HOUSE OF LORDS

Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 6 December 2016

10.05 am

Watch the meeting

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey, Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 26 Heard in Public Questions 250 - 256

Witnesses

I: Chris Wormald, Permanent Secretary, Department of Health; Professor Chris Whitty, Chief Scientific Adviser, Department of Health.

Examination of witnesses

Chris Wormald and Professor Chris Whitty.

Q250 **The Chairman:** I am glad to see you both and thank you very much for coming to help with our inquiry. Before we start, we are live on the BBC parliamentary channel for the first session. Obviously you are popular, as the BBC has chosen you, or your evidence could be riveting to the nation, so you ought to be pleased about that. Before we start, would you mind introducing yourself for the record? If you want to make an opening statement, please do so. Of course, you will be sent a transcript of the proceedings to make any corrections, if you wish. Mr Wormald, can I start with you?

Chris Wormald: I am Chris Wormald. I am the Permanent Secretary to the Department of Health.

Professor Chris Whitty: I am Chris Whitty. I am the chief scientific adviser at the Department of Health and, in that role, also head of the NIHR. I should declare I am also professor of public and international health at the London School of Hygiene and Tropical Medicine and a consultant physician at UCLH.

The Chairman: Thank you very much. Do you have any opening statement?

Chris Wormald: I will say a few words by way of introduction. The first thing to say is that we, as a department, very much welcome the work that this Committee is doing, as the Chairman and I have discussed outside this Committee. These questions about the long-term health issues are, in our view, rather underdiscussed in public. It is of course completely unsurprising that the public debate focuses on the shorter-term questions in health, which I would say is completely understandable, but it is also important that we discuss the questions that this Committee has been looking at.

I should also say a little about the department's approach to the short and the long term, because I know that has been an issue that the Committee has been interested in. Of course, as with any government department, our primary focus is on delivering the manifesto right now. Our focus is unashamedly on the next five years, delivering the five year forward view that I know you already know a lot about. That is the primary focus of our work for Ministers. However, we try to make this short-term policy and advise Ministers in the light of our understanding of the longer-term trends. The reason I am joined by Professor Whitty is that he is what we could describe as the conscience of the department on those longer-term issues. His job is to continually confront us as we make policy with what we know and what we do not know about the long term, so that we can build that into our immediate policy-making. We are not in the business of publishing long-term plans and future visions of the health service beyond the current Parliament, but we are in a continuous process of horizon scanning across those issues as they affect day-to-day

policy. I am sure we will get into a number of those questions as we go through this discussion.

There are four key areas on which we do that. I am sure we could discuss any number of things, but the main things that we look at are: first, the demographics of health; secondly, technology; thirdly, workforce; and, fourthly—I am not quite sure how properly to describe this—the future of health, disease and illness, which is possibly the trickiest area. It is basically those four areas that we look at within the department and attempt to link the long term with the short term.

The thing that links all four, and the area that you and I have discussed before, Lord Chairman, that we feel is slightly underplayed in that debate—we may come on to it as we go through this hearing—is the demand side for health as opposed to the supply side. There was a lot of debate about the supply side, rightly, about how we build the future capacity for health. We think there also needs to be a debate about the demand side and particularly about what you might call inappropriate demand: the question of where are we using either the wrong part of the health service to deal with an issue or where there are issues that should not be coming to the health service at all. We believe—as I say, we have discussed this before—that that question is rather under debated, so we particularly welcome the light the Committee is bringing to that.

The final issue, which I am sure we will debate, is the question of where decisions are best made about the future in these systems. As you know, the 2012 Act is predicated upon moving decision-making power away from Whitehall desks and towards the professions themselves and decisions in local areas. There are clearly debates to be had about the right level of decision-making and type of decision, which I am sure we will also debate as we go through the hearing.

Q251 **The Chairman:** Thank you very much. That takes me immediately on to the first question. You focused on three or four areas that you are looking at long term, and it is good to have Professor Whitty here for the demographic changes that are likely to occur by 2030. You said that you were looking in the long term at the impact of that on funding issues, on manpower issues, et cetera. You might also include the challenges that might produce for the social care side of health and social care. Could you give us a flavour of your thinking and the answers you are coming up with?

Chris Wormald: Perhaps Professor Whitty would like to say where our thinking is about the long-term demographics, and then I will come in.

Professor Chris Whitty: There are some things in the long-term demographics that are obvious and which everybody knows, and there are some things that are probably less obvious but are equally important. Then, of course, there is the issue of disease mix, which we might want to come to, because I think that is quite important for the future.

On the obvious one, it is probably worth noting that we know that the population is ageing, as it is in every country in Europe. To put some numbers on that, ONS data comparing 2019, which is the midpoint in the current system, and 2039, which is a forward view, would show 13.4 million people aged 45 to 59 now and exactly the same number at that later stage of 2039. For those 85 or over, it would be 1.7 million now and 3.6 million at that later stage. For those aged 75 and over, it would be 5.8 million now and 9.6 million in the future. Those changes are quite extreme, so the working age to age dependency ratio is going up the whole time. That clearly has some significant implications. I think this is obvious, but it is worth putting numbers on it.

Linked to that and an issue that you may wish to come back to later is the fact that the propensity to consume health services has steadily increased—it has gone up by 50%, according to the OBR—in those aged 75 and over. Not only do they naturally use more health services because ill-health tends to be clustered in older people, but that tendency has increased quite markedly in those over 75 and those over 85. That is an important driver.

There are some things about the demography that are often not recognised. I will highlight two, but we can go into others. The first is that because our cities and urban conurbations maintain their demographic structures—they import youth and they export early middle age, essentially—cities' demographic structures will look remarkably similar if you look forward 20 years from now. Therefore, inevitably, the rest of the country, the smallest towns, the semi-urban areas and the rural areas will get older a lot faster than you would predict. This has clear implications for service delivery. That is one thing that, as I say, I do not think has been fully picked up on.

Reading some of the evidence given to your Committee, it felt to me as if people thought that the UK was an island medically as well as geographically. Everyone around this Committee knows that is not true. If you look at the ageing of the rest of Europe, it is going to happen a lot more sharply than it is in the UK. Only France has a similar demographic profile to ours. For example, in Germany there will be a sudden fall off in people retiring in around 20 years, and then they will move into massive increases in healthcare use. That is important because there is a competition—I do not mean it in a negative sense—for healthcare resources across the continent, as there is in the world. If you look at the rest of the world, again, India, China, Brazil and many of the middle income countries are rapidly getting older populations and getting wealthier, and their demand for healthcare will also increase. The positive side to that is that we will turn into a global market for healthcare goods, which will probably help to push down prices over the long term.

The Chairman: What will be the funding pressures on health and social care? What will be the pressures on the workforce?

Professor Chris Whitty: That very much depends on what kind of healthcare system we choose to have in 20 years' time. The Permanent

Secretary will want to answer on this. I think there is often a misunderstanding that the NHS somehow at any given point in time is going to roll forward in an identical state. The healthcare system that we have now is totally different from what it was 20 years ago, and it will be different again in 20 years' time. It will change. The disease mix—I do not know whether you would like me to go on to that—will heavily influence that.

Chris Wormald: Shall I say something about policy in this area? There are obviously some immediate debates about social care that I know a number of people around this table contribute to, but I will stick to questions on the long term. As Chris has said, this is an issue that faces the whole of the western world, and no one is pretending that we know the exact answer to your question. This is a situation that we have not, of course, faced before. We build that back into immediate policy in two ways. One, as I think this Committee has picked up in its other hearings, is that we want to see considerably greater integration between health and social care. The Better Care Fund that we have introduced is the first time that we have, as it were, mandated integration. That is a big step, but we have a lot of learning to do from how all that works out about how you do integration well. Secondly, and vitally, out of what Chris says, in this area we will see different parts of the country developing differently with those very different demographics that Chris is describing. One of the few things that we can be definite about over this period is that we will not see a national one-size-fits-all solution to the question you are raising.

We are looking, and are already beginning to see evidence of this happening, for individual areas deciding the right answer to that question in that place. You have heard some of the individual examples; Manchester has a particularly far-advanced approach. Bluntly, and leading on from the demographics that Chris has quoted, the right solution for Manchester will not be the right solution for Dorset, Brighton or anywhere else in the country. We want to see places addressing that question and coming up with their own solution within the framework that we set out in the Better Care Fund. In the current STP process you can see a number of those STPs led by local authorities and building the local authority dimension into policy-making. It is that type of approach that we are promoting across the country, where we take the demographics that Chris is describing and try to build that kind of flexible policy response into what we are doing.

Q252 **Lord Kakkar:** I want to explore, if I may, the question of the OBR's assessment that health spending will need to grow by more than GDP in any of the scenarios that have been presented beyond 2020. Is there any calculation of what that additional funding might be for both the health and social care systems to achieve that sustainability? Is there an inclination that there should be a longer-term agreement with regard to central funding for the health and social care systems to enhance sustainability, if you think that longer-term agreement would indeed be beneficial in that regard, and how might that be provided for?

Chris Wormald: That is a remarkably complicated question and an extremely important one. I believe you have the chairman of the OBR before your Committee later today, so I am sure he will say with considerably more expertise and in greater detail some of the things that I will say. This is, of course, an issue that we discussed with the OBR, and it is very important to be clear what the OBR has done. They have done an incredibly professional job on this, but they are not attempting to make a recommendation of what they think the right answer is. I am sure Robert will explain this much better than I, but they are looking at previous trends, building into that what they know about changes in the economy and demography, and projecting those trends into the future and coming up with a number. As I say, they have done a very professional job, but it assumes that all other things are equal.

The question those OBR numbers raises is what the policy response of successive Governments will be over that period. How did they get to that number? If you simply observe—there is no calculation involved in this—the history of health spending both within the UK and across the western world, it grows as a percentage of GDP every decade. On average, it has grown 1% a decade since the foundation of the NHS. We see that across all western economies. That clearly presents a public policy choice for Governments. You can continue, as you have for the last 60 years, to accept and agree that it is right that an ever greater proportion of GDP is spent on health and prioritise accordingly—it is open for Governments to do that, and indeed that is what people have been doing across the western world—or you can decide that you wish to, in some way, seek to cap that growth. That gets you to the question I made in my opening statement about whether there is inappropriate demand in the system that one wishes to try and keep out of the system: too many people dealt with in acute care could be dealt with in primary care, too many people coming into primary care in the first place and public health being the major component of that question.

Turning to your question of whether there should be a long-term settlement of that issue, obviously there is a lot of politics in that. There are few more debated topics. My personal view is that there should probably not be. I do not see that you can deal with health spending either economically or in policy terms in isolation from the rest of government. That question of whether you want to invest a greater proportion of GDP as the economy expands is a question of how you prioritise health spending against other forms of public spending and wider economic activity. I am not sure that is a question you can have a long-term answer to. I think it is better settled by the Government of the day arguing their case before the electorate. Personally, I would not go in that direction. I know others will not agree with me on that.

I would not do it in policy terms, because a huge number of the questions relating to the demand for health are not within the health system at all—I know lots of people around the Committee know this, but I will say it anyway—they are about the long-term drivers of health, which are to do with housing, transport, exercise, diet, smoking and all the things Chris is

an expert in, although not personally obviously, that we can discuss further. I am slightly wary, therefore, of trying to treat the health budget itself as a unified thing that you take out of that wider discussion. All these points are debatable and, as I say, they are not really for me. It will be a set of political questions, but that is my take on it.

Lord Kakkar: Before Professor Whitty intervenes, I should remind the Committee of my interests as professor of surgery at UCL and at UCLH, because of Professor Whitty's connection there.

Lord Warner: Even if we accept your position on the political determination of the quantum of money for the NHS and social care, what is within the gift of the Department of Health—your department—is the way in which that quantum of money is distributed and invested. It would make sense to do the investment and distribution through a system that was likely to deliver the service delivery model that your long-term planning suggests you will need in 2030. So what work is going on in the Department of Health and what unit is working on a system that is more likely to distribute those resources in line with the service delivery needs of health and social care in 2030?

Chris Wormald: I could not point you to a specific unit, because in a way that is a question for the health system as a whole. As I said at the beginning, and Chris may want to say a bit more about this, we want a number of those decisions to be taken outside, not within, Whitehall. The key units within the department that looks at those sorts of questions would be our strategy unit and our economics unit, which reports to Chris Whitty, but all done within the context of what I said right at the beginning: that our primary aim is to deliver the Government's manifesto of the day and within the structures set out in the 2012 Act. Our focus is on how we use the current mechanisms to deliver what we want.

Lord Warner: Can I just press you on that? Are you telling me that that unit is working on the issues I have mentioned?

Chris Wormald: No. We are not designing an alternative health system, for the reasons that I have given.

Lord Warner: I am not talking about the health system; I am talking about the way the money that is granted to the Department of Health to deliver the service delivery model you want is invested and distributed. You are agnostic on that and there is no work going on. I want to be clear.

Chris Wormald: Yes. I partially misunderstood your question.

Lord Warner: Let us have another go at it, shall we, if it is not clear?

Professor Chris Whitty: Shall I have a go? I am going to approach this slightly obliquely, because this Committee is looking at 20 to 30 years ahead, not right now.

Lord Warner: We are looking at 2030.

Professor Chris Whitty: The first question is: what will be different that is predictable about health in that period? There are some very, very clear things that are predictable and there are a number of things that are uncertain, and they tend to be come about where technology is going to happen. The first big predictable change relates to cardiovascular disease, which over the last 40 years has had a complete transformation in this country. It has gone down, year on year, throughout the entire lifetimes of virtually everybody around this table—certainly the working lifetimes of everybody around this table—to the point where two weeks ago it was overtaken as the leading cause of mortality in the UK. That is an astonishing change. That is not just mortality; every year there is a 6% reduction in angina admissions to hospital. There are certain areas of health that are improving. Child mortality has fallen 64% over the last 30 years.

Lord Warner: I am sorry to interrupt you, but that does not answer the question. I am trying to get an answer to the question about what work is going on in the Department of Health now, or is being planned, to shape the distribution of resources from whatever quantum the political decision-making produces—and you have the five year forward view to give you a clue—that is likely to produce services delivered in the way that is needed in 2030. It is a simple question: is any work going on in the Department of Health on the distribution systems and the payment systems for 2030 or is it not? Yes or no?

Chris Wormald: That is basically the STP process. That is the process by which we take the resources that are allocated in this area, and individual local areas look at exactly the question you are asking. So, no, we are not trying to answer that question from Whitehall, but there is a process by which we try to answer that question in individual places.

The Chairman: Let us move on to Lord Kakkar and Lady Blackstone. A quick question and quick answer, and we will move on.

Lord Kakkar: Having an approach towards agreement for funding for health and social care into the long term would not have an impact on its sustainability. It is much better to be flexible, as you have described.

Chris Wormald: When we look across the world, if you leave out the outlier of the United States, most countries in the OECD and Europe spend roughly the same amount of GDP on health. I do not think that trying to fix that long-term quantum, either here or generally, will make that much difference to the question. The question is how you spend the percentage of GDP that you have, as opposed to an attempt to fix that percentage long term.

Baroness Blackstone: Given what you said earlier about one size not fitting all, with which it is very hard to disagree, I think you were implying that there is a need for some devolution from the centre—in fact, you more or less said it.

Chris Wormald: Yes.

Baroness Blackstone: Is it not rather important that somebody in central government, if not in the Department of Health, perhaps somewhere in the centre, ought to be thinking about how we get there and what the mechanisms are way beyond the STPs? Is local government going to play a very much different role, or is it going to be done in the Greater Manchester model? It seems a failure not to have some people who are prepared to think the unthinkable and come up with some ideas about how we can move from where we are now to where you are suggesting we probably ought to be.

Chris Wormald: I think that is debatable. As I say, we have a clear policy set of priorities at the moment and we are focused on delivering those. On a lot of the questions you are raising. the ideal answers come from both local areas and the professions themselves, as opposed to from desks in Whitehall. That is the better way of addressing this set of questions.

Of course, the department needs to think, and does think, about which framework those decisions are made in. Personally, I am not a fan of trying to answer every question from a desk in Whitehall in that way. I think there is a big role for the professions. It is not really my business. Chris, do you want to add anything?

Professor Chris Whitty: If you think about what drives the changes in the OBR figures, which Lord Kakkar mentioned earlier, the demographics are a relatively small part, and in sensitivity analysis it makes surprisingly little difference if you change them. The things that really drive it are increases in income, which is very heavily a part of their model, changes in productivity and changes in technology. Of those, some are more predictable than others. For example, although you can broadly say technology is going to lead to an increase in spending, that is likely largely because we find things to treat that we previously did not; it is not because they are necessarily more expensive. We do not know which bits of technology will make a difference, and trying to predict that now is a mug’s game, as everyone around the table knows. I have heard multiple people over my career—I am sure you have heard even more—saying that this is going to change it and it never does, but when you look back 20 years you can see technologies that have been transformational, such as angioplasty. There is the opportunity to look at the bits that we can change; productivity is probably the most important, and the better use of technology is another. There are certain things, such as the propensity of richer people to use more healthcare, which we cannot change and which we simply have to use as a given, but those tend to move at a relatively predictable rate.

The Chairman: A quick question from Lord McColl, and a quick answer, please, and then I am going to move on to Lord Willis.

Lord McColl of Dulwich: I was fascinated by your statement that you wanted to reduce demand. What about reducing need? What would be your reaction—one Minister of Health is rather interested in this—if we were to recommend an all-out nationwide campaign involving everyone,

the people, the media, politicians and so on, to reduce the real problem in the NHS, which is the obesity epidemic, which is causing diabetes, cancer, dementia, joint replacement problems, heart disease, the whole caboose? How would you react to a nationwide campaign?

The Chairman: If you could make your answer short and crisp, that would be helpful.

Chris Wormald: On the straight public health questions I will ask Professor Whitty to comment, because he knows a lot more than me. You draw a very important distinction. I used the phrase "inappropriate demand", which you could describe as need. We are not talking about demand reduction for its own sake; the question is inappropriate demand, as in: can we prevent people being ill, as opposed to reducing the demand on the health service by people who are ill? Chris, do you want to comment on the public health question?

Professor Chris Whitty: On the very specific question of obesity, Lord McColl raises a really important point, which is that in most areas of public health things are getting better, such as smoking. In obesity, clearly things are getting worse, and we have the worse situation in Europe at the moment. As Lord McColl and others around the table know, addressing obesity is not straightforward, because it requires multiple interventions, many of which are at an individual level. Moving up the ladder of intervention, there is a relatively limited number of things that government can do that would be acceptable that would have a direct impact. A lot of it is to do with things such as education, trying to change the amounts of sugars and fats in processed foods, and so on, all of which are small, incremental changes. There is no clear evidence this has worked well anywhere yet, whereas we know what works in smoking, let us say. We know certain things help a bit in obesity, such as reducing sugar in drinks, but across the board the evidence base is pretty weak. This is a really important issue.

Q253 **Lord Willis of Knaresborough:** After Lord Warner, I would like to be rather helpful here. The OBR's analysis of how productivity has grown, particularly since 1997 to 2013, shows an average of 0.9%, which is incredibly small, despite unprecedented levels of spending on health for part of that period. I think both of you would agree that productivity—Professor Whitty just mentioned it in his previous answer—will be fundamental to balancing the books in what we spend and what we deliver. Why is it so low? What can be done to improve it? Why are there such variations in productivity around the healthcare system?

Chris Wormald: I will ask Professor Whitty to answer half that question, because half of that is about how the medical profession works. Why is it so low? It is a much-debated question and I will not try to give you a pat answer, because long treaties have been written on this subject. Clearly, key to it is the relationship between health and technology. As you know, what you see in most sectors of the economy is that technology is one of the biggest drivers of productivity and then reduced cost. Health has a very different relationship with technology. Most technologies,

wonderfully, both prolong life and allow us to treat diseases that we have never been able to treat before, but they do not save money. That is probably the root cause as to why health is behind other sectors.

Lord Willis of Knaresborough: There are two things, if I might interrupt. First, all the healthcare providers over the period since 1997 have had access to the same technologies, yet their levels of productivity have varied enormously. The new dashboards are demonstrating that quite vividly.

Chris Wormald: I was going to come on to exactly those points. I was answering your strict question on why is it different from other sectors. Clearly, as set out in Lord Carter's report and elsewhere, a lot can be done on productivity in health, both to increase the absolute level and to deal with the variations that you refer to. I think you have already stolen my answer. The transparency of the data on the dashboards available is probably the single most important thing we can do in that area. We need to promote a culture in which health providers look at who is best in class and ask themselves, "What do they do?", in exactly the same way as you see in most sectors of the economy. A big component in this is about medical practice, which of course I cannot comment on, but Professor Whitty is.

Professor Chris Whitty: To make an obvious point, with masterly understatement the OBR says that measuring medical productivity is not straightforward, which is clearly true. I have to say that in this area the medical profession is its own worst enemy. There are many leaders of the medical profession around the table here. My firm plea to the medical profession would be that they should take this seriously, because currently they do not in reality. The incentives are not stacked up along trying to improve productivity in the system; they are stacked up along trying to prolong life, which is a very important thing to do, but the two need to be kept firmly in balance.

The Chairman: What are the barriers for the medical profession not taking it up? How would you break that barrier?

Professor Chris Whitty: It is quite interesting in the sense that I think the medical profession has walked itself into a place that is incredibly efficient in the single-disease management of conditions, which is what has led to many of the remarkable advances that we have seen. First, that does not deal very well with multimorbidity, which it is quite inefficient at dealing with as a result. The second problem is that the medical profession has got itself hung up, I think, on longevity rather than quality of life measures and longevity rather than efficiency measures. If you make those bits of the system as important in medical training all the way through the system, we could incrementally change it really quite a long way.

Lord Willis of Knaresborough: Can I press you there, Professor Whitty? I declare an interest as the chair of the Yorkshire and Humber CLAHRC. I would like to ask you, because you have not mentioned it in

your answer, where the NIHR, the Medical Research Council and the charitable sector, of which you put huge amounts into research, will deliver those sorts of productivity developments. I would have thought you would have come out with that answer first.

Professor Chris Whitty: Thank you. I completely agree with that question and its implication, which is that in many of these areas we have far more data on which kind of stent to use, for example.

Lord Willis of Knaresborough: But are we using it?

Professor Chris Whitty: No. We have far more data on very narrow clinical questions than we do on questions about how you make the system more efficient. It is a responsibility of the academic community and of the NIHR, for which I now have responsibility as well, to take that a lot more seriously and to say, "If we wish to make the NHS sustainable there are broadly two ways in which you can do that". One approach is increase the amount of money going into a system. The other is whatever quantum is given by the public to make the system more efficient. The data to do that and the incentives to use that are currently missing. We have a responsibility to change that.

The Chairman: The word "data" has excited Lord Scriven.

Lord Scriven: It is not because of the data, Lord Chairman, it is because of the previous answer. I am still not clear. You have identified productivity as one of the three strands that really have to change in relation to future healthcare. I am not clear what you, at the centre, are going to change to ensure that productivity starts to increase, and in a systematic way, across health and social care. What work is going on and what is going to have to change?

Chris Wormald: Three things. The most specific, and I am quite happy to send you much more detail on this, is our work to implement the recommendations of Lord Carter, all of which are about productivity one way or another. That is the most specific thing the department is doing.

The second thing is what Lord Willis pointed to, which is making productivity questions much more transparent across the system so that we get an internal drive for productivity. Key to that will be the measures we are taking to link up the work that NHSI does on financial improvement with what the CQC does about quality, and see those as the same question, so that use of resource becomes an inspection question. That will change the incentives in the system. There is a whole set of things around incentives and transparency.

The third bit is what Professor Whitty just described, which is that you need to refocus research slightly so that it addresses both the system efficiency and productivity questions as well as pure research. I say that slightly hesitantly because, of course, our current model of research is the envy of the world, and we do not want to throw any babies out with any bathwater. It is basically those three categories.

Lord Scriven: When your decentralised system does not necessarily give a systematic improvement in productivity, where does the centre hold the ground, and what incentives and levers will you pull to ensure that productivity systematically improves? Decentralisation does not necessarily lead to more productivity; it can actually lead to places being less productive. That is what we are trying to find out: what is your role going to be in sustaining the NHS and ensuring that it systematically happens?

Chris Wormald: We are working on a model, and I agree exactly with your comments that you need three things to happen simultaneously to make that model work. You need the correct devolution, you need transparency, and you need an accountability framework that holds places to account about whether they are productive. That is why the changes to inspection and the work of NHSI in this area are so vital. This is true of any devolved system; there is nothing unique to health. Devolution of itself does not solve any questions; you need that level of transparency and the accountability framework that goes round it, and those three things need to work in tandem.

I was going to add to Professor Whitty's answer that this is something the health service has demonstrated it is capable of. A very dramatic productivity gain occurred as a result of the move to day surgery. That has completely transformed the number. I know that a number of people around the table were involved in that. So we should not get ourselves into the position of saying that the health service is incapable of making these big steps; the question—exactly as your question raises—is how you make that a systematic part of thinking as opposed to the sorts of one-off changes that lead to an improvement. Is that fair enough?

Professor Chris Whitty*:* Yes.

Q254 **Lord Warner:** The reason why day surgery improved productivity was competition and the bringing in of alternative providers, and I was personally responsible for that.

Dr Chris Wormald: I said that I know a number of people around the table were involved.

Lord Warner: My question, sadly, is to bring us back to this issue of longer-term planning. The Committee has been struck by the apparent lack of longer-term planning across the health and care systems. In your previous answers you suggested that was not the job of the Department of Health; it was the job for devolved health economies around the country. That, I think, strikes many of us as a pretty odd position for the headquarters of a £140 billion a year business, which is what you are. It is a bit like Marks & Spencer deciding to leave it to the local shops to carry on selling clothing even though no one is buying it. If the way I have described it is still your position, what should the Committee be saying about who can take responsibility for planning for the longer term, and who should be charged with ensuring that? We are going to have to say something about it, and if it is not the Department of Health and it is

left to devolution and 1,000 flowers blooming, if I may put it that way, who else could play in that game of running this?

Chris Wormald: I am afraid I do not agree with the premise of your question. You have started from the presumption that the creation of a long-term plan is a given, and the question is who should carry it out. We are debating what model is best to create that long-term thinking, and we are setting out our position that we do not believe that a central body should be charged with answering that question. I appreciate that you and a number of other people may disagree with that and may recommend something different, and that is the value of the debate we are having.

Lord Warner: Sorry, but you seem to be shifting your position that you are doing some longer-term thinking.

Chris Wormald: My position is exactly as I set out in my opening statement. We do not do longer-term planning in the classic sense; we do horizon scanning. We are seeking—and, as I say, Chris leads this work and he has described how we build that into day to day policy—to identify those long-term trends and ask ourselves how we should build that into current policy. There is an alternative proposition to what you should do, which is to go beyond horizon scanning into a longer-term plan for the health service. I fully understand why people argue for that; I am just saying that is not what we currently do.

Lord Warner: What would you do if your longer-term thinking, your horizon scanning, shows that the five year forward view is heading in the wrong direction?

Chris Wormald: You will do what Governments always do, which is make policy corrections accordingly, and that is the purpose of horizon scanning. We are describing that sort of iterative process of policy-making between a constant scanning of the horizon and the translation into current policy as our answer to the very complex issues that we all face in this area. I acknowledge that there is an alternative way of doing that, which is more towards what you describe, but that is not what we are doing.

The Chairman: In your introductory remark you also mentioned workforce planning for the future.

Chris Wormald: Yes.

The Chairman: None of you, so far, has mentioned what workforce planning there is.

Chris Wormald: You have not asked us yet.

The Chairman: Very briefly then.

Chris Wormald: That is the area where, of course, we publish long-term things. The HEE is charged with thinking about the workforce, both in the

short and the long term. The reason why we do that slightly differently is pretty obvious; it takes quite a long time to train a doctor, so you have to take a longer-term view. In that area we have published two things. You have had evidence from the Centre for Workforce Intelligence, which the department commissioned to look at the longer-term trends, and Health Education England published its 15-year forward look at the end of 2015. Because of the long lead times, that is the one area where we set out much more long-term thinking. The process of operationalising that is the same, however, in that we set out that long-term thinking and then it plays out in the year-by-year commissioning arrangements that HEE puts in. It is still not a long-term plan in the way some people have described it, but we are closer to that modelling workforce than we are in the other areas, for obvious reasons.

The Chairman: Baroness Redfern, you have a supplementary, and then I will ask you to move on to your question.

Baroness Redfern: Yes, I will. Following from Lord Willis's question, you mentioned the 2012 Act and the 44 STPs, decisions being taken away from Whitehall and delivered locally.

Chris Wormald: Yes.

Baroness Redfern: How do you think the STPs can take that forward when there is concern about there being not a lot of collaboration with other local organisations as such?

Chris Wormald: For STPs to work well there has to be collaboration. This is, of course, the first time we have tried to run a system in this way, and there is a lot of learning to be done. I do not think anyone from either the department, NHSE, NHSI or elsewhere would say, "We think we have reached the finished product there", but we do think that we have the right model of trying to draw people together to look at both the health needs of an area as a whole and the total resources available as a whole, and to take decisions accordingly. As you know, that is a very tough thing to do in an individual area, and it will take time, but we think we have taken the first step on the road to that form of decision-making.

Baroness Redfern: You said earlier that it would be down to data sharing and how important that is for STPs and long-term planning. My query is: do they understand how important that remit is, particularly for workforce planning?

Chris Wormald: I think it is an evolving picture. I do not know if you have taken evidence from people running STPs, but I think they would say the same: that some good first steps have been taken but there is an awful lot of debate, discussion and decision-making to be done before we get to the position where they are doing the kinds of things I described earlier. Some of that is about data, some is about working relationships and, of course, some is about these questions locally; they are tough and they are disputed. The process of arguing through to the right answer is part of how you build the kind of system you are describing.

Q255 **Baroness Redfern:** I will move on quickly to my question. What effect is the lack of a social care settlement having on the sustainability of social care and health systems? Is there an alternative funding model that you would consider more viable? Do you think Dilnot's recommendation for a cap on social care costs can and should be delivered?

Chris Wormald: The lack of a social care settlement?

Baroness Redfern: That is right. On the sustainability of social care and health systems.

Chris Wormald: There is a social care settlement in that the Government have set out its resources.

Baroness Redfern: Is there an alternative funding model?

Chris Wormald: Social care is clearly an area—I do not think there is any dispute about this—that is under challenge and local authorities are taking a lot of tough decisions. A bit like Lord Willis's question on hospitals, however, what jumps out from the data is the level of variability between different places. The financial challenge in social care is what it is, and we need to focus on whether everyone is adopting best practice and whether they are moving towards integration in the way I described in answer to some earlier questions. That is our focus. I am not sure the funding model is relevant to that question.

Lord Scriven: Clearly, the issue of long-term sustainability for the NHS is absolutely vital to working more closely and to integration with social care. I think everyone has said it is a key element. Do you think, therefore, that there will have to be a different funding model for health and social care together to deliver this integration, or can it continue like that? Could you suggest any funding models that could help this path of integration in the future?

Chris Wormald: No, I do not think a different funding model is required. The best moves that we have seen towards integration—I pointed to some of them earlier—have been about the working relations at local level, not the funding model.

The Chairman: That comment has just excited several hands. We will have to be quick about it. Lord Bradley, Lord Warner and Lord Willis.

Lord Bradley: A number of issues have been wrapped up. You speak about devolution in Greater Manchester and the STPs being the drivers for change, and the locality plans are meant to recognise the demographic changes within each locality and bringing together the STP. But to suggest that the social care budget is "under challenge" is the understatement of the morning. We had Greater Manchester before us last week, and in terms of sustainability for the long term, which is what we are trying to get to, they see a crisis in the next financial year in social care. Unless they get extra resources into the funding and a redistribution, as Lord Warner has suggested, they will not be able to deliver the sustainability transformation that is absolutely critical to the

long-term sustainability of health and social care. What action does the Department of Health take to try to support the devolution deal to ensure its success going forward? Otherwise, your mantra of "devolution at local level is the answer going forward" falls apart.

Chris Wormald: As you know, the Government do not agree with the starting point of your question. In terms of what we are doing, they are the things we have been describing. We are working closely with our partners in local government, from the Better Care Fund and elsewhere, to try to develop the models of integration that we want to see. I acknowledge that there are funding challenges. I am not going to use the same language that you do; as I say, the Government do not agree with your position.

Lord Warner: The Government do not appear to agree with the position of the CQC, which has made it very clear in *State of Care* that providers are leaving this sector at a growing rate. Is that on the Department of Health's register of risks, or do you think it will also turn out happily at the end?

Chris Wormald: No. We monitor that and we see it as a risk.

Lord Willis of Knaresborough: Again, I am quite incredulous at that last answer. If you refer to the question I asked you earlier about productivity, if you go to any major hospital, or in fact any district hospital across the country, you will see that they will have between 10 and 60 people there bed-blocking every day of the year. That has one of the most significant effects on productivity, yet you do not seem to flag that up as a major issue which the department needs to tackle.

Chris Wormald: No, we do think that is a major issue, and there are a number of things that we do on that subject. There is considerable variability across the country on that issue, and a considerable quantity of what is termed bed-blocking is about issues in the NHS, not between the NHS and local government. As I say, the funding settlement is what it is. We see very variable performance in different areas and we seek to address those variabilities.

The Chairman: Over and over again, lots of witnesses have commented on the need to find a settlement for social care and that if we do not find it the NHS will begin to suffer even more than it is now. There are around the table members who are associated with local authorities, and they are telling us the same things. Who do you think should address this issue of finding a settlement for social care?

Chris Wormald: And by "settlement" you mean—?

The Chairman: Financial settlement.

Chris Wormald: There is a financial settlement for local government that involves considerable new resources going into social care. As I say, the Government have made their position clear on this.

The Chairman: Do you think that is adequate?

Chris Wormald: As I said, there are clearly challenges in this sector, as there are in a number of public services, and we all know the reasons why. Yes, we acknowledge there is a challenge in this area. We believe that the variability in the system is an important component of that, and that is the issue we work on with local government and others. Clearly, the debate about the right level of funding in that sector will continue.

Lord Willis of Knaresborough: Chairman, the Permanent Secretary has not answered the question on Dilnot. Is that now dead?

Chris Wormald: The Government have set out their position on Dilnot, and that has not changed.

Lord Willis of Knaresborough: Is it dead? What is the position?

Dr Chris Wormald: No. As I say, we have said we are committed to Dilnot towards the end of this Parliament, but clearly that is for future decision.

The Chairman: Professor Whitty, what do your demographic figures suggest will happen to the demands of social care, looking ahead 15 years from now?

Professor Chris Whitty: It is very clear that the demand for social care in some form—I stress that—will go up. That is partly because of an ageing effect, partly because of multimorbidity, and partly because of the advantages we have had. For example, the incidence of stroke has gone down, which is fantastic, but that means that the number of people surviving with stroke is going up. The same is true for dementia. Clearly more people will get dementia because other causes of mortality are going down. It is an inescapable fact that, viewed over a 20 to 30-year horizon, the need for social care will increase.

Lord Ribeiro: In the 1980s we had the Department of Health and Social Security, and that was separated into two areas. It seems to me that the Department of Health has lost sight of what social services do. Is it time, if we are thinking in the long term, as we are in this Committee, to bring those two units together so that DoH and social services will work together to try to work out some of the problems you have identified but do not seem to have the power to do anything about?

Chris Wormald: The social security bit of what used to be the DHSS was the benefits system. That is now the Department for Work and Pensions. I do not think it is that question. Policy responsibility for social care rests within the Department of Health. Financing questions are part of the local government settlement, which is part of the Department for Communities and Local Government. We work very closely with them on these questions. Personally, I do not think redrawing the map of Whitehall is normally the way to solve questions; indeed, most machinery of government changes create a new, rough edge somewhere, so I would much rather concentrate on how we work within the current system.

There are very, very close working relationships between us and the Department for Communities and Local Government on these questions.

Lord Ribeiro: You mentioned clinicians having a responsibility and needing to change their practice. As an ex-clinician, one of the frustrations is knowing that you are carrying out procedures but you cannot get your patients out of hospital and into the community. For clinicians, it is not so much a change of practice as a matter of closing off the tap at one end and opening the door at the other.

Chris Wormald: Yes. We appreciate that.

Q256 **Baroness Blackstone:** What is your key single suggestion for change that the Committee ought to recommend to support the sustainability of the NHS?

Chris Wormald: I am not sure it is for me to say.

The Chairman: Go on. Be daring.

Baroness Blackstone: Be brave.

Professor Chris Whitty: I will take two then.

Dr Chris Wormald: No, I will give one answer, but you have your two.

Professor Chris Whitty: Clearly, it would be inappropriate for us to say what the Committee should say to Government, but I would say two things the Committee might want to say to other bits of the system. One is to the medical profession, because there are so many leaders around the table. We have to take seriously the way multimorbidity is heading our way, and we are not doing it at the moment. We have a disease model that is very mono-disease-based, with NICE guidelines and things, all of which are aiming in the wrong direction for where we are heading in 20 years. Some advice on that to the professions, not just the medical profession but the other professions, would be a very useful thing.

Lord Willis's point that this is an area that has been under-researched in terms of getting information to do things is absolutely right. That does not mean robbing Peter to pay Paul, but this in the long run is going to make the system a lot more efficient.

Chris Wormald: As I say, I will not give recommendations that you can make back to government, but I will finish where I started. I do think that the questions this Committee is raising, both about long-term supply—and I will adopt Lord McColl's words—long-term need for health are ones that need to be debated publicly more. Whether you agree with my version of how those debates should be had or the Committee's I think is irrelevant; the most important thing is that those things are properly publicly debated. Therefore, my encouragement to the Committee will be to recommend that those debates go on and on and are given the kind of light that we have seen today.

The Chairman: Can I thank you both for coming today? It has been

most appreciated. It has been very interesting and challenging, no doubt, but, I have to assure you, a very helpful session. We appreciate you coming today. Thank you very much indeed.