

Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 6 December 2016

12.05 pm

[Watch](#) the meeting

Members present: Lord Patel (Chairman); Viscount Bridgeman; 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.

In attendance: Viscount Bridgeman

Evidence Session No. 28 Heard in Public Questions 265 -271

Witnesses

[I](#): Baroness Cavendish of Little Venice, Lord Darzi and Sir Cyril Chantler.

Examination of witnesses

Baroness Cavendish of Little Venice, Lord Darzi and Sir Cyril Chantler.

Q265 **The Chairman:** Good afternoon, lady and gentlemen, lords and ladies, and sir. Thank you for coming today. Your evidence is crucial. Camilla, I know some of the health issues may not be directly pertinent to you, but you have a wide experience of the health service, particularly training for social care workers; we will be very interested to hear about that. Thank you all for coming today. It would be helpful for the record if—Sir Cyril, starting with you—you could introduce yourselves. If you want to make a brief opening statement, please feel free to do so.

Sir Cyril Chantler: I am Cyril Chantler. I am a retired paediatrician. I have in my time been the general manager of a large hospital, dean of a medical school, chairman of Great Ormond Street, and I was the founding chairman of UCL Partners. Everything I can think of saying I have already written down for you.

Baroness Cavendish of Little Venice: I am not a clinician and it was very kind of you to invite me. I would like to make some comments about the NHS, if you do not mind, as well as social care. My background is partly as a journalist. I first became interested in the complexity of the NHS and wrote quite a lot about it. I did a report for the Department of Health on the support workforce in health and social care, and I then sat on the board of the CQC for two years. If that is of any use, I would be delighted to share my thoughts with you.

Lord Darzi of Denham: Ara Darzi. I am part of this place. I am a surgeon and at some stage in my life I was involved in policy-making. I was the author of *High Quality Care For All*.

Q266 **The Chairman:** Thank you very much. Perhaps I may start with the first question. We are looking at the long-term sustainability of healthcare, so we are looking to 2025, 2030 and beyond. The question is threefold.

By the way, before I start, I should say that Lord Bridgeman has joined the Committee, although he is not a Committee member, because he is particularly interested to hear this session. Welcome, Lord Bridgeman. I should have introduced you.

I shall start again. We are looking at the long term. The question is: what do you think we need? What would a fit-for-purpose health and social care service look like in 2030? What are the barriers, and what is the greatest threat to its long-term sustainability? How should we prioritise to get there?

Lord Darzi of Denham: This has been the question around the NHS since its birth in 1948. It is interesting that we are still asking this question. It needs a vision; it needs a strategy. The principles of the NHS are set in stone, and we know them. Looking at what is happening at the moment, I do not think the NHS is malleable or proactive enough in addressing the big challenges facing society, including the change in both

the burden and the nature of disease. Our delivery mechanisms are based on the last century in many ways. You have touched on a few of these elements, such as the integration of care, whether that is primary, secondary or social care. It needs to be properly funded and society needs to decide what that funding envelope is. I think it should have a major focus, as it did back in 2008. Quality should be the organising principle of the NHS. It needs to have a fairly strong public health and preventive strategy, which I think it has always struggled to deliver. I could go on. Quality is a moving target; historically, the NHS has not kept up with that around innovation and the exploitation of technology. I heard some of you talking about information technology. We have lived through a data revolution, and we are now going through a digital revolution. You do not see signs of that impacting healthcare delivery in terms of improving quality, dealing with the productivity challenges facing us, and better utility of the workforce. You have heard this before. It is nothing new.

The Chairman: We have heard it, but how do we deal with it all to make the NHS sustainable by 2030 and beyond?

Lord Darzi of Denham: I think devolution is one way, because local change has to happen at a local level. I am very excited to hear about Manchester. I tried to do the same in London. The most recent piece of work I did was the London Health Commission for the then Mayor, Boris Johnson. More integration at a local level, pooling of budgets was another area; joint accountability in delivery of services was again a way forward. The accountability side of things and who these joint structures report to need to be managed. That, I think, is still unresolved. What is the mayoral role in all of this? It is interesting that at a local level the mayor is as high as the Secretary of State would be in the NHS. There are a lot of tensions at that level too. All of this needs to be resolved.

You cannot do that without having the funding and the finances sorted out as well, and money coming with reform. You have to remember that we have been through this cycle before. This debate happened when the NHS was 50 years old, and there was a massive injection of cash. At the top of the envelope it said, "This money comes with reform". I think there was a reasonable amount of reform, but not the type of reform that would have been self-sustaining, where an organisation is resilient enough to keep up with the changes and the challenges that it faces.

The Chairman: Why do you think the ideas in your report about London were not implemented?

Lord Darzi of Denham: I think it happened in some areas. There was a change of leadership, mayoral change, and there were all sorts of other challenges. In some parts of London it is happening. If you look at north-west London, there is an integration. STPs present another opportunity, but how many of them have the big vision, the bold changes, and the political cover to make those changes happen? Let us not forget that the organisation is as good as the neighbouring organisation it is working with, so it is back to the local health economy. What changes are

happening at the local health economy level? We all know. I could tell you there are too many hospitals in north-west London; there have been historically. We said that in 2007. Cyril was a partner of mine when we did the first London piece of work, called *A Framework for Action*. We have not really acted in changing those services. We need strong primary and community services, not the old general practice run by one or two general practitioners. There is the idea of—the dreaded word—polyclinics, and I did so many Parliamentary Questions on polyclinics at the time. We have invested in a few but we need to expand them more, because ultimately the delivery mechanism has to be at a primary and community level. Looking at the burden of disease, that is where you put your money in—it is cheaper, more cost effective, with better quality and a better patient experience. Let us not call them polyclinics; let us call them hospitals. Whatever you call them, that is where the injection of talent, leadership and money should go.

The Chairman: Camilla, in policy terms, you are on record as saying in 2011 that the Health and Social Care Bill should have been put out of its misery.

Baroness Cavendish of Little Venice: I may well have done. Briefly, if you want to ask what a fit-for-purpose healthcare system looks like in 2030, one of the main things has to be far less variation in outcomes. If you came down from Mars and looked at the NHS, irrespective of structures, what is utterly shocking, I think, is that we still have so much variation. We have excellence in almost every part of the NHS; somewhere someone is doing something absolutely superb. The problem with the NHS, it seems to me, is that the rest of the system cannot learn from that. There is a sort of silo culture—others will know better than I do why that still exists—and a belief that each individual area is different. I go round the NHS and talk to people and I say, “Do you know what is happening at Salford?”, and they say, “Well, we’re different”. I think that that is fundamental to the cultural issue.

Obviously, we have to align incentives to allow things to happen, and that has to happen from the centre, but when you ask what the barriers to change are, the first barrier is political. Unless we address that, we are not going to get anywhere. The first barrier is the fact that, although there is a great deal of cross-party agreement in private about what needs to be done to the NHS, including reconfiguration, as Lord Darzi mentioned, no one is prepared to say that in public. Politicians are still using the NHS as a political football, and the public are rightly very sceptical about closing hospitals. How many years did it take to reconfigure the stroke unit system in London? That has saved an enormous number of lives but the reason it took so long was partly that people are very sceptical about the idea that distance no longer matters. There is a huge challenge there about the language that we use.

Similarly, you were talking about technology. Our strategy at the moment is entirely based on getting people out of hospital. Most normal people think that hospital is the safest place to be, where they know they might

see a doctor, and they are extremely sceptical about what happens out of hospital or in the community. We have not explained to people what that means. Apart from all the delayed transfers of care, which we might come on to later, clinicians are also very reluctant, frankly, to discharge people from hospital into what they see as a kind of chaos. I think there is something there about language, politics and culture.

I have been around the country in my previous job and looked at a number of areas. Manchester is, I am afraid, unique. I do not believe there is any other part of this country which has the same constellation of talent in terms of the NHS and local authorities. I do not believe there is anywhere else with the same political impetus, because it is essentially a political construct. At the moment we are basing our aspirations for STPs upon a hope that politicians in local areas will be able to come together in the way they are doing in Manchester. I think it would be very foolish to expect anywhere else to adopt the Manchester model. If you look at all these places, they have been working on this stuff for 10 or 15 years; this was not invented a year ago. The same is true in north-west London, where they are doing good work, but, again, we are seeing too much double-running. We are not seeing an integrated system anywhere.

I suppose my concern would be that, although we have in our sights some potential models of what the system should look like, we are perhaps too optimistic about proceeding on quite such a voluntary basis, with a great political reluctance at the centre to impose any models.

The Chairman: Cyril, with all your experience, what model should there be for long-term sustainability in 2030 and beyond?

Sir Cyril Chantler: I think the fundamental model of the NHS is right. It should be funded through central taxation. It is one of the things that creates equity, which is the fundamental value of the British National Health Service, and it is one the British people absolutely support and those of us who work in it are passionate about. As I pointed out in the evidence I have written for you, it comes at a price, and the price is that political accountability is necessarily upwards to the Secretary of State. Systems which are more flexible, such as social insurance systems or locally funded systems, have some advantages. The much-maligned 2012 Act created a means of getting local accountability, and maybe Manchester is exploiting that.

We are certainly exploiting it in Newham, where I currently spend a day a week. People tell you that the health and well-being boards have not achieved anything, but there is more to the doing than bidding it be done, as Charles I is said to have said. But it is beginning to happen. In Newham the mayor is about to sign a memorandum of understanding, I was assured yesterday, to invest in 35 general practices, working with federations of general practice, and build four community hubs—which is the word that Ara and I did not dream up 10 years ago but wish we had. They will achieve, I hope, the co-ordination which is necessary to bring the specialist from the hospitals, like I used to be, to work in the community with the general practitioners.

Over the years since the 1960s, when we closed small hospitals, many of which I worked in and other people here remember very well, we have had a gap between general practice and specialist practice. We moved to district general hospitals for populations of 300,000 people. We now commission services on populations of a million or more. I have recently been the vice-chairman of the National Maternity Review, and we recognised that we had to commission services for maternity on a population base of between 500,000 and over a million, depending on the part of the country. That is fine for specialist services, for secondary services, but it is not fine for the management of people with chronic illnesses, because that involves a co-ordination of social care and healthcare, and social care is the responsibility democratically of local government, so local government and health services have to work together. STPs or local maternity systems are fine for commissioning large-scale services, hospital services, but if we are going to solve the problem of looking after the 70% of NHS expenditure spent on people like me with multiple chronic illnesses, we have to give that responsibility to local government alongside the National Health Service. That could well have the advantage of taking some of the top-down pressure off the service, so we do not have to have so much fear in the system, so much top-down accountability, so much regulation, and we can at that point begin to promote back the professionalism and the need for local systems which deliver services which are directed to local patients.

I heard the evidence about regulation. It is a fact that Denmark, in 2015, abolished their institute of quality because they thought accreditation had gone far enough and they now needed to get back to getting local people working together to improve the services for patients.

Q267 Lord Warner: Can I come back to your brilliant report, *Ara, High Quality Care For All*? The interesting question is: why was it not implemented? It was not just a question of money. Can you give us a bit more detail about why you think that did not happen? You had worked very hard to get the NHS to buy into this. They could not say that this was dreamt up in Richmond House and imposed upon them. Why did it not happen? The background to my question is that we are beginning to see a sense coming out of much of the evidence that people do not feel they can change this institution. There is a learned helplessness coming out of a lot of the evidence being put to us. We need to understand why a credible report, which had been negotiated with them, did not happen.

Lord Darzi of Denham: Let me acknowledge first that a lot of good things did happen—stroke services have been mentioned—both in London and nationally. That has become a Harvard Business School case study; people talk about that around the world. Trauma centres are another example. There is now an understanding that primary and community services need a better infrastructure to address the issue of health security. Patients did not feel secure in the community when they had to go up to an attic to see a primary care physician alone. That did not build confidence. So I think that a lot of good things happened.

As to why the rest did not happen, I do not believe in conspiracy theories, so I think it was mostly incompetence. It was published in 2008, as you may remember. In 2010 we had a general election, and then we became completely preoccupied with the biggest change the NHS had seen—the CEO described it as so big that you could actually see it from space. That kept the whole system busy. Ultimately, everyone was looking at what these changes meant. It was the most destructive change, and that again completely switched off the clinicians.

It took me a year. I met 65,000 people out there—engaging them, listening to them. Part of it was therapeutic but part was strategic; understanding their local needs, because I was very anxious that this was not London repeating itself in the rest of the country. We have done all that. It was very energising, very engaging. They took the ownership of change, which has to be local; it cannot be national. The system was ready with the local plans, and then change happened, and that stopped the whole thing.

Now we have a landscape which is a bit complicated. As we have heard, no one wants to see change again. The emphasis became more on regulation. If you open *Hansard* in 2008, when I took the Bill through, and you will see that I do not believe that regulation improves quality. It is ludicrous to suggest that regulation is the way to improve quality. Regulation is there as a minimum core standard so that we can all sleep at night and know that we do not have some fraudulent doctor working without a licence in a hospital setting. It is the local culture, local leadership, the culture of quality, safety and innovation that will drive that change. We lost that between 2011 and 2012—whenever the Bill went through—to be fair. There was a gap for about a year, and that is how we lost our way.

What is also interesting is that, at the time, in 2008—I still remember this—the big financial crises were happening globally but the NHS was in the unique position whereby the tsunami would not be hitting the shores until about 2012. I dream of running a business in which I know a tsunami is coming but it will hit me in three or four years' time so I can get ready to address and deal with it.

As I said, all of that was destructive, with structural change and leadership change, which I am sure was unintended. This was not intended. No one woke up in the morning and said, "I want to stop high-quality care for all". To be fair, despite all that, throughout the period post 2010, quality has remained in the language of the NHS, in the political language, as the organising principle of the NHS. The emphasis on quality and safety still exists, and I am very gratified by that. Pre-2007, in the Government that you and I served in, it was mostly about the quantity; it was about the targets, not quality. I remember when I published *High Quality Care For All*, a couple of people said before they read it, "This is a damp squib. What does this mean? It does not have a deliverable called a target." We have moved from that, but quality has remained in the narrative, and I am happy to see that. You need to re-

switch the system, go back and focus on that, free up the system. We need light regulation. We need to use data. We can know what the terrorism activities are and where the pockets are by using data, yet we cannot even figure out where the “never events” are around the country in the NHS.

Baroness Cavendish of Little Venice: Can I make one tiny point on that? Hinchingsbrooke Hospital is surely an example which undermines your point. I sat on the CQC board when we got into hot water over Hinchingsbrooke. The truth was that all of the data suggested that Hinchingsbrooke was excellent, and if we had not had inspectors, I am afraid, going in and making qualitative judgments, we would not have uncovered what we found. That is the point I want to make. There is a role for some form of qualitative inspection.

Lord Darzi of Denham: I agree, but not to the depth and severity we are going to. That is what I am saying.

Chairman: It should be proportionate.

Lord Warner: How do we get back? The issue for this Committee is how we get back on track for 2030. What is coming up to us is a sense that the NHS on its own cannot make these changes. It is sitting there looking incapable of going fast enough in the direction of a sustainable health service in 2030.

Lord Darzi of Denham: Let us look at the narrative again. It is the only narrative I know that unites everyone, whether you are a politician, a health service manager, a doctor in the front line or a nurse or a community worker. Get that narrative back in, empower people to make that change happen at a local level, give them permission to fail, give them permission to make some of the big changes and provide them with the cover. Also, settle with some form of a financial envelope to help them to do it. That is essentially it. It is not rocket science.

Lord Kakkar: To come back to this question of how the situation is recovered, what would be the best approach to re-engaging with clinicians to bring them to the situation prior to 2012 or thereabouts that would reignite that enthusiasm and commitment? Am I right in understanding from the comments made that it is that type of commitment and enthusiasm that is ultimately an important determinant of the sustainability of the NHS?

Lord Darzi of Denham: How do we engage them? We have these STPs. First, I would change the name—I do not know what an STP is; it sounds like a disease. Engage the local clinicians; give them the opportunity to write the prescription, because they know what the prescription is—this is not a new discovery of a novel drug; and support them in implementing that within the local structures. I could not agree more: Manchester was a local leadership issue that came together and drove that, but we need to drive more of that at a local level. I think the vehicle is there; the narrative needs to change; the vision needs to be clearer; empower them

to make that change; and provide them with cover. That is all. I provided a lot of cover at the time.

The Chairman: Camilla, do you wish to comment from your policy experience.

Baroness Cavendish of Little Venice: I understand entirely why you are suggesting we need to reignite enthusiasm, and there is a morale problem in the NHS. However, what I saw in No. 10 for the first time ever—and I have had meetings with Shelford for many years in different capacities—was a bunch of really talented people, clinicians and chief executives, who for the first time seemed to be genuinely determined to change things, and I think that is because there is a burning platform. On the one hand, you have people who are extremely concerned—the financial situation is dire, people are in deficit, there is a concern that deficit will become normalised—and on the other hand there is a group of people who want to grab the opportunity to change. The gap is that we have not provided a sufficiently clear template to them for what to do, and there are some very bright people out there who are very busy, and they do not want to have to reinvent the entire wheel again in their patch.

Lord Kakkar: What mechanism should be mobilised now to provide that template? Many people would agree it needs to happen now, to ensure that we can move forward and meet that sustainability objective of 2030. I do not know, Cyril, whether you have a view?

Sir Cyril Chantler: I think you need to concentrate on the local. There is a lot of, if not waste, inefficiency in the organisation and the provision of community services—voluntary, social, nursing and so forth. I see that in the stuff I do at the moment. That needs to be organised locally. Manchester, which is where I come from, is not the same as Newham, where I work, but there are obviously similarities. There is an organisation in local government that is capable of doing this, in partnership with the National Health Service.

If we can get better care for people with chronic illnesses, we will take the pressure off the hospitals. You cannot, I submit, run hospitals safely at over 90% bed occupancy. Other countries have seen that and we have seen that. As long as we are running the present system, where people default to hospital and then cannot get out of hospital, the hospitals are under pressure and things begin to do wrong.

The first thing is to look at the political change which is necessary to understand the importance of local government in taking us forward. There are other changes that I think need to take place. They are not enormous. I think a professional change is to relook at the contracts and replace them with a more professional relationship, as has happened at the Virginia Mason Hospital in Seattle, where they have introduced compacts, which is essentially engaging with the profession in a common aim to deliver better outcomes for patients, value outcomes per pound spent.

Finally, I think some administration change is probably necessary. I do not think you want to radically reorganise the National Health Service, but when you plant a garden, sometimes it is worth while going round and looking at it.

The Chairman: I only look at it so it does not matter.

Baroness Cavendish of Little Venice: Briefly on your point, I think there are too many alternative models of care. In the *Five Year Forward View* I think Simon Stevens was right not to be too prescriptive but to say, "Let's have a couple of thousand flowers bloom and see what happens". I think it is time now—not waiting for 10 years, because these things are far too slow—to say there are one or two models of care here and you can pick. From an IT point of view in particular, there is a lot of money being invested in developing different models of IT in different places. Salford has one that is excellent. Let us just take it and let us leave it for the nation. Those are things I think we should do, which is the spine; provide the backbone from which people can innovate.

The Chairman: My pleas are not often listened to but I make a plea again for short questions, short answers; otherwise we will not get through the agenda.

Lord Ribeiro: I am very happy to hear Ara talking about the quality agenda and the move away from targets and quality outcomes—and here I declare an interest as chairman of the Independent Reconfiguration Panel—because in many of the cases we have looked at, and north-west London was a case in point, we were able to call on the changes in London to trauma, to stroke, as an indication of how quality had impacted on patients and how change needs to happen. That may not be relevant in rural communities; it may be far more important within the urban situation. The fly in the ointment, if you are going to achieve the 50,000 to 100,000 target of community work for GPs, seems to be their private contracts. GPs are the only private practitioners we have in the NHS who can make those changes in the hospital sector. How are we going to do it in general practice?

Lord Darzi of Denham: Finance is a means to an end. It should not be the difficulty or the challenge here. What we got wrong in the original polyclinic—and I will blame Cyril for this—is that we described what this looked like, a federation, but we never really looked at the business model. In the NHS we are not good at business model innovation. We look at technological process innovation, but there are many business models that you can use to ignite the interest in primary care, whether they are partnership or employment models. We have to understand that the primary care community and leadership are also very divided; we can stratify them into those who would like employment contracts and those who would like to build partnerships. So I do not see that as an issue. I never saw the mode of employment or the mode of contractual arrangement as an issue. I think we need to mature up and say, "This is the best model for this region; this is what we need to commission", and to do that you need strong commissioning.

Baroness Redfern: Lord Darzi mentioned the need for digital revolution and data sharing. What incentives do you think are needed to move that on? Just financial ones? That helps of course, but I think something needs to be enhanced to move this on quickly for 2030.

Lord Darzi of Denham: First, you need to remove the obstacles before you talk about the finances. There are many obstacles but, thanks to Fiona Caldicott and the review being done on privacy, data security, and data sharing, they are starting to be removed. The quicker we roll that out and win the public confidence on those very sensitive matters, which are extremely important, the quicker we will start investing. You talk about innovation and the NHS being slow but I have noticed a number of junior doctors coming through who are absolutely engaged with the whole digital era in every way possible—for example, the use of simple digital technology such as WhatsApp to deal with patients and improve things. That generation wants this to happen, and there are many vendors out there. We are not talking about a £15 billion—

Baroness Redfern: It is not about wanting it to happen but making it happen.

Lord Darzi of Denham: It is making it happen, absolutely. There are a lot of people, a lot of vendors, out there who are trying to redesign pathways of care using digital platforms. In terms of handing over care; one of the big safety gaps in healthcare at the moment is the transition of care between teams in the hospital, between primary and secondary. Digital will sort this out.

Baroness Redfern: Why can we not make it happen quicker?

Baroness Blackstone: I wanted to pick up the fact that all of you have said that there are some very talented people out there and they need to be empowered and they need more autonomy. Cyril, you said that there was a climate of fear. Could you talk a bit more about that and how we liberate those people from something which I recognise too when you talk about a climate of fear? What are the specific things that this Committee ought to recommend to get rid of that, so that we can have far more local decision-making and can give people with ideas, who are capable of promoting innovation and implementing it, the power to get on with it?

Sir Cyril Chantler: As I have suggested, I think it comes from the nature of the top-down organisation of a healthcare system funded through taxation, which is what Beveridge and Bevan put in place. It is the right model but with it comes a responsibility upwards which leads to downward control. That is what the two groups that Ara commissioned to look at the NHS in 2007-08 said. My submission is that the way round that is to have more localisation and more democratic accountability locally, as they have in Scandinavian countries, which will free up the system. At the same time, we need to go back to a model of employment of healthcare professionals where they are encouraged more to work for love but to high professional standards.

I do not think there is one simple solution, but there are solutions. The digital thing is happening wonderfully well. In the practice I chair in outer north-east London, in a year we had a system running with a digital care plan, a contemporary record, and sharing it across other healthcare workers. We are getting there, and I think we can move faster if we concentrate on doing it locally rather than just centrally.

Q268 Lord Willis of Knaresborough: Perhaps I may address most of my questions to Camilla. We hear constantly about the need for change, the need to integrate health and social care and the increasing demand for social care by 2030 and beyond, yet for the 1.3 million social care staff currently working in our care homes, in the community and, indeed, in hospital settings, their levels of training and career development are pathetic compared with what we are offering medics. Camilla, in your report you recommended the care certificate. Do you feel that that has made an impact? Do you feel the steps beyond that are being put in place so that we have a social care workforce that is capable of delivering the very care that every expert we have had before us says needs to be delivered?

Baroness Cavendish of Little Venice: You and I have talked about this many times, and thank you for all your work on the same subject. It is probably for other people on the front line to judge whether the care certificate is working or not. I have had some very encouraging feedback, and I have had a lot of feedback from individuals on the front line saying this is raising the status of workers, which was one of the objectives, but it is also training people better. I do not think we will know whether that is the case until we see whether employers are accepting that certificate and not doing what they have previously done, which is retraining people themselves. If people accept that training, and if the practice is sufficiently observed so that it is not a tick-box exercise, I think we can judge it as working. I know 90,000 social care workers have taken the care certificate. I do not know what that means in practice, but I am quite encouraged by it.

You rightly ask about the next steps. Just to remind you, one of the things I recommended which I felt very strongly about was that we should be training health and social care workers in the same way, because of course we will really need one workforce to underpin the system we are talking about. We all know that the lines are blurring. Ten years ago people who are now in care homes would have been in hospitals. Where we draw the line between health and social care is increasingly difficult, is it not? We all know about the overlap, and one of the things I discovered and was very surprised about was the fact that nurses were finding it very difficult even to manage healthcare assistants, because their training was entirely different. We are finding exactly the same thing with district nurses, so you are going into someone's home as a social care worker and you find the district nurse has left a note. We all know this is a chaotic system where there is an enormous amount of duplication. We absolutely need to have that workforce speaking the same language. That is as important as acquiring the knowledge. It is

speaking in the same way about that knowledge, as well as filling in the gaps about lifting and handling or whatever it may be.

I think that is beginning to happen but I would like to see more training on site of those different workforces together, and I would also like to see us offering volunteers that training, because I believe that volunteers are playing an important part and they should be able to access that training as well—why on earth not? There are people looking after their own spouses who are already doing those things that we require other people to be qualified to do. We need to treat all these people as one in some way. We need to go to the next step, and, as I understand it, that next step is being developed, that advanced care certificate that you and I talked about.

The other thing that I think is quite encouraging is that we are beginning to put in some career ladders for people. Again, I think there was an announcement about nurse apprentices the other day but that is also very important. If people in this profession, particularly in social care, do not see this as a career, or cannot see any way to move forward, their morale will be low and we will have the kind of turnover we have seen before. There is absolutely no reason, in my view, why some of those people, who are excellent, should not be able to move up in their own system or even into the health service, but I think there is a lot more work to be done on that.

Lord Willis of Knaresborough: One of the big barriers, as I see it, moving forward in this new world in which localism will rule, is that the Health and Social Care Act, whatever we think of it, has created a whole set of different organisations out there, each with their own authority, which in some ways militates against having those common standards, where somebody who has done a phlebotomy course in Manchester will be accepted when they go to Newham.

Baroness Cavendish of Little Venice: Yes. That is one of the reasons why I recommended that certificate. It was not the ideal; we would not have started from where we started. You have to have common standards, from the point of view not only of patients and users but of employers. Otherwise, as I said earlier, if hospital trusts or care providers do not have faith in the training and the standards, they will simply go on and duplicate those things. The measure of success will be if that entire sort of cowboy industry of training providers has disappeared in a few years' time. Then we will know that it worked.

Lord Lipsey: I agree with everything you have said about the problems in this field but there is an elephant in the room, which is pay, particularly as we move forward with Brexit and stricter immigration control. You cannot go on saying you are respecting people, providing career ladders and all that, but they are only paid peanuts and the reason is that local authority can only pay peanuts for the care it is buying for its people.

Baroness Cavendish of Little Venice: Yes. Equally, care providers would say that our introduction of the national living wage has ruined their margins. I was very proud to be part of the Government that introduced the national living wage, not least because of the impact for some of those people, and it will help those people, but we need to accept that the impact on providers is significant. I totally agree. You come back to the financial question, which is a much bigger one. I do not know if you want to address that separately.

The Chairman: Please go ahead, with your recent experience of the policy unit.

Baroness Cavendish of Little Venice: I am not going to say anything that people in this room do not already know. Obviously, unless you can find some way of quantifying the money that you save by reducing delayed discharge into the NHS, you can never cycle it back into social care. That is what the Better Care Fund was about. The fact that we have hospital deficits means that the STP money is ending up being funnelled into that and not into innovation. There is a danger, as we know, of leakage from the BCF. This is the perennial problem that has dogged government for quite a long time.

I do not think there is a lack of concern at the centre of government about this. Lots of great people in government are trying to solve this problem. Lord Patel, the other day, was raising the question of insurance. I think we need to be much clearer with the public about what is a disease and what is not a disease. It is arguable that dementia is a disease and we should classify it as a disease. If we did that, suddenly, lo and behold, we discover that the NHS is going to have to pay for that. There is a real question about whether we are up to date in terms of defining what is a disease which needs to be paid for by the NHS and which people are entitled to have for free, and what is not, and what kind of provision they should make for their old age. Also, do not forget about adults with learning disabilities, which is a growing part of the challenge here. At the moment, partly because this has all happened quite quickly, partly because of the politics of this, we are stuck; we have a growing ageing population and an enormous demand on funds and we have not been honest with the public about what they can expect in their old age. We are not seeing people making provision for that. Make of that what you will but we have to do something about it.

Q269 **Lord Scriven:** All three of you have touched on the STPs, which are seen as quite an important future way of working in the health service and social care. What contribution do you think the STPs will make to longer-term NHS sustainability? Do you see any issues that arise? Two of you have mentioned some things that have not been mentioned before and I would like to explore them. Camilla, you talked about local leadership in Manchester being unique. I would like you to unpick that or explain more about that, because I think that is quite important. It backs up a recent report from the Treasury and DCLG, about three years ago, which talked about collaborative leadership not being at a local level. Cyril, you talked

about the STPs going way beyond acute hospitals and much more about the 70% with chronic disease. Could you explore those, please?

Sir Cyril Chantler: I think STPs are an important development. They recognise the need to commission certain services on a larger population than we have done heretofore, but they are not the solution to the total problem. The fundamental problem of sustainability is that medicine has changed and the demography of our nation has changed but the National Health Service has not changed adequately to reflect that. We need to recognise the need to bring health and social care together and the need for health and social care workers to learn together, and that is one of the things they can do in the community hubs, as we now hope to call them. All these things have to change, but my notion is that that has to be done from the bottom up, with co-ordination from the top down. You cannot have a hundred different systems and lots of different people competing to produce different digital systems. You need a combination of these things. It was sort of expressed in our report when we said centralise where necessary and localise where possible, and that is the process.

Baroness Cavendish of Little Venice: I sometimes try to unpick these things for myself by going round and looking at things and talking to people on the ground. I have done quite a lot of that. What I meant about Manchester was simply that you have an extraordinary set of characters there who are able to rise above their own political party allegiances or their own fiefdoms. You have two major hospital trust chief executives and a really great constellation of political leaders who have come together, as I said before, over very many years. The point is that these are voluntary contracts.

Part of my view is I spent five years running a public-private sector partnership regenerating a part of London. I sat in a lot of those committees and I know that the bigger the committee gets, the harder it is to make decisions, and I know how much time those committees take. There are a lot of committees around London where marvellous people are spending a lot of time sitting around tables, trying to figure out from scratch in their own area how we work together, what kind of IT system we will have. I just do not think that is rational. It is marvellous until you realise it is taking energy away from the front line. There are some fantastic clinicians who are now caught up in quangos, sitting on local committees. There is so much energy in there. I totally agree with what Sir Cyril said: we ought to be able to be much clearer about what we centralise and give these people something to cling on to. At the moment I feel it is much too voluntary. A lot of people do not want to spend time reinventing the wheel; they would like to hear about what someone else did and maybe have it provided prescriptively. That is all I meant. I have been to a lot of places where there is great energy and great ideas, but I do not see enough harnessing of that at the centre in a way which can help all the other people who are still stuck at the table.

Lord Warner: Is there not a problem that we have never, under successive Governments, got the NHS to understand that a key part of

this solution is a properly funded and sustained funding of social care which at the very least is equivalent to the increases in the NHS? That is a political failure as much as anything else. If we do not tackle that issue, we will not get anywhere. Is there not an inherent political reluctance to take that step with local government over a long time?

Baroness Cavendish of Little Venice: Yes.

Lord Warner: I wanted someone to say that.

Baroness Cavendish of Little Venice: You know better than anyone; you have been there.

Lord Warner: But it is not what the NHS is saying. They are saying give more money. We have had people in front of us arguing that they should take over care homes—people in the Shelford group, because they would do a better job.

Lord Darzi of Denham: I can see where they are coming from. The cost per bed occupied is significantly greater. In fact they could even make money on top of it. They are the clever ones. The answer to your question is absolutely, yes. Is the NHS asking for it? Yes, it is. Simon Stevens is on the record as asking for the money to be given to them. But a long-term sustainable settlement for social care is an important one, and it is getting more and more difficult as the social care needs are getting greater and greater. If there was a political reluctance, it is getting worse. I can see why they would do it. It is a Pandora's Box.

Q270 **Lord Kakkar:** This question was about a lasting social care settlement but I think much of that has already been rehearsed. I want to ask two specific questions. What kind of model might provide for that longer-term social care settlement? Secondly, if such a model were available, what might that contribute to improved productivity across the entire system?

Sir Cyril Chantler: I cannot deal with the first one; that is beyond my pay grade. I can deal with the second one. I have been surprised by the redundancy in the organisation of community services and the number of things which are done as tasks without any proper appraisal of what the client's needs are. I have on my iPad something UCL Partners did looking at services available in the community in outer north-east London, and they are simply duplicated and not connected. There is a lot of efficiency that can be gained from that. I quote the Buurtzorg model. They have increased their efficiency of delivery of home nursing by 40% on the appraisal by Ernst & Young. Proper organisation locally of whatever means of providing a proper long-term settlement is to me the way forward, and I think that that is where we should concentrate. If we do not get that right our hospitals will always struggle and we will not be able to introduce the new technology which is so important to improve the outcomes. These things are co-ordinated and linked.

The Chairman: To the first part of the question, Camilla or Ara.

Baroness Cavendish of Little Venice: I think there is a big question, as I said earlier, about where you draw the line as to what social care is, but let us say that we have done that—

Lord Kakkar: You have identified it; how should it be funded?

Baroness Cavendish of Little Venice: I think there is a very strong argument for some kind of insurance system, because we are seeing virtually limitless demand here. Where are we going to draw the line? It is extremely difficult. Other countries have developed various types of insurance systems. I think that, politically, an insurance system for the NHS is absolutely impossible. I believe very strongly, as you said, in an NHS that is free at the point of use. I think this Committee should certainly look at something like that.

Productivity is an interesting question. It is arguable that the social care industry is a cottage industry and that some form of consolidation will be needed in that sort of industry. I cannot think of the right analogy, but it is very fragmented. Some local authorities have hundreds of small domiciliary care agencies, and the travel time—it is what you are saying. There are deep-rooted inefficiencies in there which do not make an awful lot of sense.

One thing that could be done from the centre which is very simple, which I am always going on about, is to reduce bureaucracy. The amount of paperwork and pressure put on the front line by central government and the whole of this landscape of quangos is utterly unacceptable. I find that people in the centre of government or in the quangos have no understanding of that, have no overview of how the amount of data they require overlaps with the amount of data other people require. Other people have recommended endlessly that we need one single data set that should be required by all of these public agencies from all of these providers, whether they are in health or social care. I am not saying that that is the answer but I think you would find productivity would increase dramatically.

Sir Cyril Chantler: Can I second that, and whatever else I can do to support it? I am not against regulation; regulation is important. There are just too many of them all trying to do the same thing. There are too many agencies as part of the central system of the National Health Service now. I do not want them reorganised but a bit of rationalisation would be quite useful.

The Chairman: Ara, do you have any comment?

Lord Darzi of Denham: I think it needs some form of a settlement with society in identifying the best business model to do social care funding. It could be insurance, it could be a combination of the two, whatever it is, and I would ask the clever people who do these types of things to come up with three options.

Lord Willis of Knaresborough: You did not mention Dilnot. Is that dead

now?

Lord Darzi of Denham: I have not heard his name mentioned for a while, yes.

Baroness Cavendish of Little Venice: If you have talked to Dilnot lately—maybe you should ask him, because I think you might be interested by what he says.

Q271 **Baroness Blackstone:** This is a “Today” programme question. What is your single key suggestion for change that you think this Committee should recommend to support the sustainability of the NHS?

Sir Cyril Chantler: Local reorganisation. As I have suggested, to me, it is absolutely key.

Baroness Cavendish of Little Venice: A three-year freeze on all central government directives and a single data set to be required from providers.

Lord Darzi of Denham: Those two would be on top. Giving people the permission to go ahead and make the changes happen based on their local needs. Support the STPs. You have to remember—we did not cover this—STPs have filled a gap at a local level, and they should be there in continuity. It is not just one element of it. Just give the permission to make the change happen.

The Chairman: Thank you all very much. We could have gone on for longer with you but we have run out of time. Thank you very much indeed for coming.