous step to bring it together at the top end.

Bishop of Carlisle: That is very helpful. Would the department for health and social care be the department responsible for doing this long-term planning, do you think?

Dr Helen Stokes-Lampard: I would have thought so.

Q215 **Baroness Blackstone:** What is your single key suggestion for change that the Committee ought to recommend to support the long-term sustainability of the NHS?

Professor Cathy Warwick: I think looking at the workforce is absolutely critical. Modelling the future workforce need on the care provision we want really has to happen, so we have to work out how we get a workforce that can deliver care in the community and take responsibility for that. Within that, I think I would say we need far less constraints around the workforce; we need to enable our workforce to work in far more innovative, enterprising sorts of ways. At the moment the regulatory and government structures make that incredibly difficult.

Baroness Blackstone: What you are suggesting is less regulation and less attempt to use bureaucracies to enforce particular ways of operating.

Professor Cathy Warwick: Absolutely. We need a framework which is much looser and allows grass-roots innovation, the kinds of initiatives that Janet has already described in nursing, to flourish.

Janet Davies: If it is one thing, for me it would be more investment into community services, and getting rid of those barriers between health and social care, focusing on that person and having that system looking at that.

Baroness Blackstone: Does that mean that local authorities might be the best people to run these services?

Janet Davies: They may be—I would not know—but I think there has to be some overall organisation, which is combined in some way, whether that is health coming into local authorities, local authorities coming into health or taking the health elements, I do not know, but whichever way you look at it, a person's health is very much what happens to them in their life and their community. Local authorities have a lot more effect on that in public health, housing, and the conditions that people live in, which need to be seen together, as they were originally, when we established the NHS.

Dr Helen Stokes-Lampard: Building on what both my colleagues have said, without primary care thriving, without the community sector thriving, the NHS cannot survive. Therefore, my plea to you would be to ensure that the promises given in the GP Forward View and the Five-Year Forward View are delivered on so that the workforce in the primary care sector, the whole workforce—I am not just talking about GPs; I am talking about the whole primary care workforce—is built so that the primary care sector is sustainable for the future, particularly the mental health care side of things, which we have not spent much time on today but it is a serious concern, and I think you will get a lot of buy-in from the profession if that happens.

The Chairman: Thank you very much indeed. If any of you have further material to submit—you might even disagree with some of the responses you heard from your fellow witnesses—feel free to do so. You will get a transcript to look at. Thank you for coming today.