



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

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

Tuesday 13 December 2016

11.35 am

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

Evidence Session No. 31

Heard in Public

Questions 286 - 291

### Witness

[I](#): Dr Sarah Wollaston MP, Chair, House of Commons Health Select Committee.

## Examination of witness

Dr Sarah Wollaston MP.

Q286 **The Chairman:** Good morning, Sarah. Having watched last Thursday's "Question Time", which you were subjected to, I am hoping that this is a better experience. On the other hand, we do not have a couple of the characters who were on that panel, although I will not name them. Thank you, Sarah, for coming. Your evidence is important to us because you have been involved on a weekly or daily basis sometimes in looking at the health service and, as we want to hear about, the current issues and how they can be made to make the NHS sustainable looking at 2025 to 2030 and beyond. It is that aspect that we want to hear from you. We know who you are, but this is a new experience for you sitting that side of the table.

**Dr Sarah Wollaston:** Indeed, it is very strange being on this side of the table.

**The Chairman:** If you do not mind, say who you are and, if you want to make an opening statement, please feel free to do so.

**Dr Sarah Wollaston:** I am Sarah Wollaston and I am currently Chair of the Health Select Committee. I have been the Member of Parliament for Totnes, which is in south Devon, since 2010. Prior to changing my initials from "GP" to "MP", I was a clinician in the NHS for 24 years and was also involved in education in that I was teaching and training junior doctors and medical students and was an examiner for the Royal College of GPs as well part time in primary care in Dartmoor.

**The Chairman:** Do you have an opening statement?

**Dr Sarah Wollaston:** No.

**The Chairman:** I will kick off then. I saw you were sitting there in the session with Simon Stevens and it is the same question: looking at 2030, what does sustainable healthcare of 2030 look like and what do we have to do to get there? What do you think are the greatest threats to the long-term sustainability of the NHS and how will you overcome them?

**Dr Sarah Wollaston:** First, I think we need a more integrated health and social care system, but we should not look at this as an academic sort of exercise in administration. It matters that we integrate care around individuals, that we can better meet their needs and that we try to go further on reducing health inequality. That is the inequality not just in life expectancy but in disease-free life expectancy and, to do that, we have to go far further on prevention, which I know has also been a focus for this Committee. Underlying this, we need to resource it properly, and that represents, in my view, very good value for money and that the public really value our NHS, and rightly so. What we need to do is make sure that we think about it being both health and social care together. It is something we have been trying to do throughout the history of the

NHS, but I think there is more we can do to make it a better system for people.

**The Chairman:** I see that you wrote a letter on 26 October to the Chancellor about your current concern. Is the concern that you highlight of the current status likely to continue?

**Dr Sarah Wollaston:** The issue that we wrote about was that we felt that perhaps the Government think they have given more to the health system than is really the case. What we have traditionally looked at is total health spending, so when the Government talk about spending an extra £10 billion on the NHS, what they are referring to is NHS England, not the totality of health spend, which also includes things such as prevention and Health Education England. Therefore, if you shift money from budgets, such as prevention and health education, into NHS England, you can artificially appear to be giving more.

Equally, if you change the baseline so that you include a six-year period rather than a five-year period and you adjust the data on which you calculate real-terms increases, then you can move from £4.5 billion to £10 billion, which is an altogether different figure. If you are thinking that you have invested £10 billion in the NHS, why would you feel that you should invest more? Therefore, I think it is very important that the Government are very clear in their use of data and understand that the scale of the increase of demand is quite extraordinary. If we have seen a 31% increase in the number of people living to 85 and beyond in the decade to 2015, that does not increase the costs of defence and not so much of the Home Office, but it leads to an extraordinary increase in demand for the health and care system. Of course, it is a fantastic thing and is a great success that we are living longer, but it requires much more planning and an understanding of the true costs of that if people are going to be able to live with dignity and as independently as possible.

Q287 **Lord Warner:** The Committee has had a lot of evidence to show, and the previous witness referred to this, that over the last 20 to 25 years there has been a huge lumpiness in the way money has been given to the NHS and, indeed, to social care, with very little synchronisation year on year between the money given to the NHS and the money given to social care. It has not been a happy history for the longer-term planning of using whatever money is available in a sensible way. Has that been a feature in the work done by your Committee? What work has been undertaken on the way NHS finances have been handled? How confident are you that those systems and processes will produce a sustainable NHS in, say, 2030?

**Dr Sarah Wollaston:** Both this Committee and the last Committee have had a focus on social care and the balance between health and social care. I think you, Lord Warner, stated that we would not start from here if we are spending less than 1% of our GDP on social care. If you look now at where our population sits and the change in our demographic, that clearly is not meeting people's needs, and that is the point here. We now have more than a million people who have unmet care needs and we

have many informal carers providing more than 50 hours a week of care with no support at all. The problem is that these people are now ending up in more expensive settings, where they do not want to be, receiving worse care, because if you do not need to be in secondary care in a hospital it is not the safest place for you to be.

This is creating huge costs, which is something the Committee has looked at and many others, of course. For example, I know that the National Audit Office has estimated a huge cost of, I think from memory, £820 million in delayed discharge costs. We are seeing all the other markers of stress in the system, be that increased waiting times in A&E, increased waits to move from A&E after a decision to admit into secondary care or delayed discharges through the system. Overarching that, if you step aside from the figures, there is the amount of personal distress it causes to individuals and their families when their care needs are not met, so it is of great concern. I think we have the balance wrong, which needs to be addressed, and there is an issue with underfunding now of the whole system.

Yes, there is much that the NHS could do to improve its efficiency. We have heard evidence that efficiencies in social care have reached the limit, the system is now cut to the bone, and there is very little room for further efficiencies in social care. Overall, this is a system in distress, so it is very welcome that this Committee is looking not just at what needs to be done immediately but the horizon-scanning up to 2030.

**Lord Warner:** What help can you give us on the views of your Committee on where additional sources of funding could come from for health and care?

**Dr Sarah Wollaston:** We took evidence from Kate Barker of the Barker commission, and of course there are a number of options on the table here about how this could be funded. My personal view, because I cannot speak for my Committee on this, is that our current system serves us very well and we have a very efficient system, which is publicly funded. The evidence that we heard in the last Committee from Kate Barker was that, if you move to having a system of private insurance, it ends up being topped up by the state for those who cannot afford to pay in any case, so how does that look different from a system where the insurance model is state-based? Personally, that is the system I think we should stick with, whether we go down a route which is more taxation or a route that more looks at how you build intergenerational fairness into the way we fund it around national insurance, with which you will all be very familiar, and we have heard from other witnesses what those options are.

I also think that we need to look further at the opportunities we have to nudge behaviour change at the same time as raising money. The sugary drinks levy, I think, is a very good example of that where you can help to nudge behaviour change and a reformulation by manufacturers at the same time as raising money. As you heard from your previous witness, what needs to be there is transparency for the public so that, if this money is not being directly hypothecated, they can see that the intention

is to spend it on health gains, because that commands public support. We know from polling that the public support increased funding and increased taxation if it is going to health and social care.

**Lord Warner:** So, as an elected politician, you would favour a move towards some form of hypothecation?

**Dr Sarah Wollaston:** The trouble with direct hypothecation is that as your economy moves up and down you can end up having these fluctuations, which you have already spoken of, Lord Warner. I think a very clear statement that this is the intent for it and that there will be a commitment to give this funding, in principle, to healthcare gives it greater public support, and they can see transparently where it is going.

**Baroness Blackstone:** Would you use national insurance payments for this purpose?

**Dr Sarah Wollaston:** Yes. Well, that was one of the suggestions, which has been that those over 40, who can afford to do so, should be paying more through their national insurance. Of course, the other suggestion was that those who are over pensionable age should continue to pay national insurance contributions. As I say, it would not be for me to say which model this Committee should adopt, but I certainly think that is a very interesting proposal and, as I say, some intergenerational fairness, I think, is important in this.

**Lord Kakkar:** To pursue this point of the lumpiness and the need to get a more consistent, long-term, five or 10-year settlement in terms of funding for the NHS and social care, do you think, sitting in the House of Commons, that it would be possible to achieve that kind of political consensus? Is there a will for that in such a way that this could be deliverable?

**Dr Sarah Wollaston:** I cannot tell you how depressing I find it sitting in the Commons Chamber and hearing the kind of yah-boo politics over this issue. I personally think that we need to do the same with health and social care as was eventually done over pensions: an acceptance that the scale of this is so great and it will be a challenge for whoever is in power, so it is in the interests of all political parties to get together and have a mature discussion about how we fund this so that it does not become such a political football. I personally feel that this is the right time in the electoral cycle for that to happen because the closer you get to an election the more difficult that becomes.

**Bishop of Carlisle:** Can I clarify what you were saying earlier? A number of our witnesses have said that the integration of health and social care would greatly improve the quality of care for individuals, but would not save much money in the long term, just redistribute it. I got the impression from what you were saying before that you think it could save quite a lot of money as well.

**Dr Sarah Wollaston:** I think it is a good thing. Of course integration can identify unmet need, so it does not necessarily save you money, but it can help to identify individuals whose needs you are not currently meeting. Also, I think you need to give it time because some of these measures will take time to deliver their results.

I would say that it is not just about pooling the budget; it is about people working together and remembering the purpose. Sometimes, you can have a joined-up system, but unless it feels joined-up to the person receiving it, it is pretty pointless. What matters to individuals, for example, is that they have a single point of contact, that they do not have to keep telling their story over and over again and that they have more control over their records and who shares those records. There are lots of different ways to talk about integration, but as long as you remember that it is about the individual rather than the system I think you get a more effective response. It is about relationships and allowing people across health and social care to develop those joint relationships. Sometimes, putting people physically in the same building can make a difference, but if you think that joining up the budgets on its own is going to do the trick, I do not think so; it is about a change of culture and practice as well.

**Lord Willis of Knaresborough:** Most witnesses have described local government as being very close to the social care issue because that is one of their prime jobs, looking after the vulnerable within their community. What we are seeing is that the 2% has not been applied by all authorities and, despite all the *cris de coeur* that we see in the media, local authority balances have started to increase in many cases. The question I would like to ask you is: should we not put a greater level of responsibility on local government to increase their ability to raise a precept up to, say, 5% to achieve a significant amount of new income into the system directly responsible to the people who are going to gain from it? Surely that is the way rather than looking to central government all the time to provide funding. If you agree with that premise, what are the pitfalls?

**Dr Sarah Wollaston:** One of the pitfalls immediately is the wealth of your local area. If you are in a relatively wealthy area, then it is easier for you to raise money from the precept, but, within that area, you will have a higher proportion of people who are self-funders in any case. If you are a local authority in a very deprived area, a much higher proportion of your population will have care needs that they are not funding themselves, yet your ability to raise funding will be less through that system. Yes, I would support, as a short-term measure, more flexibility to increase the precept, but I do not think that we should think of that as being the solution here, particularly for the most challenged local authorities, because it simply will not work for them and we will need something that will support the system through another mechanism, in my view.

**Lord Willis of Knaresborough:** We had the same argument over

business rates, which are collected and rebalanced. Surely we have to look imaginatively at how we involve local politicians and local communities in raising the revenue to support their people rather than saying, "This will not work"?

**Dr Sarah Wollaston:** Yes, I absolutely support the principle that some of this is raised locally, but, as I say, unless you have a redistribution mechanism of some sort, you will find that the people with the most severe needs will be left behind. That is my concern.

Q288 **Baroness Blackstone:** We have heard a lot of evidence of the pressures on the workforce in health and social care, whether it be too much bureaucracy and regulation, skill shortages that are not met or a failure to change the nature of the skills mix. Could you say something about where you think the main pressures are coming from?

**Dr Sarah Wollaston:** Certainly, having workforce shortfalls increases pressure, and not just shortfalls in the NHS but in social care as well, and that is very serious. I think you are absolutely right about the skills mix. When I look back to when I started as a doctor in 1986, at that time there was very little, relative to today, that nursing staff were doing. They were not putting in intravenous lines, very few of them were taking blood or administering intravenous drugs or changing ventilator settings. All of that is now part of the skillset of nursing staff, and that is absolutely the direction that we will need to continue to travel in. If we are going to meet workforce needs in primary care, for example, we will not do it all through general practitioners; we will need to bring in many more specialist nursing skills, community pharmacist skills, physician associates, physiotherapists and mental healthcare workers. I think the primary care of tomorrow will look very different from the primary care of today, just as practice now is very different from how it was 20 years ago. What we need to do, however, is train that workforce. It is not only about recruiting them but about the ongoing, continuing professional development that you give people that allows them to feel valued and retained within the service.

I think there is a huge amount that we should be doing, and regulation, of course, is part of it. It is of great regret that the draft Law Commission Bill on the regulation of healthcare professionals was not taken forward; it would have been an ideal opportunity to have done that at the end of the last Parliament. We have a very inflexible system. We are training up, for example, a number of physician assistants to work in primary care, and this is an unregistered, unregulated workforce. That makes it more difficult for them to be employed because of the issue of insurance, so we may be letting these people down; there may be a lot of people being trained for roles in which it is very complex to be able to employ them. The Government absolutely need to get on and sort out the regulation rather than doing this in a piecemeal fashion. They need to allow more flexibility for the system to adapt and respond to the new workforce.

**Baroness Blackstone:** Do we also need better workforce planning?

**Dr Sarah Wollaston:** Yes.

**Baroness Blackstone:** How will we get that?

**Dr Sarah Wollaston:** Obviously, the system we have now looks as if it may be more promising, having a sort of overarching body in Health Education England, though it is very unfortunate that it has had its budget cut in real terms. Also, there are a lot of things on the horizon which will be difficult to plan for in the sense that we do not know what the effect of Brexit will be. I think it should be an early and first priority of the negotiations to sort out the status of EU nationals in the UK, as well as UK nationals in the wider EU, because of the impact on our workforce, so that is an unknown.

There is also the change away from the bursary system. I can see the principle of that in allowing more places for people to train, but we do not yet know how many people who currently choose to train not just in nursing, but as radiographers, speech therapists and so forth—the wider workforce—would choose a different degree as a result of the loss of bursaries. There are a lot of uncertainties ahead and it is very difficult to have a system that plans accurately for that, but it does need to have the flexibility to adapt rapidly if it can be seen that recruitment is suffering as a result of those changes.

**The Chairman:** From the inquiries of your Committee, does it give you confidence that there is some forward thinking done by anybody of this nature?

**Dr Sarah Wollaston:** There is some forward advice and thinking, but, as I say, there are a lot of unknowns and uncertainties in our future workforce. We need to be as flexible as possible to respond where there are problems. The system that we currently have with regulation is an example of something that is totally, woefully inflexible to deal with having a future workforce. However, there are some things I feel very hopeful about—for example, as we heard earlier, allowing people who are currently working as healthcare assistants to progress through into nursing. If you look at the Cavendish review, for example, looking at the problem in the healthcare assistant workforce, both within hospitals and social care, there is a very high turnover in social care which is not just about low pay but about the lack of opportunities. In some areas, there is around a 40% or 50% turnover in the care sector. Allowing people to have opportunities to see that as a career and move all the way through into being assistant practitioners and nursing associates and on into degree nursing through the apprenticeship route, I think, is absolutely fantastic. That is an example of the system being responsive to needs, so I do not think this is altogether a story of failure, but there needs to be much more flexibility.

**Lord Warner:** You mentioned Brexit, but we have been lacking in self-sufficiency in health and care staff for a very long period, and we still have a position where 40% of the care staff in London come from overseas and 40% of the surgical specialists are trained overseas. Is it a

delusion that we can become self-sufficient, or will we always, not just with Brexit, have to have an immigration system that allows us to recruit people from abroad, certainly in the period up to 2030?

**Dr Sarah Wollaston:** Personally, I think we benefit from having a mixed workforce, we benefit from understanding about other people's systems and our health professionals benefit from being able to work abroad as well. I ought to declare a slight personal conflict in that my daughter is currently working in Australia for a year, so I ought to make that clear. When she returns next year, she will not only be good at dealing with snake bites but there are all sorts of things that you bring from that experience of working abroad, so I think we should welcome all of those staff. When we think about the care system in particular, 80,000 of the 1.3 million social care workers are born in other countries in the EU. Our system would absolutely collapse if we did not allow and encourage people to move flexibly, so I think, as I say, it should be a very early priority of negotiations to protect and value this workforce.

**Lord Warner:** But it is not just Brexit?

**Dr Sarah Wollaston:** No.

**Lord Warner:** This is a wider issue than just the EU, is it not?

**Dr Sarah Wollaston:** A wider issue, yes, I think so, but I personally think that it is a benefit. If we have an attitude that says that only home-grown doctors are good enough, I think the NHS will be missing out on understanding about a wider global perspective of health and care.

**Lord Ribeiro:** From a large section of doctors at the Southend Medical and Dental Society on Thursday, I got a real sense of disempowerment. They feel, as a workforce, that they do not have control of their lives and that maybe that is because of the structure of management. One of the things that has happened is that if you go around Europe or the United States you will find medically qualified chief executives. I think probably the last medically qualified chief executive we had was Jonathan Michael at Oxford. Is there something about the career structure that needs to change? Do we need to encourage more doctors to think about management as opposed to just clinical practice?

**Dr Sarah Wollaston:** Yes, that is absolutely true; we should give people experience of management within their training. Keogh's clinical fellow scheme is an example of a good scheme that allows people in their training to have time out to do that. Also, as people get towards the end of their careers, rather than retiring, encouraging people to be retaining their skills within the system, within management and training is a very positive thing. There is much more we could learn from other systems about morale more generally and how other systems maintain that. We are not very good, for example, at allowing clinicians across clinical boundaries to work in the same hospital as their partners, which has a huge impact on morale. I think there is much more we could do to

support health professionals to feel valued and want to continue in the NHS.

**Lord Ribeiro:** Do you see this getting worse as the gender mix of the health service changes?

**Dr Sarah Wollaston:** I heard earlier about the criticism that a lot of female GPs work part time, but, in essence, many of them work part time while their families are very young, but then, as I did, come back in and do other roles. If you are teaching and training part time and working part time as a clinician, it does not necessarily mean that the system loses you altogether, but you may be coming in in a mixed role and spending five or 10 years when you are not working so many hours. As I say, that also adds something when you come back perhaps with a more mixed skillset.

**Lord Scriven:** Sarah, you started by giving a very nice description of integration around the individual and, clearly, there is a lot of talk within both health and social care about that. I am getting the feeling from workforce planning that the NHS is doing its thing and local government in social care is doing its own thing. Has your Committee come across any place-based approach to workforce planning and integration of staff? If not, do you think that this is something that will need to be seriously thought about and implemented to bring about a more seamless system of both planning and implementation of service to individuals?

**Dr Sarah Wollaston:** I think it is patchy, so some areas are doing better than others, but there needs to be a complete refocus on this. If, for example, you put an advert out for somebody to be a healthcare assistant within a hospital, you will be flooded with applicants; if you do that within a social care setting in the community, you will not, so is there a way that we can make it so that people can rotate through? How can we make sure that, during people's training, they get more exposure within community settings? That is not just for nursing staff but also for medical practitioners and pharmacists. The trouble is that people do not think "community" when they are going through their training—the status seems to be all about being in a hospital—but, in fact, what we need is a rebalance. Because of our changing demographic, we need to rebalance and think about what people's needs are for the community. In order to get people thinking about community settings when they are qualified, they need to have sufficient exposure to that during their training, and that is not happening across the board, I am afraid.

**Lord Scriven:** Obviously, some of that will be local, but do you think there has to be any systematic change, either in training bodies or funding, to make this happen? A lot of people talk about things locally, but I am not clear as to who at the central level is driving that.

**Dr Sarah Wollaston:** To give you an example, through SIFT, the service increment for teaching, what percentage of that is paid to primary care for training as opposed to hospitals for training? We know that from the Health Education England budget of £5 billion, £3.5 billion goes directly to

funding the salaries of staff and training. How can we change the way that resource is distributed so that more of it allows for training periods in primary care? How can we get bodies, such as the GMC, for example, to look at the curriculum so that there is more emphasis on primary care? This is where the need is, and 70% of everything we spend, we were told as a Committee, in the NHS is on long-term conditions and that will get greater as our demographic continues to change. We have the resourcing in the wrong place to cope with that demand. We are facing ever-more demand on primary care and the ability to cope is really stretched to the limit.

**Q289 Baroness Redfern:** How can we reduce the impact that pressures in the social care system are having on the NHS? You have alluded to joined-up budgets not being an answer and you have mentioned the short-term increase in precepts for local authorities or looking at other mechanisms or the redistribution of mechanisms, as such. I wondered what your thoughts were on the reforms you would like to see to the funding for social care.

**Dr Sarah Wollaston:** I am not saying that we should not join up budgets, but we should not just think of it as being the solution in itself. I think it would help because, unfortunately, sometimes you can spend money in one part of the system and it creates savings for the other part, which is not much of an incentive. I am not saying that they are not part of it, but I think people think that just by joining them together you automatically get improvements, so I do not think that is the case. We need to do all of the above, in other words. We need to look at how we integrate around individuals, how we get individuals within the systems working together and how we integrate around individuals so that they have a single point of contact. There is a whole series of things that we need to do to get to where we want to be, even things, for example, such as the way we look at records. We still have a very paternalistic attitude to medical records, that they are all the property of the Secretary of State. I think we have to radically rethink that so that individuals have their own records or have full access to their own records and can decide who to share them with in every part of the system and how much of them they wish to share. They might wish to share, for example, just their drug history with their local community pharmacist, or they might wish all of it to be available to the out-of-hours care provider or to those who are looking after them in social care, so let us look at the way records can empower proper integration and self-care.

**Baroness Redfern:** So it is about confidence in that data sharing, as such.

**Dr Sarah Wollaston:** Of course, absolutely, and it needs to be within the power of individuals to say that they do not want certain people to be able to access their full records and how much of them they would like to share. To have a properly integrated system, record sharing is very much a part of that, if you are going to be able to have a system that works better to meet your needs and where you are not going to be constantly having to repeat your story at every turn and have the wrong records in

your notes, for example, because, if you own and see your records, you will pretty soon spot if somebody has made an error.

**Baroness Redfern:** How do you think progress is being made on the integration of social and health care?

**Dr Sarah Wollaston:** I think the big challenge at the moment is funding. For example, the system in Torbay does very well in integrating health and social care, but the real limiting factor now that it is up against is funding. Because of that, we have seen that the Care Quality Commission has recently rated the prime provider of care within Torbay, which is Mears, as inadequate. That is due to a combination of things, such as understaffing, a very high turnover of staff, inadequate staff training—all these things. If you do not have sufficient funding within the systems, you have many staff vacancies, you have providers withdrawing from the market and it makes it much more difficult for you to move towards a fully integrated health and care system. I think funding is essential, training the workforce is essential, as are joint working, shared records and an absolute focus on it being about individuals and how you wrap a system around them rather than just thinking of it as a sort of academic system issue.

**Baroness Redfern:** On the issue of funding, and I do not want to put you on the spot, do you think there should be a shift with more money coming to social care and less to the acute sector?

**Dr Sarah Wollaston:** I would not say less to the acute sector right now because they are already in a very significant deficit. Just saying, “We will move it from here” and giving them an even greater deficit would not be the answer. I think that the system, as a whole, is short of funding and that needs to be addressed. If there were extra money available right now, I think it should be prioritised for social care, which would benefit health as well because we are seeing so many people ending up in acute settings because of the problems in social care.

**Baroness Redfern:** There should probably be another step, intermediate care, in the middle of that so that we can get people out of the expensive acute beds and not necessarily going into care homes.

**Dr Sarah Wollaston:** Yes.

**Baroness Redfern:** As Simon Stevens said, to remove the lumps probably there should be a middle way.

**Dr Sarah Wollaston:** Absolutely, and the best bed is your own bed, if that is the right place to be. If there is the intermediate, yes, it is not just about those intermediate beds in the sense of being a step up so that you go there as an alternative to hospital; it is also about the step down as you come out when you might not be quite ready for home, but you have rehabilitation beds within the community that can get you ready for independent living again.

**Lord Warner:** I find it a bit curious, and I wonder if you do, that, under

successive Governments, we have managed to run a system where we say that we are in favour of integrating health and social care, but we leave one Cabinet Minister responsible for health and the care policy, but we give another Cabinet Minister the responsibility for the money for social care. That is an interesting way of running things, but it sounds not likely to produce the results that you want in terms of integration over time, and all Governments have done that. Do you think that it is time to revisit that particular issue?

**Dr Sarah Wollaston:** Absolutely, I do, and it is at other levels of the system as well, so a single commissioner locally for healthcare and even, preferably, for housing as well because they are all part of the same, at Cabinet level, yes, to have health and social care within a single departmental responsibility and, if we look at prevention, because we need a radical upgrade on prevention, a Cabinet Minister responsible for looking at that. There is a Marmot agenda about it being the wider determinants of health, which is looking across government and joining up how we can improve prevention.

**Lord Willis of Knaresborough:** I would like to take you back to this issue of funding because simply putting a lump of money in at this moment in time to support social care, which I am not saying is not the right thing to do, by the way, does not resolve the problem. We are talking about sustainability and I want you to give a personal view on creating a sustainable funding stream for social care. Where does it come from?

**Dr Sarah Wollaston:** There is an issue about right now.

**Lord Willis of Knaresborough:** I accept that.

**Dr Sarah Wollaston:** We have so many markers of distress in the system, but I absolutely agree that you need to take the views of how we do this and not to have the sort of bumpy ride, feast and famine, that we have heard about. If you link it directly to being a percentage of GDP, that would not be the right way forward; we need the health and care system to know exactly what is coming down the line so that it is phased and not a very sudden increase.

**Lord Willis of Knaresborough:** Is it coming from direct tax? Are you going to put up taxes then?

**Dr Sarah Wollaston:** I personally think that we should use a public mechanism.

**Lord Willis of Knaresborough:** So we raise income tax.

**Dr Sarah Wollaston:** Either that or through national insurance, but I think you need a mechanism to bring more money into the system as a whole. It is not for me to tell you which would be the right mechanism, but I think that needs to be something with cross-party consensus about how we achieve that in the long term.

**Q290 Lord McColl of Dulwich:** Are we doing enough on prevention to ensure that the healthcare system will be sustainable over the long term? What do you think are the greatest barriers to progress on prevention?

**Dr Sarah Wollaston:** The answer is we are not doing enough. I think there are very good reasons for doing this. First, we save the system more down the line if we do it, but also it is about reducing inequalities. The Prime Minister, in the first paragraph of her first speech, talked about the burning injustice of the life expectancy inequality, but we also need to look at disease-free life expectancy. You are not only likely to die sooner if you are disadvantaged, but you are also likely to live more of your life with the burden of disease, and much of that is preventable, so we should be doing everything we can to look at that and to see it as a social justice issue as well.

I think the key barrier to this is political will, frankly, because sometimes it means making politically difficult choices. If you explain to people why you are making those choices and present it as a form of nudge, you are not telling people that they cannot do things, you are not banning things, but you are making it, at the point people are making decisions, easier to make a better choice. I think that the sugary drinks levy, for example, is an opportunity for that to happen, and it is of great regret that there is not a direction that it has to be passed on at the point of sale. Although it will have an effect in helping to drive reformulation because of the different bands of the levy, there is no requirement to pass it on as a price differential. At the point that you choose a carbonated drink, if there is no difference in the price it is less likely to be effective, and we know that even small price differentials can make a huge difference. If you look at the plastic bag levy, for example, you can spend £100 on your shopping, but you will not spend 5p on that plastic bag. I think it is an example of how it does nudge people, because there is nothing to prevent you from buying the plastic bag, but there was an extraordinary change in behaviour and there was an over 80% drop in the sales of plastic bags. I think small price differentials can make a big difference, but they take political will. I think it is the political will to do it that is lacking and the Government need to get on and do it.

Particularly if you are taking money out of the public health system—and there have been real cuts, including in-year cuts, to public health—there is an even greater responsibility on the Government to give councils the levers to do things themselves. For example, you could choose to give local councils the ability to have health as a material consideration in the planning system or you could choose to make health a consideration in the licensing system, and I do not know why they do not just get on and do that, so there are lots of things the Government could do to make a difference and they should get on and do it, in my view.

**Lord McColl of Dulwich:** If you had a Minister for preventive medicine, would you see his role as trying to stop the vast amount of conflicting advice that has been given from the Government and from authorities, such as you must not have more than two eggs a week, which is quite wrong, or that doctors must not call patients “obese” because it is

judgmental, although it is an accurate diagnosis? With this Minister you envisage, would he have some sort of control or direction?

**Dr Sarah Wollaston:** I would not necessarily think that it should be the Minister that should be telling people what to do because there is not a great deal of evidence-based thinking that goes on in the Government, as far as I can see, but I think certainly they should take advice. Of course, thinking does sometimes change over the years and we should update that advice when the evidence is there to update it.

**Lord Warner:** Would it surprise you, Sarah, to know that the officials in the Department of Health said that there has been no in-year cut to public health, so it is very interesting to have your testimony on that particular issue?

**Dr Sarah Wollaston:** It was an in-year cut when I looked at it.

**Lord Warner:** On the issue of funding for public health—and you mentioned the ability to slightly sneakily put money across to NHS England—is there a case for creating a more independent focus for public health and prevention? Who is really in charge of the nation's health, and can truth be spoken to power in this particular area, which in many ways is a Cinderella service? Do we need something more robust that advises the Government about some of these issues and cannot just be shut up?

**Dr Sarah Wollaston:** One of the things that was welcome from the Health and Social Care Act was the shift of public health and to have the responsibility primarily sitting within local authorities, because that is primarily where public health happens. Yes, there have been some caveats with that, but I think that that was the right thing to do to make that happen. Of course, local authorities have, in many cases, been imaginative about how they commission those services, thinking about what users want, so there are examples of services that look more user-friendly in the way they are delivered since they have been commissioned by local authorities. However, a lot of what they do is also what we would traditionally think of as front-line health services, such as sexual health and various other prevention services—for example, smoking cessation services. All these kinds of things and health visiting are now sitting within local authorities. If their budgets are being restricted and squeezed, the things that they have to provide as statutory services can continue, but it is the rest of it that is being very severely cut back in prevention services, such as weight management services and stop-smoking services. This, I think, is a real threat to making the changes we want to see going forward of having people leading healthier lives, and it is things around physical activity which, we know and I agree, independently of diet, are very important. All those kinds of services are being cut back, which is a great shame; it is very short-sighted.

**Lord Warner:** So we have a protection problem locally and nationally.

**Dr Sarah Wollaston:** I think it should be protected. The public health budget should be ring-fenced because, otherwise, as local authority

budgets are squeezed, it is the things that are non-statutory that get cut, and we have heard in our Committee evidence that that is taking place.

**Q291 The Chairman:** Your Committee has taken lots of evidence over the years, and you have been Chair of the Committee for the last parliamentary Session and this one, so you have huge experience and knowledge about what is going right and what is going wrong. Let me ask you this question: what are the three or four likely scenarios that, if not addressed, will make healthcare unsustainable looking forward to 2025 to 2030?

**Dr Sarah Wollaston:** I think we need absolutely to focus on prevention and self-care. That is very clearly the case. I think that if we continue to have a very fragmented model we will be missing many opportunities to commission much more logically for health and social care. We are wasting huge amounts of energy in endless contracting rounds, for example, rather than having it integrated, where genuine integration can trump competition and the wasteful contracting. By having separated, fragmented systems for health and social care, we are wasting energy and money and are not meeting people's needs, so I think that should be a clear priority for the future.

**The Chairman:** I stole Lady Blackstone's question.

**Baroness Blackstone:** I think you have covered it really, unless you want to identify a single key suggestion.

**Dr Sarah Wollaston:** The other area is the effect of variation: there is leadership, there is what is happening with the workforce and there is safety. There are so many issues—I think yours will be a very long report—that there is not time to touch on today. The role of leadership is extraordinary. We have heard time and again that that is what is driving culture change, making things happen and dealing with variation and morale within the workforce. You can make differences and make efficiencies in the way health and care operate, but, without good leadership, that is much more challenging.

**The Chairman:** Your Committee has covered a lot on the issues of funding and financing, but, going back to Lord Warner's question, I do not think your inquiry has covered the issue about the cyclical nature of funding.

**Dr Sarah Wollaston:** We have certainly heard people comment on it. Having a huge glut of funding arriving at one time is not a challenge that we have faced in this last Parliament, I have to say. That, in itself, can be a challenge as well. We are half-way through the most austere decade in the NHS's history. We spent in the last Parliament, an average, we heard as a Committee, of a 1.1% increase, and that is well below the background rate of increase in demand, so that is the key challenge we face here and now and we must address that; the system is short of funding.

**Lord Warner:** Can I ask you the question I asked Simon Stevens? We

traditionally get into a mess on the NHS from time to time and we ask for a commission to be set up to sort it out, and the commission comes along and we may or may not take any notice of what it says. Is there a case for moving along what I call the Office for Budget Responsibility path and saying, "Well, it is very difficult for elected politicians to make big changes in this system, and there should be a kind of guardian keeping an eye on the longer-term funding systems, the workforce issues and investment decisions", not to interfere in the work of Simon Stevens or NHS Improvement or whoever, but to keep the Government focused on what the five or 10-year needs are of this national icon? Do we need to start thinking about that?

**Dr Sarah Wollaston:** I absolutely agree with that so that you have somebody taking the long view and saying, "What do we need to make this sustainable in the long term?" and to be responsive to changes. Yes, I agree with that.

**Lord Lipsey:** To follow that up, is there a greater role for an assertive Parliament? The fact that we passed the Health and Social Care Act 2012, despite, I think, a near universal view, except by the Secretary of State, that it was not really fit for purpose is a criticism of all of us in both Houses, I think.

**Dr Sarah Wollaston:** That is right. I think certainly Parliament should insist that there is a political will for parties to work together in the national interest to come up with a sustainable, long-term funding settlement, because the public really value the NHS and social care and there is so clearly a problem.

**Lord Willis of Knaresborough:** When answering my questions about the funding of social care, the one area you did not mention was Dilnot.

**Dr Sarah Wollaston:** Yes.

**Lord Willis of Knaresborough:** On 15 November, Lord Prior made the point that it would be implemented by the end of this Parliament. Is it your Committee's view that that is still live and that, if it is live, it will be a significant part of the solution to sustainable funding of social care?

**Dr Sarah Wollaston:** Part 2 of the Health and Social Care Act was rather dumped in, I thought, a disgraceful fashion. Being snuck out as a Written Statement just before Parliament rose, I thought, was the wrong way to do this. Even though there had been a clear call for it in response to the introduction of the living wage, it was clearly not going to be possible for them to do both. They have kicked it down the road a bit, but it is still there because we legislated for that, and I was on the Care Bill with Lord Warner. They cannot keep ducking it. Apart from anything else, councils will have to start again putting a lot of energy into how they are going to put the machinery in place for the metering of that because, otherwise, they will be facing appeal after appeal with people arguing about whether something was included or not included towards the cap in their care costs. They need to get to grips with this. Either they need to say, "It's

not affordable" and be honest with the electorate, or they need to be setting out how they are going to fund it, in my view.

**Lord Willis of Knaresborough:** Could your Committee give them a nudge on this?

**Dr Sarah Wollaston:** I will put it on the list, yes, thank you very much.

**The Chairman:** I assume that you are a member of the Liaison Committee.

**Dr Sarah Wollaston:** Yes.

**The Chairman:** The Liaison Committee on 20 December, which is next week, is taking evidence from the Prime Minister, and one of the questions you are expected to cover is the funding of the National Health Service and social care.

**Dr Sarah Wollaston:** Yes.

**The Chairman:** What are you expecting the Prime Minister to say to that?

**Dr Sarah Wollaston:** I cannot speak for what she will say in advance, but I shall certainly be asking a lot of questions about the future sustainability of health and social care; it is of critical interest to all of our constituents.

**The Chairman:** We will watch with interest.

**Dr Sarah Wollaston:** I shall also be asking her about it at PMQs tomorrow.

**The Chairman:** Sarah, thank you very much. You have been absolutely candid and very helpful. Thank you for coming.