HOUSE OF COMMONS

Health Committee

Oral evidence: Report of the House of Lords Committee on the Long-term Sustainability of the NHS, HC 510

Tuesday 24 October 2017

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Dr Caroline Johnson; Diana Johnson; Johnny Mercer; Andrew Selous; Maggie Throup; Dr Paul Williams.

Questions 1 - 46

Witnesses

I: Lord Patel, Chair of the House of Lords Committee on the Long-term Sustainability of the NHS; Lord Warner, member of the House of Lords Committee on the Long-term Sustainability of the NHS; Lord Willis of Knaresborough, member of the House of Lords Committee on the Long-term Sustainability of the NHS; and Lord Ribeiro, member of the House of Lords Committee on the Long-term Sustainability of the NHS.

Examination of witnesses

Witnesses: Lord Patel, Lord Ribeiro, Lord Warner and Lord Willis of Knaresborough.

Q1 **Chair:** Thank you very much for coming. I am afraid the general election got in the way last time we were planning to hear from you, following your excellent report. I am delighted that all three of you are able to be here to help draw attention to many of your conclusions. We will explore some of those today.

For those following outside this room, could you all introduce yourselves, starting with you, Lord Patel?

Lord Patel: I am Naren Patel. I was Chairman of the House of Lords Committee on the Long-term Sustainability of the NHS and Adult Social Care. I am a Cross Bencher—I do not belong with these politicos.

Lord Willis of Knaresborough: So pure.

Lord Warner: I am Norman Warner, a Cross-Bench peer. I am a former Labour Health Minister and a member of the Select Committee.

Lord Willis of Knaresborough: I am Lord Willis, a Liberal Democrat peer and a junior member of Naren Patel's Select Committee.

Q2 **Chair:** Naren, could I start by drawing attention to the point that you make very powerfully in your report about the short-termism that we see across health and social care, and the variations that we see across the system? Now that we are three years already into the five year forward view, which you point out is the only example you came across of longish medium-term planning, could you explain to the Committee what conclusions you came to around short-termism and how we should address it?

Lord Patel: That was a key issue. When we started taking evidence it was quite clear that there was a culture of short-termism within all the health sectors, starting with the Department of Health. There was a culture of fixing the problem as it occurred, rather than thinking out what we might require in the long term. The Department of Health was quite clear that it does not engage in any long-term planning or thinking.

We also came across that culture with other health-related bodies. There was a here and now. The only area where there was perhaps any long-term thinking was the five year forward plan. That was the only plan that was looking beyond the now or the one year. There was a predominant culture of short-termism across the board.

You asked a second question. We recommend that, in the medium term—that is, going on to 2025—NHS England, together with other bodies, give consideration to producing a plan that will take us at least to 2025. That is a recommendation that we make.

Lord Willis of Knaresborough: Although I totally agree with those conclusions, it is fair to say that some of the NDPBs that were set up, particularly Health Education England, were in fact attempting to do some longer-term planning. Two reports were commissioned: one on medics, "Shape of Training", and one on nurses, which was "Shape of Caring". Both pieces, which were commissioned by Health Education England, were looking ahead. Unfortunately, they were clashing with other ministerial objectives, and indeed with the Department's objectives. So, even when they were trying to plan ahead, as indeed was the principle behind the Health and Social Care Act, they were not in fact allowed to do it by the architecture that still exists. That is a real issue, which your Committee clearly needs to look at.

Lord Warner: I think there is a striking difference between the tone and content of the evidence from the Department of Health and that from NHS England in particular, where it felt to me as though they had tried to grab an agenda about long-term planning in the absence of anybody else doing it; that is what it felt like. In the evidence they gave to us part way through our inquiry, they made it clear that the five year forward view was not sufficient. They were starting to think about what came after the five year forward view—another five years after that. That was the only real convincing evidence I saw in that Committee that there were some serious people trying to think about the period up to 2025.

As Lord Willis has said, Health Education England recognised that, particularly with medical training, it had to take a longer view than the next 12 months, because of the length of time it takes to produce doctors, but it was operating, I would say, in a kind of cocoon of its own—the planning that was going on there—and it certainly did not reach into the timescales we were looking at, which was 2030 to 2035.

Q3 **Chair:** You made some recommendations about this, as you say. Have you yet had any response from the Government?

Lord Patel: That is an interesting point. Of course, the first excuse was that the election got in the way. The second thing was an official letter that came from a Minister in the Department of Health—a Minister in the Lords—saying, "Sorry for the delay." They were not happy with the first response that was produced, but they did not indicate which part they were not happy with.

The latest I have is from last week: an email, which I am slightly surprised about—I could be stronger in my language than that—because it came from a deputy clerk in the Department of Health, saying that we will not get a response until after the Budget. It may be that the Budget is going to be so full of surprises that 25 recommendations are accepted.

Chair: Accepted in full.

Lord Patel: That is where we are. We will not get a response until after the Budget.

Q4 **Chair:** Right—so, we know that it will not be at least until then. When I come to my very final question of the afternoon, I will be asking you what you would like me to put to the Secretary of State if you were sitting on this side of the table next week. I shall add that to the list, about having a response.

Could I explore more your points about setting up an office for health and care sustainability?

Lord Patel: We recommended that there should be an office. We took a lot of evidence, and we have set out in our appendix how these different offices—not just the OBR but others—work and function. The reason for saying that is that it is not a body that would interfere with the business, and it would not be running the show; it is just advisory. However, we say that it should initially focus on three key areas. The first is the demographic changes in the population, which might affect health. The second is the requirement in the future for workforce planning issues. The third is a prevention issue.

The reason why we suggested setting up this body—I will let my colleagues come in in a minute—is that it would serve as an overarching body, an advisory body, looking at the longer term, 15 to 20 years ahead, which nobody does.

Lord Warner: One thing we were concerned about, on which we took some evidence, was the prospects for any kind of cross-party consensus—achieving some kind of agreement about how the NHS should be reshaped, reformed and made fit for purpose for the future. Everybody pays lip service to that, but we did not see a lot of evidence that this was actually going to happen. We thought, if I may put it this way from the appointed House, that the elected political cadre would find it easier to come together if there was an independent body standing at arm's length from the day-to-day hurly-burly of the NHS that was able to put data in the public arena, in the same way as the OBR puts data in the public arena about the economy. That might itself foster a greater sense of cross-party working and understanding.

Chair: Having a trusted evidence base that everyone can see.

Lord Warner: Yes.

Lord Willis of Knaresborough: It is fair to say, in defence of successive Governments, that the health agenda is a space that is incredibly complex, and getting evidence that is broadly accepted across the piece is a difficult task. If you can take it out of the political arena and get in that evidence, using the eminent think-tanks that we have available to us—Nuffield, the King's Fund and so on—you should be able to get a body of evidence that at least you can agree on as a starting point for future policy discussions. It is up to politicians at that point what decisions they make, but at least having the evidence there would take a huge amount of heat out of the agenda, and it would allow the public to have

confidence that what we were planning for was something that was real, rather than imagined by—was it pointy heads that he said?

Q5 **Chair:** Thank you. Now on to the role of politicians.

Lord Patel: What it said exactly was a body "to assist the Government"—that is important—"in safeguarding the long-term sustainability of an integrated health and adult social care system." In the first instance, it will do "the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change." Also, lastly, it should address "the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding." That is exactly what it says.

Q6 **Dr Williams:** I am new to this place but, within your Committee, there are many people with many years of experience. I would like to draw on that experience and to continue listening to your thoughts around cross-party co-operation.

I have heard what you have said, that the office for health and care sustainability would help to foster and help to take the discussion and the debate out of politics, but there must be some responsibility on politicians as well. Realistically, what do you think are the prospects and what are the barriers? What would you like to see happening?

Lord Patel: As an ex-Minister, perhaps Lord Warner is best answering that.

Lord Warner: Chair, I have also been a civil servant, so I have served Ministers of different Governments as a civil servant in this area, and I have been a Minister. It is very difficult if you are in a Government—it doesn't matter which party we are talking about for the moment—and if you are the Health Secretary, you probably know you are not going to be there that long, in all probability. The short timescales do not help the fact that people have no real incentive to think longer term, because they know they won't be there. It is very difficult for elected politicians—I am not being unkind to them—but, at the end of the day, they have to get elected, and they have to go with the flow, to some extent, of what the public expects and what the public wants. It is very difficult, unless we can create some help for them, to think longer term. It is not built into the system to encourage people to think longer term. That poses a real dilemma.

We found some of these same problems outside health. We found problems with infrastructure, which is why the National Infrastructure Commission was set up to try to assist the politicians, in a sense, to think slightly longer term and not to look for political advantage.

If you look at the history of the NHS, it has always been a political battleground. It did not start as though it was some easy birth that everybody had agreed on and was going to work nice and smoothly in

support of. It is in the nature of the beast that it is intrinsically quite difficult to secure consensus around some of these issues.

We do get it. Integration has probably now become an issue on which there is political consensus. In principle, doing more to have care provided outside hospitals is a large measure of political consensus. Where it falls down is in what we are going to invest in. Gnomes do not come in the night and produce community services. There has to be an agreement on a strategy and a delivery model to bring these changes about. It is that transformation where a lot of the discomfort, politically, starts to arise.

There are some issues, which the politicians need help with, on the delivery side. If you are a politician—I saw this with stroke in London—if you are having services taken away from your local hospital, it is quite difficult to stand up and say, "Well, actually, it's best that those stroke services go in that hospital, which is 10 miles away."

Q7 **Dr Williams:** I found myself in the general election campaign in a very similar position, so I understand that.

Are there any other tips from anybody else on how we—

Lord Willis of Knaresborough: There are two positive things. As a Liberal Democrat I am always positive; you are not a politician any more. In reality, the agenda is radically changing, whether we like it or not. The integration of health and social care actually gives a fantastic opportunity, because you are not simply tinkering with the path; you are creating a new pathway into the future.

I think that the parameters around that are agreed by people in all political parties, from the extremes of the political parties, too. That gives you a starting point.

Secondly, there is the advent of the technological revolution—the data revolution—of what is happening with new medicines, new procedures, the introduction of genomics and bioinformatics and all the other new techniques. These are new pathways, which can be incorporated, where you can get consensus. This is also where you have to include the public as well. This is a debate that transcends political parties—it is actually a public debate. We have looked at the political agenda not only in Britain but of course in the United States and across Europe, and we are seeing that single issues often unite the most extremes of political opponents and friends. There are opportunities there, but you can only do it if you can map out an agenda that people can agree it is worth while trying to achieve. That is why the new system we have suggested is fundamental to putting together that information for politicians and the public alike.

Lord Patel: Before we produced our report, we commissioned a piece of work to see how the other bodies work and what advantage such a body would be in health, and the evidence that there was a lack of long-term thinking and why there might be a lack of long-term thinking. That is why

we have the whole chapter at the end, in the appendix. If you look at that, there are about 18 bodies—independent public bodies. Most of them are advisory, including the OBR. However, they are able to do this at leisure and look in detail at issues that the Department of Health does not do or perhaps cannot do. It is an independent, overarching body. It is all about health and care. It looks at demography, changing disease patterns and innovations that might be coming, how that may affect the workforce and what kind of skilled workforce you might need in 10 years' time. It is not rocket science to say that, right now, the workforce that is required in health and social care 10 years from now will have different skills than the ones we have now, because of robots, intelligent technology and so on. At this point, we can look ahead and inform us all.

Dr Williams: We will come on in a minute to talk about the consensus or the lack of it on funding.

Chair: I would like to come on to talk about service transformation in more detail. Andrew is going to lead on that.

Q8 **Andrew Selous:** I wanted to ask you about sustainability and transformation plans. The word "sustainability" is in the title of your report, and you make completely fair points about the importance of engagement locally, and governance. What is your view on the need for urgency of sustainability in transformation plans and how do you see them moving forward?

Lord Patel: Before I get my colleagues to come in, I would say that this was one of the key issues, about transformation being an important issue for healthcare and social care moving forward, and what that may look like and what we need to do to make sure it happens in a consistent and effective manner.

The other issue is about whether service transformation can occur without introducing any new piece of legislation. Therefore, has the 2012 Act become an impediment to doing that? We suggest that, if transformation is going to occur, and integration is what we all talk about—integrating as one area of transformation—we also recommend that NHS England and NHS Improvement should be merged. That will make an effective organisation to deliver healthcare and transformation, but perhaps why it can't be done lies in the Act.

Perhaps you want to go first on other areas.

Lord Warner: We did not see STPs through rose-tinted glasses. They were very much new kids on the block. They were exploratory in many parts of the country. We had evidence that, in some parts of the country, local government did not feel it had been properly involved in some of those activities. It was very clear that they were quite varied in quality, so we were not really saying that, if we just go on with 44 STPs or whatever, the world will be a much better place. That was not our starting point. However, in the absence of anything else that was starting

to address the issue of transformation, they looked the best bet to get behind from where we were sitting.

Since we reported, we have had a debate in the Lords on STPs in London, for example. What is clear regarding some of these STPs is that the revenue and capital requirements to implement them do not look as though they are likely to happen, frankly. There is a kind of funding issue, and, for me, that has raised the issue about whether they are wishful thinking, or is there a credible delivery plan behind this to get the investment in transformation?

I am old enough to remember that Lord Darzi had a go at this 10 years ago. He ran into the same problem—that there was not the up-front investment to secure the transformation, particularly from hospital delivery into community-based services. That remains a key issue.

Looking at other spheres, I worry about the absence of any serious delivery mechanism. When we tried to put on the Olympic games, we appointed a delivery authority. Parliament is appointing a delivery authority—if it ever gets round to agreeing on the repairs to the parliamentary fabric. There is no evidence that there is a serious delivery capability that is going to make this happen with an underpinning investment programme

Q9 **Andrew Selous:** I just want to press you a little more on that issue that you mentioned about how we get hospital services out into the community, in particular the role of GPs, which is fundamental in all this. Did you have any thoughts on how that could be done, notwithstanding the statutory architecture that we are very well aware of?

Lord Patel: Coming to the GPs, we did make comments, which I am sure most of the primary care community probably did not like, but the evidence was given also by the primary care community that there needs to be a new model of primary care that promotes integration between both acute and social care and primary care, so that it becomes a seamless care. There was evidence that the current model of delivery of primary care does not quite fit into that. There was a separate issue about whether the contractual basis of general practitioners needs to be changed or not, but I personally do not think that is as strong an issue as the need to integrate, become part of the community and work in a larger group. Dare I say all this when I know there are a couple of primary care doctors sitting on the other side?

That was a review as far as primary care was concerned, but it was solely for the purpose of integrating for the new model of service transformation that we are trying to implement, which is locally based. I am familiar in my own area, where it works, and the GP is working in a larger centre providing a diagnostic service and so on. That is what we suggest in here.

Q10 **Andrew Selous:** Can I ask you about the integration of secondary and community care? I remember Simon Stevens telling us that we spend

roughly £10 billion, I think, in the whole of NHS England on community care overall. Did you have any thoughts on how community and secondary care could be integrated, and could you see the contracts being placed elsewhere, perhaps with hospitals, for example?

Lord Patel: I will let Lord Willis and Lord Warner come in, but, on transformation, we also commented that secondary care needs to be reconfigured so that it becomes more specialist based and reconfigured to where the populations are, where it works closer—and in an integrated way—to primary care, community care and social care.

Lord Warner: There is no inherent objection to the hospital providing more community-based services. There is nothing that says that that shouldn't happen, because many of them are well placed in their geographical location to do that, but it would mean them changing and the doctors and the nurses changing their working practices.

One of the weaknesses of the STP in my view—this certainly came through in the evidence—is that the STPs have not been tied into a workforce plan. If you were going to transform the services, you might need a different coalition of workforce to deliver those services, but we were still busily churning out more doctors, nurses and other professionals to meet the existing model of service. We do not see any kind of plan to get the hospital services to change their way of working or, on going to scale, to consolidate some of their highly specialist services on fewer sites, as has been done with stroke in London, so that doctors and nurses could do different things from what they are doing now, possibly on the hospital side. At the moment, in most parts of the country, it is certainly being left to local people to try to work out the workforce changes that go with transformation of service delivery.

Q11 **Andrew Selous:** Finally from me on this section, on service transformation, I noted that, on page 5 of your report, you make the comment that "there is no plan to bring about a greater consistency in levels of performance" as regards specialist services. Have you come across the Getting It Right First Time programme? My understanding of that programme is that that is exactly what it is trying to do. It is very much a data-driven approach to variation in data produced by clinicians that is shown to other clinicians. Did you come across this programme?

Lord Patel: The short answer is no, we did not come across any evidence that said that it was being implemented across the board.

Lord Willis of Knaresborough: That is one of the big challenges. Let us be frank: there is some brilliant performance going on around the whole of the NHS, with some phenomenal work going on particularly in place-based care. There are examples in north London, in Manchester and in the north-east, where people have, despite the system in many ways, grasped what is required to put these processes together.

You have hit, Andrew, on one of the biggest issues, which is, "What do you do with their estate?" So much of the current NHS is driven by estate and maintaining that estate. Some of the tariff systems are based on that as well, which perpetuates that whole process. Unless you start to unpack that, and unless you can start to shift resources in a way that will be supported not only by the public but in Parliament by politicians, who, as Naren says, are seeking election at the next general election, that is not going to go down well.

We found the STPs a really sound, good idea. We did not have the opportunity to examine them in detail, because they had not completed their original proposals by that time, but it is clearly evident since then that there are some superb ideas. However, the idea that they are all going to be like Manchester is just a nonsense. We have to get it clear that there are going to be an awful lot of different systems in operation, where rural Cornwall will be very different from inner London. Unless you can have an explanation as to why that is going to benefit patients in the long run, you are not going to win on that argument.

We talked about governance, but it was not a matter of dissing—as my granddaughter would say—the Health and Social Care Act. As Andrew was saying, is the architecture of that working against the sorts of things that I think members of all political parties now want to see by way of integration?

If we take the Manchester scheme, for instance, there is not a governance structure for that. The governance lies with composite bodies, which feed into that, rather than with Manchester itself. That is a real issue as we move forward. If you look at the skills that Naren has talked about, we have not begun to think about the integrated skills that we would need to deliver a more holistic, community-based set-up, even though that is what we are told, from polling, that the public would support. There is a huge engagement exercise to go on before we can start to move in that direction.

My final point here is that the number of patients who are going into acute settings is growing. The number of people they are treating is growing, for a whole host of reasons, so changing that mindset is a real challenge.

Chair: Paul and Rosie want to come in with supplementaries.

Q12 **Dr Williams:** Lord Patel, as a GP and a primary care doctor, I share your view that primary care doctors need to work in different ways. I led a GP federation of 40 separate practices before I came into this place, with the intention of being that delivery body that you are talking about. I guess my question is around the topic of leadership change that is going to happen. You talked about a workforce that needs to be transformed in order to be able to run and work within community-based providers, but if you just get the acute trusts that have particular expertise and particular leadership skills in treating people and ask them to run

population health systems, do you have the right leadership there, or should we be thinking more about public health leadership?

Lord Patel: In regional or community-based services, I am not so sure that leadership is becoming a bigger issue. What is becoming a bigger issue is that the services are integrated to deliver the best care to the patient in a seamless manner. We should therefore look at the models that will deliver that. As I said, it is not just general practice—there needs to be transformation in how secondary care delivers its care across. As a doctor, I was well used to doing community antenatal clinics in four different sites, including in GP surgeries, sometimes together. It is not an issue about leadership. We will get into trouble if we say that leadership comes from the acute sector, not the primary sector—it is perfectly all right where it comes from.

Lord Warner: Sometimes, the system gets in the way of good leadership. I heard you hinting at the merits of population-based health allocations, which I would personally support entirely. Indeed, STPs could lend themselves to a population-based allocation of resources, which, to some extent, would encourage creativity and leadership in local areas to sort of grab the agenda. What we have, however, is a resource allocation system that largely feeds institutions and types of service. It does not feed whole populations. We did not have time to go into that kind of detail, but it is at the nub of some of the problems we face. You can't have population-based healthcare without a resource allocation system that supports it.

Q13 **Rosie Cooper:** This marries Paul's comments and yours, in that everybody is almost saying that we have to have integration of acute and community, that it has to happen for the sake of the patient, but where should the emphasis be? Should the control lie with the acute sector or with the community? I would encourage the community to go out and take patients from GPs and take them out of hospital, as opposed to the acute sector pushing patients out into the community, which that community may or may not have the skills for. Do you see that there is a benefit in empowering community organisations to take and pull those patients, as opposed to being given them?

Lord Patel: Yes.

Rosie Cooper: Good—because I think that is the solution.

Chair: That was a nice answer.

Rosie Cooper: All my experience says that that is the opposite of what is happening, and the community organisations need the power to pull, not just getting whatever they are being thrown. That will be the secret to starting to address winter pressures.

Lord Warner: But they need the money as well. If you look at what is happening, the deficits in the NHS are all in the acute hospitals. What we have lived through under successive Governments is underinvestment in

the community-based services. The gnomes do not come in the night and make those community services appear and flourish. They require action by people, resources, training of staff and positioning of staff to make it all happen—but we are with you in spirit.

Q14 **Rosie Cooper:** How do you encourage community trusts and organisations to go out and feel powerful enough to start to drag that power to them?

Lord Patel: Although that is not in our report, what is in our report is that a model of primary care needs to be looked at—this is now a personal view—for exactly that reason. I think it will give more power to the primary care doctors to organise the services in the community so that they deliver holistic care in the community. They are the ones who then think, "I have worked in the acute sector. I never worked in the primary care sector. In my job, if I was sent a patient, I had to do whatever was necessary and get the patient back in the community or in primary care." But now, we have to ask the question, why are we getting the acute sector—and that was one of the key things we found out when we did this report. We started off with a report that was only going to address the NHS. It quickly found that we can't do that unless we also address the issue in social care, because a lack of long-term sustainability in social care is now putting pressure on the NHS sector, which will break if that continues.

Chair: We will now go on to another area that you addressed, around workforce.

Q15 **Dr Caroline Johnson:** The NHS workforce is one area where long-term planning is most important, as it takes so long to train medical staff in particular. In your report, you describe a lack of comprehensive workforce strategy, which represents the "biggest internal threat" to sustainability. What did you mean by that? Can you expand on that?

Lord Patel: Lord Willis will not stop in a minute—

Lord Willis of Knaresborough: I will try.

Lord Patel: Because he is really fired up about it, and quite rightly.

We have a problem about the long-term workforce plan. In an earlier response, Lord Willis said that we had some indication that Health Education England was trying to do something about this, but it did not have the authority to take it forward. We also had some evidence from an individual from the Department of Health who really was looking at long-term planning, but we were not quite sure where that was going to go, or whether it was just an internal exercise.

There is another issue. When you say "long term" you have to consider what the demography of the population is going to be, what the disease pattern is going to be, what innovations there will be, what integrated care will mean as regards the workforce and what skills they require, as

well as other issues. The long-term planning for the workforce should address all those issues.

I do not know whether some of you recently saw the lecture given by Chris Whitty, the chief scientific officer in the Department of Health. He gave a brilliant lecture, I thought, about demography, what the disease pattern might be and how that might be changed. For example, we might see less cardiovascular disease, and we might even see less vascular-related dementia. We might see less stroke. Older people get more of a prevalence of stroke, although the incidence might go down. You have to look at all of these when you plan the workforce.

A further issue is what kind of workforce there should be. Is it doctors, nurses, integrated, multiskill or whatever?

Lord Willis of Knaresborough: There are two concerns. I confess I wrote the "Shape of Caring" report, which was basically looking forward to how we are going to educate and train nurses. It became very clear after the first week of doing the research for that piece of work that, unless you included healthcare support staff within that planning, the whole thing would be a nonsense. We had to go back to the bosses of Health Education England to say, "Can we actually include healthcare support workers?" The initial answer was, "No. We're only responsible for nurses."

That is a little scenario that shows you what is actually wrong. The way in which we look at our workforce is silo based. It is not about what the patients need overall or what communities need overall; it is about how we look at individual groups within that. That goes from consultants right through to registered nurses and midwives. That was the biggest problem.

I looked to see whether there was any systematic planning of the workforce at all. In reality, I think that most Secretaries of State of different political persuasions would accept that, ever since the NHS was set up, there has not been an effective workforce planning system, mainly because what happens is that, as soon as a problem arises, we fix that problem, but it is a retrospective problem and we are never looking forward. That is why we had these very strong recommendations in our report.

What concerned us most of all when we were taking evidence was that, first of all, there was a constant stream of people who were saying that regulation was a barrier to effective workforce reform and workforce planning. However, nobody was in charge of driving the workforce and doing what Naren has just talked about—looking at future demography, future disease patterns and future technologies, and feeding that in.

Although we were getting some traction in new staff, be they nurses, midwives or doctors, we were virtually getting no training as far as existing staff were concerned, apart from medics. This whole population

of staff who are working within the health service did not get any systematic training in relation to what was coming downstream.

We need a reform of regulation. We have far too many regulators—there are some nine of them working in this field. We need a huge reform of training. We need to ask questions about the length of training. What is the training for? What is it that we are trying to deliver a workforce to do? We need to fight to curb the power of the royal colleges, which are often seen as very wise, but in fact they are often a brake on innovation and change within the system. We also need to stop this business of constantly thinking in silos and to ask, "What are the health needs of the population? What are the skills that we need to meet that? How do we train people in order to meet those needs?" That means, quite frankly—and we have said this in the report—that there needs to be a far greater sense of generalism, whether that is in training medics, training nurses or supporting midwives, rather than going for ever more specialised services.

Lord Patel: It is a big task.

Lord Warner: I will add two specific points. The first point is about the evidence that we have about what the workforce should look like in 2035, given the likely disease and demographic profile in that period. It shows overwhelmingly that you need more healthcare assistants and people below professional qualification. It is not 10,000 more doctors; it is actually a different profile, because you need care staff, lower than medics, for the care threshold. There is no one planning for that at all, and there is no one really planning for the workforce required in social care, which is off there on one side—not really anybody's responsibility.

The second point is very specifically on regulation. The members of the GMC are beside themselves at the lack of any legislation to bring up to date the current system for regulating doctors. In that package, there is an absence of any regulatory system for what you might call the physician assistant or the nursing assistant. It is just not there. You need to have a proper regulatory system. You need legislation on those two issues.

Q16 **Dr Cameron:** You paint a picture of a reactive, rather than proactive, planning scenario, which is concerning. Did you pick up any additional concerns about the potential impact of Brexit on the workforce going forward, particularly regarding social care staffing, which is something that we have had evidence about previously? And you laughed at that question.

Lord Willis of Knaresborough: No—it is a very important question. When you look at the numbers of nurses who are registered with the Nursing and Midwifery Council who are working in the system—indeed, twice as many are working as care assistants throughout the system—if we cannot secure their future in the short to medium term, then we really have a problem on our hands.

However, I think there is a genuine attempt to be able to do that, so I am not quite as pessimistic about that, but we clearly say in the report that the overreliance on EU and, in fact, non-EU, staff throughout our health service is something that cannot go on. It is quite wrong, in my view, that we are denuding some of the poorest parts of the world of their specialist staff in order to supply people that we should be supplying ourselves. The report is quite clear that that has to be a primary objective as far as we are concerned.

Associated with that is this whole issue of retention. The fact is that, for every nurse we train, we lose one out the side. It is the leaky bucket syndrome. It costs £78,000 to train a nurse and, within the first three to five years, they have gone, because we are not looking after them. There is a whole issue of retention that is fundamental to the issue of growing our own and keeping them.

Q17 **Dr Cameron:** When you say that we are not looking after them, what do you mean by that? What do we need to be doing to look after them?

Lord Willis of Knaresborough: We have had pay restraint now for a significant number of years. We understand the reasons why that is the case, but it is hugely demoralising when you are losing staff. There are more than 50,000 vacancies for health-related staff at the moment. People are filling in. They are doing banks on top of their full-time jobs. They are being restrained in terms of their pay. They do not see an effective career structure looking forward. They do not see investment in their skills while they are working. Yet here we are, sitting here and saying, "We're going to have another revolution to do even more with you." You will not achieve that unless you get people looked after in the very basic sense. That is what John Lewis does, and it is what the NHS should do.

Dr Lisa Cameron: Thank you—that is helpful.

Lord Willis of Knaresborough: I am not a shareholder.

Lord Warner: Witness after witness came before us saying that morale among staff in the NHS was in a downward trajectory, getting steeper. No one came before us saying that the workforce is a happy, satisfied group of people who are pleased to be working for the NHS.

Lord Patel: You started with a Brexit question. Yes, it is true—we have this in numbers—that, if every nurse and doctor working in health and social care from the EU left, we would have a serious problem.

However, the important point is the one that Lord Willis made: in long-term planning, we need to start growing our own. There are various reasons why that is important. That is not in the report itself. Chris Whitty, the chief scientific officer at the Department of Health, has data about this. If you look at the demography of the population of the United Kingdom and, let us say, of France, Germany, Spain and Italy, it is quite

clear that, within 15 years, we will no longer be able to rely on a European health workforce to come here, because they will be short of it themselves, as the demography is different. In fact, ours is slightly better shaped than theirs.

Then we go back to where we used to get our doctors and nurses from before, which was the developing world. We should not ever contemplate that again, because that is draining them of their people. That world health workforce is at least 3 million to 5 million short. The fundamental thing is that we need a strategy that grows overall. That strategy has to make people want to work in the health service and must support them to work in the health service, as opposed to now, which is low-pay strategy for five years, with a morale issue and staffing level issues. That is what we meant when we said that somebody needs to do some long-term thinking.

Dr Cameron: Thank you—that is very helpful.

Q18 **Dr Caroline Johnson:** I should probably mention at this point that I am a member of the Royal College of Paediatrics and Child Health.

You talked about the need for integrated skill sets, and you said something that I strongly agree with. We have regulation for doctors and regulation for nurses and midwives. There are a number of new roles coming out, and I agree that we need to ensure that they are properly regulated, too.

We have also talked about the difference between the need for more generalists—Andrew mentioned the GIRFT programme, which often leads to increased specialisation. How do you think we should balance those two centrally competing objectives?

Lord Patel: It is true that we will need more generalists. At the same time, we will need specialists as specialties develop further into sub-specialisation. That has always been the case. However, if the pendulum swings too far, in that, if we have more and more in smaller and smaller areas of sub-specialisation, we end up needing more and more people doing smaller amounts of work. What therefore happens is that the generalist idea goes.

I refer again to the primary care model with primary care specialists. Who is the generalist at the end of the day? I go to my GP for all kinds of things if I want to; right? That is what he does.

So, yes, we need both, but more generalists is what is needed, particularly in certain specialisms. If you take my old specialty, obstetrics and gynaecology, we need large numbers of obstetricians and gynaecologists on the general side, but we need very few—my college is going to send me a letter tomorrow—in the very highly sub-specialist areas such as cancer or some area of foetal surgery or something. Most of it needs to be generalists. That is what we mean by generalists.

Lord Willis of Knaresborough: I have found in my work that a mental health nurse on a three-year graduate programme, for instance, was not able, in some cases, to treat a wound, because they had not done the general nursing. I found that general nursing had all the nurses, who could not deal with mental health issues. They had had less than one morning of training in a three-year graduate programme. That is clearly not right.

The trouble is that, when you say general, it is a sort of derogatory term in many ways. We want to see specialists. In fact, raising the level of generic skills so that people can go in all sorts of different directions at a later stage is clearly is in the interests of the individual as well as in those of the patients they are treating. We have to get that message over, however. We have to get a buy-in from the royal colleges, and indeed from other bodies that produce the training programmes—the HEIs, which are often wedded to things that they know best.

Q19 **Dr Caroline Johnson:** Do you think that that is more prevalent within the nursing profession, not because that individual mental health nurse couldn't treat the wound, but because the particular job description that she has means that she or he has not been signed off to do that particular role? I think that is more specific to nursing practice than to medical practice, where you train a general doctor in everything before you then specialise. Nurses specialise earlier, don't they, into mental health, children's nursing and adult nursing?

Lord Willis of Knaresborough: Yes, they do. I would certainly agree with you in that case. I cannot speak for the medical profession, but this is a cadre of staff who are fundamental to having what we are talking about: a more community-based healthcare system. You cannot have a situation where they do not have that sort of grounding in what I call whole-person care. There are children's nurses who really did not know a great deal about treating people in later life. When you are treating the child, you are often treating the family, as you well know, at the same time, because they are fundamental to the child's care.

Q20 **Rosie Cooper:** I would like to address the derogatory point. We have talked about nurses—

Lord Willis of Knaresborough: A sense of perception—it is not what it is.

Rosie Cooper: Well—I will perhaps talk a little bit more on that. It is indeed a perception, but we have talked about nurses, and I am now going to talk about consultants. I used to chair a women's hospital. It was very clear that I had two generalists who would go and do all the jobs that the hospital needed doing, but there were specialist consultants who saw those jobs as below them, and therefore they did not want to do them. It is not only derogatory in the sense of perceived, but there is an inbuilt thing whereby your status would derive from your level of specialism. How would you change that?

Lord Patel: That is the point about changing the culture. To change the culture, they need to understand the changing demography of disease patterns and who can deliver. Our recommendation, which was addressed to Health Education England, was to convene a group of all the bodies that are interested in workforce, training and so on to come under one umbrella and discuss what is needed, and how you are going to treat the people—unless you get that conversation that says, "I'm a super-specialist; therefore, I am superior to you." By the way, I never regarded them as superior. If we do not change that culture and if we regard being highly super-specialised as the thing to do, we will never get that culture change.

Q21 **Rosie Cooper:** Absolutely. My generalists were saints. We could not function without them.

Lord Patel: Lord Ribeiro, who is sitting behind me, was a surgeon by training, and he was a member of the Committee. I do not know whether he would regard himself as a bit more generalist, or as a specialist.

Lord Ribeiro: I would always consider myself a generalist. Part of the issue lies in ensuring that you have those who can see the wood for the trees, and we still need people who are able to do that, at whatever level.

Lord Patel: I am sorry to break the convention.

Chair: No—and you are very welcome to join us, Lord Ribeiro. I am not sure who it was who decided that it was going to be the three of you coming, but it is always welcome to have any member of your Committee coming here.

Lord Patel: Thank you.

Chair: So, do feel free to join us.

Q22 **Rosie Cooper:** We need to treat each person and all their skills equally.

Lord Patel: Yes.

Rosie Cooper: They are all part of the team.

Lord Patel: That is what Lord Willis was referring to. I think you referred to it in your report that you produced, about this multiskilling and who might do the multiskilling. Nurses and other professionals, if they are properly trained, can do highly specialised things—nurses in neonatal nursing do highly specialised things, which an average paediatrician probably couldn't do—that a neonatal paediatrician probably could. In my specialty, midwives could do highly specialised things that I was not able to do.

Lord Willis of Knaresborough: The issue that we brought up in the report is that nobody is leading this. Under the Health and Social Care Act, Health Education England should be doing it. I am a strong supporter of that proposal in the Act to set up Health Education England. We say in

our report that it has, in some ways, failed to deliver on what was expected of it—until you start to unpack that and you see that it does not have the authority at present to bring that together and drive it forward. The Committee thinks that it was really important to do that.

If we have a body that is responsible for delivering the generic workforce—and I mean that in its true sense, for locally based practice—it must have the authority to do it. We make it quite clear that it should be given an enhanced responsibility. There should be a clear duty to do that. It should have the budget in order to support that, and it should not be raided every time there is a shortage of resource. It was scandalous that training money was taken away last year in order to fill the revenue coffers elsewhere. You cannot do that if you want to ensure that you have a properly trained workforce.

Chair: Indeed. That was a point that the Committee also made in our report.

Lord Willis of Knaresborough: Indeed you did.

Lord Patel: We heard that from you when you were giving evidence.

Q23 **Chair:** I will make a point and I will then ask for your comments. Sometimes, when doctors want to change to more generalist specialties, to change from specialty training to general practice, they find it difficult to have their previous experience counted and to have that flexibility that was available to doctors of my generation. Yet each of the various bodies seems to blame each other for not allowing this to happen. It seems to me from your report that you are suggesting that somebody should be holding the reins, and that that should be Health Education England, which should be given greater powers to do that. Was that the view of the whole Committee?

Lord Patel: Yes, it was. It would give it more independence, and it would give it resources, so that the money is not taken away from it. We are giving it responsibility and authority, and the finance.

Chair: Yes. Thank you.

Lord Warner: Chair, could I make a plea for the sub-professionals? We found this very easy in the Committee. I am a layman; I do not have any of these professional qualifications. We found it very easy to slip into the business of the problems of the doctors and the nurses. If you look at the data, we need far more people below that level of professionalism. It is the failure of that system below the professions that is holding up the sustainability of health and care.

Chair: So, we should maintain our focus on that in the meantime.

Lord Patel: They do not have a voice.

Lord Warner: They do not have a voice. There is also the regulation of them. As a Minister, I did a lot of work on training people at sub-professional level. Nurse prescribing is a good example. Employers do not take them up on the scale to which we train nurses to prescribe.

We have a system that is rigidly drawn between the professional, qualified staff. When the public think about the NHS, they think about doctors and nurses; they do not think about all the other people who are running the health and care system. That is a very difficult issue to get right, because the system does not pay enough attention to those people we need, who are properly regulated, properly trained and properly employed at the level below nurses and doctors. Sorry for that pitch—

Q24 **Chair:** No, no. So, to try and paraphrase, you are saying that we are thinking too much about what the professionals want, rather than what the patients need.

Lord Warner: Yes.

Q25 **Dr Caroline Johnson:** We know how a lot of services run in regions, rather than in individual trusts, so, although patients may access an individual trust, the services are being run in a wider geographical area, often with the tertiary centre and what you would call the more specialist consultants leading those organisations. To what extent do you think that their desire to build their own services and grow their own super-specialist departments works against the generalist? Do you think that it works against generalists?

We have talked about the GIRFT programme and the degree to which a surgeon, perhaps one who has worked for 20 years in orthopaedic surgery, may have operated on a number of different joints, doing a number of different operations, and that has to some extent reduced—it certainly has in other specialties as well—as a result of the idea that you need to do so many procedures and see so many people with a particular condition before you can be deemed competent.

Given that, particularly in our smaller hospitals, those skills may not be kept up to date to an arbitrary number—and it is an arbitrary number, because you can have someone perform much fewer procedures well, and someone else may perform dozens and dozens of them—to what extent do you think this regionalisation of services contributes in a negative way towards generalists, or do you not think it does?

Lord Patel: It is not an issue that we investigated in the report, because we focused on major issues such as workforce. The comments are not based on our report.

It depends on how complex the treatment is, and therefore on how many procedures you would need to do before being regarded as competent. If it was highly complex, and you had only done 10 procedures, you would of course not have the competency to do that. Normally, you find that,

for a simple procedure, lots of people will be doing it, so they are the generalists. You do not have to have two people doing 1,000.

I will give you an example. It is personal. I had an intraventricular bleed in my eye. My retina was torn and detached. I needed to ensure that the person who was going to deal with me had treated a significant number of these. I am a doctor, so I would challenge that, wouldn't I? The ordinary public might not, however. However, for a cataract operation, there are thousands, and everybody doing them will have enough skill, because they will be doing hundreds of them.

Then you get highly specialised stuff—I was a high-risk obstetrician, so I saw only high-risk mothers. They were high risk either because of a foetal problem or because of a maternal problem. We did not need everybody to do that, because they would not have seen enough people among the number of patients. That allowed me—in fact, there were two of us—to develop the skills at the level required for me to be able to deal with that. Other consultants would refer patients to me. We would have super-regional centres—but we already have some. You would not have many centres for pancreatic surgery. We only have three in England. That is adequate, because it is highly complex surgery, and only so many people should do it. We should not have liver transplant centres everywhere, because they are highly specialised.

Q26 **Dr Caroline Johnson:** I understand that, but you seem to think that we have the balance right at the moment between those two objectives.

Lord Patel: Do we have the balance right? You have to look at the totality of the service you provide and the prevalence of the disease and so on, which changes from time to time. As I said earlier on, cardiovascular disease will change in incidence but not necessarily in prevalence. It depends on the changing nature as to which centres are required. We will always require some highly specialised centres, and we will require some centres that are below that level. Then, there are general ones. It depends on the size of the population.

Chair: Thank you for joining us, Lord Ribeiro.

Lord Ribeiro: Not at all—it is a pleasure.

You have mentioned Getting It Right First Time. Blowing my own trumpet, I note that Tim Briggs, who led that, used be an old registrar of mine. What he did with that project was get the evidence behind the need to concentrate the work among those who were able to do it.

The issue that I think Norman referred to, about centralisation and where the service is good, follows that. We have seen in the UK, for the past few years, a movement towards concentrating resources and expertise. That does not mean to say that you can get away with a generalist in the process as well; you can have that at a different level.

One of the things about Getting It Right First Time is that we must get

the profession to understand that what they are doing should be based on the evidence of the outcomes of the patient, rather than their belief of "I have always done it this way. Therefore I will carry on doing this." That is the real basis behind that.

Chair: I would now like to move on to the area of funding that you focused on in your report.

Q27 **Johnny Mercer:** "Funding" is a terribly dirty word, but, looking at the expenditure that we put out on health at the moment, what is it exactly? The OECD rejigging of the figures helps us, doesn't it? However, it also perhaps diminishes what we do in social care. Can you expand on that part of the report?

Lord Willis of Knaresborough: Lord Warner certainly can.

Johnny Mercer: Excellent.

Lord Warner: In the middle of our inquiry, the OECD changed the rules, so to speak, on how you measure it. That was not one of the most helpful things to happen. We had started off where we looked as though we were much lower in the league table, certainly as far as health is concerned, compared with where we ended up after the OECD identified it.

A wider general point was made about funding. On the evidence that we took, it was that the way that you raised the money was less important, often, than the way you spent the money. You had to have sufficiency, but, after you have some level of sufficiency of money into your system, the real difference often came from how you chose to spend it. Classically, that would be whether you had the balance right, putting it very simply, between hospital, non-hospital, medical and social care. Getting that balance right was as important as marginal changes or putting some more money in. That became true.

It also became true that international comparisons have a degree of limited value, because there is often something culturally different between countries. The really tricky bit is comparing our rather rigid separation of health and social care with some other countries, where nursing home care, for example, will be in their health budget, whereas nursing home care is in our social care budget. You had to be pretty cautious.

On the whole, however, it looks as though—Simon Stevens is now saying this—we are a bit behind Germany and France as a comparator. Where we ended up with the OECD was that you could not really lay all the claims about that shortage of money being the threat to the sustainability of healthcare. Where we ended up, as a Committee, was absolutely united that the biggest external threat was the failure to adequately fund social care over a long period of time. The beauty of it is that no one party can be blamed for it. It has gone on over a long time.

I direct the Committee to page 55 of our report, which shows the tracking of health and social care funding over 25 years. No one running a business would have these expenditures zig-zagging up and down like that, and the health and social care systems are not even zig-zagging in the same zig-zags. You have the most extraordinary profile of funding. No change to social insurance or private funding would change that profile of funding. Putting it brutally, it is barmy. No one would run any business on that basis, yet we have managed to run our health and care system on that basis. Simon Stevens put it very elegantly, that it is feast and famine. That is what we have done.

Lord Patel: He said sugar high and starvation.

Q28 **Johnny Mercer:** That comes back to what we were saying at the beginning on personnel and Ministers being in the job—about having that longevity and strategic vision around health and social care. That has ultimately inhibited our ability to supply.

Lord Warner: I lived as a Minister through a feast period. I was a Minister from 2003 to 2007. Money was coming into the NHS as though there was no tomorrow. Did the NHS transform itself? No, it did not. From my experience, the issue of how you spend the money is absolutely critical. That is where we have ended up.

Lord Patel: In his time, they got £40 billion extra.

Johnny Mercer: Right.

Lord Patel: Something like that.

Lord Warner: I am not here defending my position as a brilliant Minister in the Department of Health.

Johnny Mercer: Absolutely not. We would not ask you to do that.

Lord Warner: I allow my record to speak for itself, Chair.

Lord Patel: To come back to funding, we found that there was a lot of evidence given to us about the funding issue, as you can imagine. The evidence ranged from, "We need a 4% year-on-year increase in the healthcare budget," to something realistic.

In our whole report, we are quite realistic about it. We recognise the financial pressures, and we recognise other pressures. The recommendation that we made, number 17, was extremely important. It said: "To truly protect the sustainability of the NHS the Government needs to set out plans to increase health funding to match growing and foreseeable financial pressures more realistically. We recommend health spending beyond 2020 should increase at least in line with the growth." We say a similar thing—that social care funding should match the healthcare increases. Before that, we say that, in the short term, the Government may need to put in more money before 2020. It is realistic.

Removing this volatility is important, so that NHS England can plan better for the five to 10 years ahead. Even the Secretary of State agreed that, yes, we have got that wrong in the recent past, about volatility.

Lord Willis of Knaresborough: There are two caveats here. First, despite whatever we want to say about the OECD changes, there is a shortfall. We have actually spent less. On average, we have spent 3.7% since the beginning of the NHS. We have dropped down to roughly 1% since 2010, on average. You cannot take that cut without something else happening.

If, at the same time, we were transforming our systems and we were actually changing them—that is my second caveat. My first is that you have to raise it to a level at which you can then begin, attaching it to GDP in the future, for stability. I do not think that we are at that point yet, although we may well get to it in the budget, which is why they have not answered our report.

The second issue is that you must have the sorts of reforms that we have suggested in the report, which deliver different types of services in different formations in different locations in the future. Without that transformation, quite frankly, simply putting in more money will actually create more of a problem down the line.

Lord Patel: Remember that our report was on long-term sustainability, so it did not look at the current problems and pressures that the health service is facing—because everybody knows that. We do say that it probably needs more money in the short term.

Q29 **Johnny Mercer:** Is it even possible to say—you say we are below where we should be—what is the right level of expenditure? What is the answer to that?

Lord Warner: We have kind of skated over social care a bit. We made quite a thing about social care in the report.

Johnny Mercer: Presumably they are coming back—

Lord Warner: We are coming back to it. The social care issue is important. It is the one bit where we are in a bad place now for the future. We have got ourselves into a very bad place financially. That is because we have seen very real cuts in social care, going back to 2010, and there is no plan to fill the bucket up again. The plan is just to put just enough money into the bucket to stop total disaster happening. That is where we are.

Since 2010, we are talking about a 10% real-terms cut in social care, when the demography is going in the wrong direction. We have some major problems there. It is the one place where something has to happen now and in the next few years to take away the risk that the underfunding of social care poses to the NHS. The NHS is the carer of last resort. As the carer of last resort, if you neglect social care, people end

up in the NHS system who are stopping other people from getting into the NHS. That is the cause of the rationing, and it is often the cause of the underperformance of the NHS, because it has a lot of people in acute hospitals who actually shouldn't be there.

We have managed to create a situation where, in public policy terms, we have a lot of people in hospitals who shouldn't be there and don't want to be there, and it is the most expensive form of care. As a policy wonk, it takes some skill to get yourself into that position, which is what we have managed to do. Unless we tackle that, it is quite difficult to say what the adequacy of the funding for the NHS should be.

Johnny Mercer: That is a key indicator. In my hospital in Plymouth, on that patient transfer, they reckon they have a couple of wards-full of people who do not need to be there, and there are inherent problems with that.

We have talked a little bit about how that money is raised. Do you want me to go into hypothecated taxation?

Q30 **Chair:** Just before we go on to that, could I ask one thing? One of the complications is marrying up systems, one of which is free at the point of use and the other is means tested. You looked at various options for that in your report. Is there anything that any of you would like to add on that point, while you are here?

Lord Patel: We say that, because one is free at the point of use and the other one is not, whatever system emerges in the future, the comment comes up that it is likely that there will be some kind of means testing attached to it, unless they go for a national social insurance system—which I personally think needs seriously to be looked at. Also, one is administered by the local authority. We say that these are challenges, but we still think, in the recommendation that we make, that it is achievable, even with separate budgets, to make care integrated and to make the funding levels integrated.

Q31 **Chair:** The Government are currently proposing to have a social care Green Paper. Many of us have made the comment that we think it should be health and social care, because otherwise we just keep separating them. Would that be the view—that we should have health and social care together?

Lord Patel: We have that in the report. To make that achievable, we are suggesting that the Department of Health should be renamed the "Department of Health and Care." It is absolutely logical. If you go out on the street and say, "By the way, we have a Department of Health that doesn't actually look after your social care," people will say, "Why not?" It is only the politics that stops us from doing it. Then the budget will be one, and they can look at the totality of the budget and decide which side needs what in budgetary terms, and how best to spend it.

Q32 **Chair:** So, the Green Paper should be "Health and Social Care."

Lord Patel: Yes.

Lord Willis of Knaresborough: There is a fundamental problem here, which is a machinery-of-government problem: the funding of social care has been left with the Department for Communities and Local Government, and the policy on social care is with the Department of Health. In my experience as a civil servant, it is fairly unusual to have the policy in one department and the budgetary responsibility in another one. That is the machinery of government, however.

Lord Patel: It is an absolutely crazy policy.

Lord Warner: We say that we think that those budgets should be brought together at the very least in national terms, in one department, although we acknowledge that integrating budgets between health and social care locally is rather more tricky. We come out very strongly against using the precept as a way of propping up the social care budget.

The big point that I would like to leave you with in answer to your question, Chair, is that no one has come up with a system that produces a guaranteed stream of revenue going into social care that would cope with the demography and disease profile of the next 20 years. It isn't there. One has to be quite optimistic to think that the Green Paper is actually going to solve that problem. That is why we raised the issue that the Chairman has raised, of a social insurance system for social care—not for the NHS, for social care—where, if you follow the system in Japan, for example, people start contributing at middle age towards their long-term care costs. The Committee was united: we did not in any way say that you should move social care to a totally free system. Those who can afford to pay for their care should go on paying for their care, but they should not be absolutely at risk, individually, for what that care may cost.

Lord Willis of Knaresborough: But we do say that the German and Japanese systems should be looked at, and one hopes that, when the Green Paper comes out, it will float some ideas, with some serious discussion about how that element of non-taxpayer-funded social care is met.

Lord Patel: If we talk about people who need or might end up needing social care, if you are at my level of pension, for instance, I pay no national insurance, because I am not employed; but it seems ridiculous to me, and there must be millions of people like me who get benefits of all kinds just because they are older. They are cash rich, yet they pay no social insurance and no national insurance towards their social care. It makes no sense to me.

Yes, you can have a means test. If your old-age pension is not above a certain level, you don't pay towards your social insurance, but, if it is, you pay towards it at a designated percentage level.

Lord Willis of Knaresborough: In Japan they pay more.

Lord Patel: In Japan they pay 2.3%, and in Germany they have just raised it by 0.2%, so it is 2.2%. The benefits they give in Germany are slightly different from the benefits they give in Japan—in Japan it is much wider. In the German system, the Government say to the population, "This is what you will get for your social insurance. Above that, we advise you to take out insurance for other needs." That allows the insurance companies to come in and market their insurance. We do not have insurance companies marketing any kind of social insurance. I inquired, by the way, albeit not for the report—it is not in the report—what I will have to pay for insurance for them to guarantee me care if I needed it. They said to me that, if I paid up front, £250,000.

Lord Willis of Knaresborough: It is a drop in the ocean.

Lord Ribeiro: I am very glad that we were all pretty unanimous on the age of 40 as being the time when this should come in. The problem with the health service at the moment is the perception that it is free at the point of need, and our younger generation going through the system will expect to be cared for right till the very end. We need to start thinking that they are also responsible for their old age and for what happens subsequently.

Lord Patel: We do not make any recommendations about that. We just say that there is a German system and a Japanese system. We also make a remark about Dilnot and that the Green Paper should explore the German and Japanese systems and others. We do not make any recommendations related to that.

Q33 **Chair:** Do you feel there is a danger regarding one of the lessons learned from the election campaign—that, if you ever set out to people what they need to pay, you will be punished in the polls? Does that get in the way of political consensus building?

Lord Warner: Let me declare my interest as a member of the Dilnot commission. We were set up to solve a particular problem, which was that people should not have to dispose of all their assets to pay, in extreme cases, for their social care, so we proposed a cap. That does not solve the problem that I was mentioning of a guaranteed stream of revenue that meets the demographic needs of social care. It is a social justice measure that puts a cap on individual liability. Where we ended up, as a Committee, was that, without that guaranteed stream of revenue stretching into the 2020s and 2030s, you never solve the problem of how you fund long-term care, and you end up with crises all the time and trying to find some sticking plaster to sort of cope with it along the way. That is what we have now, for some time, been doing on social care—we are becoming quite good at it.

However, we would never solve the problem of how to keep the funding flow for social care in some kind of matching with the funding of the NHS. You have to do that if you want to keep a means-tested system going for social care, and the only way to avoid that is to transfer the whole lot into

the NHS, which has huge dead-weight costs, for all those people who are currently paying for their social care who suddenly get it free—you shift it all over.

So, no, we were never arguing for that, but we feel strongly that you have to find a way of producing a reliable stream of revenue as the population ages. We are not very good. We are good at life expectancy; we are rather less good at living healthily to the end of our life, which is part of the problem.

Q34 **Dr Cameron:** I have a question on funding and transparency. You have illustrated that putting in lots of extra money has not always given the increase in services in the past that had been hoped for at the time. I am wondering about transparency. Is it transparent enough where the money goes, and does it get to the frontline? Do you have any thoughts on that? Are we actually getting the money to clinicians on the frontline, be it in the NHS or in social care, to ensure that those posts are filled, or is the money being lost somewhere along the way?

Lord Patel: As part of our inquiry, we did not look to see whether the money gets in the right amounts to the people who need it. It was too detailed a task for us to do that. How did you do it when you were a Minister?

Lord Warner: I can tell you what we did. We got the NHS to really perform in its acute hospital service. The access system was brilliant. The NHS became very popular with the public, because the A&E performances and the cancer performances—all the performances of that system and even some of the performances of the GP, such as your access to the GP— improved.

I think it was pretty transparent where the money went, because it went to the huge improvement in access to services for people, particularly when they had cancer. The cancer performances showed dramatic improvements.

What it did not do was change the model of delivering care. It did not anticipate what needed to happen in primary care. Social care did not do too badly. We never really had an investment plan. It was not untransparent—it just never happened. There was no investment plan in community and health services. If I am honest about it, the GPs took the money and ran in 2003. I should not offend the GPs who may have been practising in 2003, but they got a jolly good deal in the 2003 GP contract, with no real incentives to change their practices that much. That is a kind of candid view of what happened when the money was around.

Lord Willis of Knaresborough: I think your question is hugely important. The Committee invited, and had, a number of witnesses, who came to talk about the outcomes in particular, asking what is being put into a particular hospital or a particular service, and what the outcomes

are for that resource. We saw some interesting new sorts of dashboards, which are occurring throughout the system.

I think that that work, the use of data and the way in which data are used effectively to drive up quality of services, is probably better than just crudely saying, "How much money do they get, and do they spend it?"—we have too many bean counters counting the same beans—rather than saying what the public actually want, "Does my hospital, my GP and my community service actually deliver really good outcomes for the resource that goes in?" That is a really interesting thing, which can be done, and it is why we put NHS England and NHS Improvement together, so that you can drive that, rather than seeing them as two separate entities. They are two sides of the same coin.

Lord Patel: Commissioning practice needs to improve, learn and mature a bit more, and to become a bit more expert at trying to commission care that delivers better outcomes. We all know that our outcomes are not as good as those of some other countries.

Chair: We are going to move on to another subject: innovation, technology and productivity.

Q35 **Dr Cameron:** This is a hugely important area and, for future sustainability, it is going to be key. Having worked in the NHS for a long time as a member of staff, I know that you are running to catch your tail all the time. How can innovation and technology improve sustainability in the future? What are the barriers? You said in the report that the NHS is slow in terms of the practice of innovation and taking it up. I would suggest that staff are so busy running to stand still that it is very difficult to learn new skills and to embrace innovation with motivation and positivity when you are trying to hold everything together at the same time. How will it make a difference? How can we make it manageable and feasible for staff who are already under such great demands?

Lord Patel: You are absolutely right. As you say, staff are trying to keep pace with the jobs that they have in patient care. The volume of it is great, and they are not able to catch up with it, so how are they then going to have time to adapt to innovation and go beyond that to become innovative themselves?

If you are going to have—and we must have—a health service that is good both at adapting to innovations and at doing innovations, we need to find a strategy that will allow that to happen and the staff to do that. Is it each and every member of staff who has to do that? Perhaps not, but there has to be some kind of strategy within each trust that allows that to happen.

Yes, staff will need time. That is what happens with our health service: we bring in an innovation but we do not train the staff. Then, when they make a mistake with it, we blame them for it. Some innovations require training. In my specialty, the biggest litigation risk that we have is in

obstetrics just now. We all know that. We know the figures. The settlements are also big. More often than not—90% of the time—they are related to misinterpretation of foetal heartbeat patterns. To train somebody to recognise foetal heartbeat patterns is not easy, and to train somebody to recognise them in the context of the particular individual patient is even more difficult. That is because we have not had time—we do not spend time—training people. Yet we do mind facing a huge litigation bill afterwards. We can cut that. With the new technology developing at an incredible rate, that innovation will come in, and we will need to pay people and train them properly.

There has to be a national strategy for how the NHS will adapt to innovation and become innovative. Within each trust, there must be a strategy, and a department that teaches people and brings in innovation. The value of this innovation should be in best practice, and it should deliver for the patients. We must do that, otherwise our health service will look like yesterday's health service.

Lord Willis of Knaresborough: We took some really good evidence on innovation, in particular from Professor Bell, who basically said that we ought to have a carrot-and-stick process. There are far too many flowers being allowed to bloom, many of which die before they can be picked because we do not have anyone to water them. That is very true. He was giving an example of what had happened in the States, particularly with the use of patient information and data systems supporting the patient information system. All of you who work within the health service will know about the huge variation in the use of patient data. One of the conclusions in the report is that nobody is driving technology and innovation within the health service. It is very much left to people at a relatively local level to adopt or not to adopt particular technologies.

If you take the use of big data, you are collecting absolutely masses of data within the health service on a daily basis. GPs are collecting a mass of data on a daily basis. The question is: why are we not making full use of those data? You cannot expect a hard-pressed workforce to suddenly say, "That is going to be my priority tomorrow," because it is not—it is their patients.

I was up in Birmingham last week, looking at how they are using data with genomic medicine—but not using NHS staff. They were using scientists—bioinformatic scientists and IT scientists—who were developing the algorithms to look at different patterns to supply to the clinicians to use in their practice. They need to look outside the box. Innovation has not been adopted and used by the existing people. There is a huge army of other people who can be brought in to serve and support those needs.

This goes back to the point that Lord Warner was making earlier, that we need to look beyond the traditional workforce in order to say, "Who actually supports this?" Genomic medicine will be mainstream within five

years. Are we expecting the whole of the NHS workforce to be trained in those particular areas? That is fanciful. However, there will be key people who will be able to do it, and there are people to help.

Lord Patel: The key point is that we need a leadership to embrace innovations. This morning, on the Science and Technology Committee, we took evidence about Sir John Bell's report on life sciences and industrial strategy from the NHS trust. If you have not done it already, you might do an inquiry on how many acute trusts are fully digital. If they are not digitised, they are never going to embrace the new innovations—genomics and others that come in.

Lord Willis of Knaresborough: Or the community.

Q36 **Dr Cameron:** It sounds like you are saying that, without true leadership, we are going to have a postcode lottery for patients, depending on where they are and who is taking up the mantle. That is obviously not good for patient care. The other issue is, if it is dependent upon areas or pockets of excellence, we will not have transfer. If a patient moves from one area to the next, how do their data move with them? How do we get that system in place? That should be happening. They should not move from having had excellent service in one place, then they move house and, all of a sudden, their data are lost; no one can access them. We are not innovating or using technology appropriately.

Lord Warner: That is because the NHS is a consequence-free zone. That was brought home to us very clearly by two witnesses. We have already mentioned Professor Bell. The other hero is Professor Muir Gray. I refer you to his quote in paragraph 266. It is worth reading: "I have brought along one of our atlases of variation, which we publish to destabilise the professions, to show huge variation: a fourfold variation in amputation"—and he goes on in that vein.

There is a link between the variation in performance and the take-up of innovation. The people who do not look at their performance against other people are usually the same people who do not take up innovation. What John Bell is saying is pretty much my point about the consequence-free zone: that there are no consequences for not taking account of innovation. He is a transatlantic man—he comes from Canada—and he was suggesting that we use money more, or the taking away of services, for people who do not change. The public want to go to the places that are higher performing. We can talk about leadership, in a sense, until we are blue in the face, but, at the end of the day, if there are no consequences for not changing, the only people who suffer are the public, who are on the receiving end of a substandard service in their particular community.

Some of this evidence is quite uncomfortable about the NHS. It requires a level of engagement by the senior management—political and non-political—to organise some consequences for people who are never going to change. Muir Gray was brutal about that. I can still remember it: "We

should lock 'em all up in a room at the local level to actually get their house in order." One jokes about it but, in a sense, he is right.

Lord Patel: All these things will be driven if you have leadership that says, "That is what we need to do with the NHS. That is what is going to happen."

Q37 **Maggie Throup:** You have already mentioned life sciences strategy, and I want to home in on that a bit more. The UK is world leading when it comes to life sciences, yet that does not translate into what we see in the NHS. You have touched on it, but can you take that a bit further? When we have it home grown, why are we not using it?

Lord Patel: This is not the report we are talking about.

Lord Willis of Knaresborough: So we can wax lyrical on this.

Lord Patel: Yesterday, we had a debate about science, innovation and industrial strategy. I used the phrase—I am quite pleased about using it, although I think I borrowed it from somebody else—we are good at converting money into ideas, but we are not good at converting ideas into money. We are actually extremely poor.

We have two universities now that are top of the league, Oxford and Cambridge. They are in the top 100 universities in the world. If you look at innovation universities, however, we are fewer in number. The first one ranks at number 13 in the world. Then we drop off rapidly, and we only have 12 in the top 100. Twelve is better than none, but none the less.

On life sciences strategy and innovation, we are poor at innovating. There are many reasons why we are not innovating. Take, for instance, Stanford, which is number 1 in innovation in the world. In the 1940s, it was regarded as a third-rate engineering school. This year, the alumni of Stanford University delivered $3 trillion to the economy, and they employ 5.4 million people. They are Google, Netflix, Hewlett Packard, Cisco and many others. Look at how they do innovation in universities: that is the problem we have—our universities do not seem to gear up. The universities in the UK themselves accept that they would like help now in asking, "How do we take our science to innovations?" We have to do that.

If the industrial strategy for the life science industries is to succeed, we need to become more innovative, and we need to have the NHS. If the NHS does not adapt to innovations or become innovative and engage with pharma and other industries to innovate, that strategy is not going to work.

Lord Willis of Knaresborough: It goes right from the beginning of what it says in our report. Unless you have somebody leading the innovation space within wherever it is—it would be NHS England and NHS Improvement and the new organisation—you will continue to have the difficulties of the adoption of technology.

It is far too localised at the moment. You want somebody to be able to appraise quickly and then go in. The people you talk to from leading universities, particularly with technologies rather than pharma, because technologies is something that we often ignore, say that they find immense difficulty even getting a foot in the door to talk about a new technology. They immediately go away with a sheet of paper of people they have to speak to before they can even come back. We really have to cut through all that. You don't see that in the States, but you do see it in some parts—not Dundee.

Lord Patel: Dundee is very good.

In evidence today, the chief executive of Birmingham hospitals gave a good example. They are fully digitised. Therefore, for outpatients, they have introduced people who are able to make appointments but also do video time, cutting down the number of people who have to come to the hospital for advice. The commissioners refuse to pay, because you are not seeing the patient. In the first year, she said that the trust lost £400,000 until they sorted out that it actually is seeing the patient, and is helping to cut down pollution and so on.

Q38 **Maggie Throup:** Lord Willis, you have already mentioned the workforce being in silos. When it comes to innovation, is that in silos, too? For example, there is innovation in primary care, but the money would traditionally have been spent in secondary care, so secondary care hangs on to that money and does not give it up. We need to break down those barriers. You have just spoken about Birmingham.

Lord Willis of Knaresborough: There is no doubt that there are those silos there as well. The further trouble with innovation is that, because we have such a devolved healthcare system, it is very difficult in a local patch just to get adoption. It is not just the money. However, once you get out of the major trusts, it is the devil's own job to get any sort of capital resource to experiment with innovation and bring it forward. You have to break through that.

There is John Bell's idea of carrot and stick and saying, "We will incentivise you, and, if you don't want to take up the incentive, that is quite in order, but you ain't getting any money."

Chair: Thank you. We will now move on to a section on public health.

Q39 **Luciana Berger:** Your report contains a number of very strong criticisms about the state of public health and prevention. You chose to catalogue them within the text of your report. Referring to some of the references, the OECD rep said that we were "poor on public health prevention" and there was reference to the view that "the Government does not take prevention and the sustainability of the NHS seriously." The word "failure" was used. Yet, also in your report, you took evidence from the Secretary of State, who sought to justify cuts to public health. You chose in your report to reject that analysis by the Secretary of State. Can you share

with us why that was? Also, what do you think it is going to take to prioritise prevention and keep people well?

Lord Patel: Good questions. There were time constraints on us. We were set up to take evidence about this time last year, and we had to report by March this year. It was a very short time. Despite that, we had about half a million words of written evidence, and we saw 100 witnesses.

I say all that just to be a bit defensive about the depth and breadth of our chapter on prevention. If Lord McColl was sitting behind me, you would have got chapter and verse from him, as he is passionate about it. He is particularly passionate about the lack of strategy to deal with our obesity problem. We are now No. 2 the world in the incidence of obesity—male, female and children. We are just behind the United States, which has serious problems, too. We have a lack of strategy for that. We have no obesity reduction strategy. We came out with a childhood obesity measure. The sole tag on that is a reduction in sugary drinks, and we do not know what effect that will have as yet, if any. We have no strategy for a reduction in alcohol usage. We have no strategy about how we will advise communities and help communities and individuals to stay healthy.

We have plenty of evidence that has said that, although the demography is shifting in age terms and we will live longer, it is a question of how many unhealthy years we will have, which will put pressures on our resources in all kinds of ways. It is the postponement of ill health that requires a strategy. The evidence was quite clear that we do not actually have a strategy of keeping people healthy. We need to engage with all kinds of industries to produce a strategy.

By the way, the Secretary of State accepted that a national campaign might help, but it is not something that is being done. The example used was the HIV campaign; I suppose you are too young to remember it, but the HIV campaign in the media was highly effective. That is where we are.

Lord Warner: Your original question was, "Why did we say what we said?" We were not convinced by what the Government told us.

Lord Patel: Yes—that is true.

Lord Warner: We were clear in the report. There was very confusing evidence given to us about whether the Public Health England budget had been cut or not cut. The overwhelming evidence was that, at national and local level, there have been cuts in the budget—not just flatlining, but cuts. A lot of documentary evidence was given to us. We were not convinced that the Government were actually serious about public health. The evidence we took before the child obesity White Paper was published blew it up. We were promised a document that was going to produce intergenerational change by the officials in the Department of Health. What came out was a poor imitation of anything that would produce

intergenerational change, and it was clearly a different document from what the Department of Health officials had been telling us was going to come out.

At that point in our proceedings, it would have taken a lot to convince us that there was a convincing story to tell about it. Of all the subject areas, for me, it was the area that was the least convincing of anything that we were told. That is the brutal truth.

Lord Patel: By the way, we also say that there needs to be a prevention strategy for mental health. That is pretty important, too.

Q40 **Luciana Berger:** That takes me to my next question. You rightly point out that we now have it enshrined in law that we should have this equality, this "parity of esteem" for mental health. You say that commissioners and regulators should have it as their "top priority" to go on that journey. Could you flesh that out, based on the evidence that you received? Was there anything specific that you think would make a difference to ensure that we are actively on the journey to achieving that?

Lord Patel: I am going to claim that the only thing I ever achieved in the years I have been in Parliament was winning a vote to make mental health equal in esteem to physical health, and you guys did not reverse it. That vote was won in the Lords. That is probably the only achievement that I will claim to have had.

Yes, we do say that about mental health, particularly a prevention strategy. There needs to be a strategy to do that—apart from other mental health services.

Lord Willis of Knaresborough: I agree with the analysis that Naren has made. I would make one proviso: that the Health and Social Care Act put the responsibility for public health back with local government. We certainly thought that that is the right place where it should be. If you are looking at other, broader strategies, with more community-based health, then prevention is part of that, and local government is certainly the right place to put it.

On this journey for parity of esteem, there is frankly a long way to go. We even found witnesses who came to our Committee—I remember one particular witness who said they had dropped that as an objective within the particular area where she was working. You would have to go back to the evidence to find out specifically who it was. There is a real worry about that.

I was recently working in Sheffield, looking at smoking cessation, which you would think was a public health objective right across the piece, and found out that, in mental health facilities, people could still smoke—both staff and patients. That is being driven out. We have produced a piece of evidence to say that their health was not affected.

There is a long way to go, but on this classic case of the epidemic of obesity, we have been given clear evidence that, within 10 or 15 years, it would drive phenomenal expenditure in the healthcare system. It is not simply a matter of getting people healthier; it is a huge time bomb in terms of resources that will have to be spent on looking after people who are suffering from being overweight.

Chair: Following on from an earlier point, the Committee will be holding a follow-up session on 21 November, looking in more detail at mental health funding, prevention, early intervention and so forth.

Q41 **Maggie Throup:** Let us go back to obesity, which, as you rightly say, is a ticking time bomb. We held an inquiry as well, and we came to the same conclusions: we need to be bold and brave. We were bitterly disappointed that the plan—rather than a strategy—was only 13 pages.

You mention in your report that there should be a cross-departmental, nationwide campaign. The way I interpreted it—I may have got it wrong—is that it is to do with the food outlets and that side of it. Do you think more should be done to target the advertising? I get a feeling that it was perhaps the Department for Culture, Media and Sport that changed some of the emphasis and watered down the plan, because that is income for advertising, too. How much pressure is being put on by the industry that needs to be overcome?

Lord Patel: Both are obviously required, but the reason why we came down with a recommendation about an interdepartmental Government-backed campaign was that it ends up targeting all the etiological factors of obesity: bad food, sugary food, sugary drinks and other products that are put in drinks that are obesogenic. It also produces the key advantage, which is education. If you educate the population, particularly children and young people, that being obese is a bad idea, and about what makes you obese—what you should therefore eat and not eat—that itself produces benefits in the long run.

Remember that we had a smoking campaign at one time, which said that smoking causes X, Y and Z in disease terms. I mentioned the HIV campaign earlier. A national interdepartmental campaign would have that benefit. The Secretary of State said that that is a good idea. He did not say, "I'll take it forward," but he did say it is a good idea.

Q42 **Maggie Throup:** We have obviously banned tobacco advertising on TV. Should we ban more—

Lord Patel: Yes, but doing it piecemeal, such as reducing sugar now—it has to be a campaign that addresses all the issues, including advertising.

Q43 **Luciana Berger:** Your report contains a number of different recommendations. I ask the Chairman, which of the recommendations—one or perhaps two of them—do you think are the most important? If those recommendations are not adopted, what do you think the repercussions are going to be for our NHS?

Lord Patel: If there is no long-term sustainable solution for social care, that will be a key thing. Of course, it similarly applies to workforce. If it does not happen with social care, that will affect the social care side and the healthcare side.

Chair: I should point out that there is a Division in the Lords. Do any of you need to go?

Lord Patel: A Division in the Lords?

Lord Ribeiro: I will probably need to go. I give my apologies.

Lord Warner: I have considered the matter carefully and decided not to vote.

Lord Patel: I did not know there was going to be a vote today. It is an ad hoc vote.

Chair: It is usually this side of the table that keeps people waiting for a Division.

Lord Patel: It is an ad hoc vote. I do not know what it is all about.

Chair: So, it is okay to finish off on these points.

Q44 **Andrew Selous:** I wanted to tease out what you say on patient responsibility, which I thought was a welcome part of your report. In your recommendation, you target quite a wide range of institutions and different people. You mention "children, young people, schools, colleges, further education institutions and employers." Could you say a little more about how you felt that should be rolled out? Should there perhaps be some explicit links about the future sustainability of the NHS built into that patient responsibility campaign?

Lord Patel: We did not go into depth as to how that should be rolled out. We do say that the constitution should be revised to indicate that this is the constitution that the health service—and perhaps the social care service—will deliver, but this is the addition: that you, the citizen, also have responsibility about X, Y and Z. That filters into the campaign about healthy living and the prevention of illness. I am not going as far as saying, "If you don't take care of yourself, X, Y and Z will happen to you." We just say, "If you do not take care of yourself, lifestyle diseases"—there are several, including 40% of the cancers—"are the risk you run, so you have a responsibility." At the same time, the state should have a responsibility to say how the state will assist people in keeping their health. All we are saying is that the constitution needs to include that and to be revised.

Lord Warner: We were also saying something a bit broader. If you look at the wording, we carefully used the phrase "the Government should," not "the Department of Health should." That was deliberate in the sense that that Department on its own could not drive this agenda. If I may put

it this way unkindly, the evidence of what happened to the child obesity White Paper suggested that the Department on its own could not drive that particular agenda.

It is important that, somewhere in the government machine, there is something more widespread and more coherent across government that engages with the public on health—and, on the other side of the coin, the Government have their responsibilities.

Q45 **Andrew Selous:** Did you look internationally at any campaigns that had been effective and that caught your eye in this area? There was the intervention with the HIV campaign in the UK previously, and anti-smoking campaigns, but is there anything that you would point to by way of nudging people to behave more responsibly?

Lord Warner: I was on the Science and Technology Committee, which produced a report on nudge some years ago. We took evidence from industry and all sorts of other people. That showed that the really successful campaigns had a mixture of regulation, education and nudging people. Road safety was one area. HIV/AIDS was another area. Smoking was another area. It was a mixed menu of activities by Government, which have produced changes of behaviour in the public over time. They all had the feature that they stuck at it for quite a long time. It was not a one-off initiative for a couple of months, and then it was forgotten. All those successful campaigns had stuck at this over a period of time across Governments. So it was not just one Government that owned it; it carried on being owned as a campaign if there was an election.

Lord Willis of Knaresborough: To be fair, we did not—

Lord Patel: Not an international comparison.

Lord Willis of Knaresborough: In terms of international comparisons, because this was a piece at the end of our work.

It is interesting. I took part in a discussion in my part of the world, where one trust had said that it was not going to treat particular people, because they were obese, and they had to lose weight before they would be treated. It did it for a whole set of reasons. What I found interesting about it was how we created a really good public debate, polarising those people who said, "You should be shot," and those who said that the trust was quite right. Getting that sort of public discourse right is very difficult indeed, however. Certainly, that was an extreme measure, which frankly had to be reversed, because the public would not stand for it, even though they thought it was right.

Q46 **Chair:** My final question to each of you is this. We will have the Secretary of State sitting where you are sitting next week. If you were sitting this side of the table, what would you want to ask him, following your report?

Lord Patel: I am quite clear about that. "Secretary of State, set up the office of health and care sustainability and you will leave that as your legacy."

Lord Willis of Knaresborough: I would say to him, "Give Health Education England the responsibility and the trust to deliver on transforming the workforce," and they will do it—I hope.

Lord Warner: A new secure stream of revenue for social care.

Chair: Thank you.

Lord Patel: Just tell him to do all three. That will be fine.

Chair: We will get him on the case next week. Thank you very much, and thank you for your fantastic report.