

Health and Social Care Committee

Oral evidence: Implications of the Budget for health and social care, HC 1712

Tuesday 20 November 2018

Ordered by the House of Commons to be published on 20 November 2018.

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

Questions 1 - 101

Witnesses

[I](#): Sally Gainsbury, Senior Policy Analyst, Nuffield Trust; Anita Charlesworth, Director of Research and Economics, Health Foundation; and Richard Murray, Director of Policy, The King's Fund.

[II](#): Jeanelle de Gruchy, President, Association of Directors of Public Health; Ian Dalton, Chief Executive, NHS Improvement; and Glen Garrod, President, Association of Directors of Adult Social Services.

Examination of witnesses

Witnesses: Sally Gainsbury, Anita Charlesworth and Richard Murray.

Q1 Chair: Welcome to our session, which is examining the implications of the Budget for health and social care. Welcome to our first panel and, Richard, congratulations on your new appointment. Could I ask you to introduce yourselves to those following from outside the room?

Sally Gainsbury: I am Sally Gainsbury, senior policy analyst at the Nuffield Trust think-tank.

Anita Charlesworth: I am Anita Charlesworth, director of research and economics at the Health Foundation.

Richard Murray: I am Richard Murray. I am currently director of policy at the King's Fund and chief executive designate.

Q2 Chair: Thank you. Could I start by looking at the discrepancy in the Budget Red Book between spending on the Department of Health and Social Care and NHS England? I know all of you have raised concerns about that discrepancy and what it means. Could I go first to Anita Charlesworth to give your overview of what it means for non-NHS England funding? Perhaps you can set out for those who are following this debate why it matters and what it means.

Anita Charlesworth: The Budget confirmed that for NHS England the allocation will increase by £20.5 billion in real terms by 2023-24 in line with the Prime Minister's commitment in the summer. In the summer, they had indicated that they knew that pension costs were going to be increased and that there would be some additional funding to meet those pension costs. Next year that is £1.25 billion for NHS England, and the Budget confirmed that that was added to the NHS England number.

The issue is that the Government said that decisions about departmental budgets are for the spending review, which will occur in 2019. There is some money in the Budget arithmetic for additional pension costs across Government, but they did not in the Budget commit firmly to increase the Department of Health allocation overall by that same £1.25 billion.

If they increase the Department of Health allocation next year, we are where we thought we were, which is still with issues around the budget for education and training, the public health grant and capital from that central pot in the Department of Health. If they do not increase it next year—the spending review will happen after the start of the financial year and is principally for allocations for 2020-21 onwards—it leaves the Department's central budget, broadly speaking, just over £1 billion short.

That budget covers things that are really important for the delivery of healthcare. It covers the budget for education and training, for new and existing staff to upskill. It covers, critically, the public health grant to local authorities, which funds things such as smoking cessation services



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and sexual health services, which are already being cut. Many of those things are really important, not just in their own right but for how efficiently you can spend money at the frontline of the NHS. If there are not enough staff, the NHS is forced to rely on agency staff, who are more expensive. There is a kind of double-whammy impact if that money is not forthcoming next year.

The Treasury could give the Department more money even now. We have not reached the point where they cannot add that total for next year, but the local government allocations for public health are due in December and Health Education England needs its budgets before the start of the financial year so that it can plan training places. They cannot leave it until the spending review, because they would push the Department into a position where it is setting budgets for its agencies that it does not have expenditure to cover, and that is not appropriate, obviously, for an accounting officer in the Department to do. It is not that it is impossible for them to do that, but time is running out, and it is perplexing that they would make clear that for NHS England they were going to do that, but not make clear that they were going to do it for the Department of Health.

Q3 Chair: Sally and Richard, do you want to add to that, or do you agree with that assessment?

Sally Gainsbury: We agree. I think what Anita is saying is that reductions to the Department of Health's much smaller budget have a direct impact on the frontline NHS, which of course is the bit of the NHS that the Treasury is trying to protect. For example, hospital trusts lost in the region of £50 million over the last two years in funding for education and training placements for nurses and medics. That is a direct hit on the hospital trusts, which, as we know, are currently in deficit.

In addition, we think there have been some substantial losses for R&D funding that came from Department of Health central budgets. For an NHS provider used to receiving about £1 billion a year in R&D funding, that has reduced, we think, by about £100 million over the last two years as well. That is another direct impact of reductions in the Department of Health budget, in addition to what we think is a real-terms reduction in health spending of around £100 million a year since the spending review in 2015.

Richard Murray: Remember that £1 billion against NHS total funding may not sound like a particularly big number, but the Department does not have many budgets left: public health and the training budget are the giants of the money that it has left, so £1.25 billion off that is a startling number. Even if you told HEE now that it was going to lose the money, whether it could bring down its spending fast enough or not is a moot point, so there is even a deliverability point about this; it is very late to tell people of quite a big shift in budget. We are all hoping that at some point early in the new year we will see the money reappear in the Department's budget.



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Q4 **Chair:** Are you particularly worried because of the amount of resource the DH is having to put into contingency planning in the event of a no-deal Brexit? It cannot cut that part of its resource, so do you see anywhere else it could take it from other than training and public health?

Richard Murray: It is hard to see where you would generate £1.25 billion, frankly. There are couple of ways in which the Department gets income. It can get income from the drugs companies through PPRS. There is a new PPRS deal coming, we expect. That may generate some money for the Department, but £1.25 billion is a striking number. As I say, it is big enough that it is questionable whether people such as HEE could bring its spending down that quickly, even if it tried to.

Q5 **Chair:** Last time we had this kind of transfer, it came from cutting bursaries, as I recall. There is absolutely no fat on the bone, is there, when it comes to HEE's budget now?

Richard Murray: No. Indeed, some of the funding we saw appear in the NHS for sustainability also came from the Department, so we think it has effectively cleared out all its own contingencies already, and there is nowhere else to go.

Q6 **Chair:** You cannot see anywhere else it could come from.

Richard Murray: No.

Q7 **Chair:** Do you think it would be better if some of the increased funding for the NHS went to other areas covered by the whole of the DH budget? In other words, should it be spread more fairly over things like public health, health education and training?

Richard Murray: It is slightly odd at the time you are constructing a long-term plan that the pieces you hold out of the long-term plan are public health, the training of the workforce and capital spending. The three things that you need to know about for the long term are the three things that are not there. You could use some of the money that will be given to NHS England to do that, but you need to be clear that it is not quite as generous as it appears if it starts picking up pressures in other parts of the health budget.

Q8 **Chair:** No, and the point has been made in evidence to us that it is not a 3.4% increase; it is more like a 2.7% average increase. Do you agree with that figure?

Anita Charlesworth: If the extra funding for pensions does not come through, it would be an increase of 2.7% a year on the whole health budget. That is below the estimate in the work we did with the IFS of the minimum you would need to stand still, which is 3.3% a year.

Q9 **Chair:** It is substantially lower.

Anita Charlesworth: Yes, it would be.

Chair: We are going to look in more detail at some of the other things



that might make it worse still.

- Q10 Rosie Cooper:** We are looking at inflation and at some of the things that have been written. Higher than expected inflation means that we are going to need something like another £260 million straight off from the Chancellor. You highlighted the fact that higher than expected inflation means the real-terms increase is now smaller than we had expected. How will higher than expected inflation on top of that hit health budgets in practice?

Anita Charlesworth: The Treasury has said that for the spending review it will reset the cash amount that it is going to give the Department of Health and NHS England up to 2023-24, so that in real terms it adds up to £20.5 billion, which was the Prime Minister's commitment. I think what it will do is this. The next set of economic and fiscal forecasts the OBR will produce will be in March, and they will set out inflation estimates at that time, including the GDP deflator, which is the inflation estimate that the Treasury uses for these purposes. We can expect that it will fix the amount at that point.

If the inflation estimates stay at the ones in the Budget, that is £260 million extra for 2019-20. It is £1 billion extra in 2022-23. That might sound like some micro-technicality, but we are saying that the treatment of pension costs and the treatment of inflation are not micro-technicalities. They produce big numbers, which are really important, bearing in mind as well that, when you add up the pressures on the system from the ageing population, rising chronic disease, rising input costs, because we are now having to pay higher pay awards and NHS pay is going up by more than inflation, certainly for Agenda for Change staff, there is less than £1 billion left from that announcement for purely discretionary purposes. If you move a little bit either way in what seems like a technicality, it has a very big impact on your ability to invest in change.

- Q11 Rosie Cooper:** If NHS inflation is ahead of economy-wide inflation, how does that factor in on top of all of that?

Anita Charlesworth: There are a couple of things. It is very difficult. They do not produce an NHS inflation index any more. There is pay, and pay has obviously been held down in recent years. We know now that, for the next three years, pay will rise by more than inflation. That is one reason for getting the £20 billion. Working out what is going to go on with drug costs is very difficult. As Richard said, the PPRS deal is up next year. We have always done quite well in negotiating that. NHS England and NICE have negotiated a new arrangement for drugs that will have a large impact on the budget of the NHS, to try to strengthen our negotiating hand.

We have done very well in the UK in the move to generics, but with the Brexit vote the pound has moved against us. We import a lot and industrial strategy post Brexit may mean that it is particularly important



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to us that we have a good and constructive relationship with the pharmaceutical industry, which is a very important contributor to economic growth and jobs. Quite how the drugs piece, which is the second big area of costs, will play out is quite difficult to know.

Richard Murray: This has happened before. I think the piece about healthcare inflation is not sleight of hand. It is always difficult to work that out, and the health service always carries a risk, particularly around pay, that it might move faster than economy-wide inflation. There is a particular set of uncertainties now, obviously, around some of the prices of other things, such as medicines.

Sally Gainsbury: We have done some estimates. For NHS Providers in particular, at the moment it looks as if expenditure is between £80 billion and £85 billion. Inflation for them over the next couple of years will be around 3%, so that is a full percentage point above whole economy inflation. When the Treasury talks about real-terms increases, the reference point is whole economy inflation, so there is roughly another £1 billion cost pressure on top of that.

As the others have said, there are some uncertainties around drug pricing, but the main change is obviously on the pay deal. There is substantial uncertainty, however, around the pay deal as well, because, although we know the headline cost of living increases, what we do not know is what impact the Agenda for Change pay deal will have on pay drift, which is how much pay expenditure goes up because people are rising through their pay bands.

As part of the pay deal, there has been a substantial change in pay bands. The point of the changes is to recruit and retain more staff. In very recent years, pay drift—the amount that pay goes up depending on people rising up—has actually been negative, because people have been leaving at the top of their band and replaced by people who are cheaper, and are either at the bottom of their band or in a lower band.

We now have a new deal, which, if it is successful, will stop that happening. Potentially, pay drift will stop being negative and will be substantially bigger. You might want to explore this with the Department of Health, but my understanding is that there is quite a wide difference in what the Department of Health estimates pay drift will be going forward, which is around 0.1%. I think its 10-year average has been about 0.6%, and some local modelling from trusts I have spoken to is nearer 1%. There is a difference of about £400 million in the cost implications for NHS Providers, so it is quite important to get to the bottom of it. Some of it is uncertain because we do not know how the pay deal will play out in practice.

Q12 **Rosie Cooper:** Can I ask all the panel what the health service can do to shield itself from higher than expected wage and price rises? Is there anything it can do to shield itself?



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Richard Murray: On pharmaceutical prices, yes; it is almost a monopoly buyer, and so as long as it uses that power well it can provide some degree of protection both from higher prices and from drugs that do not seem to work as well as we might want them to.

The Government can set pay. The thing to remember on pay is that the NHS also needs to be a good employer. If you reach a point where the combination of terms and conditions, pay and working life gets too bad, you drift into a workforce crisis. It is an awful lot more expensive getting out of a workforce crisis when you are in it than avoiding it in the first place. That is one of the risks we are facing.

Anita Charlesworth: On the pay front, one thing that is quite important to bear in mind is that, while the NHS Agenda for Change pay deal is funded as part of the settlement for NHS England, local authorities are very conscious that at the lower bands of the pay scale social care is often fishing for workers in the same pool as the NHS. In the NHS, for very good reason, this pay deal gives a big increase to the lower level starting salary of people in the NHS. The Association of Directors of Adult Social Services estimated that, if social care tried to match that, it would add £3 billion to the budget for social care.

There is no provision for the knock-on consequences, bearing in mind that there are already issues about high turnover problems, recruiting and reliance on an EU workforce. The Migration Advisory Committee in its advice to the Government on post-Brexit migration policy said very clearly that it was not minded to recommend a dedicated route for social care; they felt that the problem was in the pay and terms and conditions for social care staff. Fixing that is very expensive, and there is no margin in the amounts that are currently paid to providers for them to fix that.

Chair: We will probably explore that in more detail with our second panel, but thank you for raising it now.

Q13 **Mr Bradshaw:** Why do this Government keep cutting public health and social care, which save the NHS money? Why is there this Treasury fixation with giving what small increases there are to hospitals, which only ends up making the whole situation worse? What is the cultural problem, Anita?

Anita Charlesworth: I think there are two things. It has been easier to do in the short term.

Q14 **Mr Bradshaw:** Why is it easier?

Anita Charlesworth: In essence, you are caught between the devil and the deep blue sea; you have full A&Es and full hospitals from which you cannot discharge patients. That is a here and now emergency situation. You know that you are locked in a vicious cycle; there is a better way of delivering care fundamentally that would use resources better, but if you have constrained resources you cannot afford the double-running. You



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get stuck in a position where you are compounding the problem because you cannot see a way of breaking out of that vicious cycle.

We have been very ill-served by the language of the frontline. Creating a separate, so-called frontline NHS budget has underplayed the extent to which many of our public health services, such as health visiting, are absolutely what people would understand as core services; they are not discretionary add-ons. Some of that narrative has made it easier to appear to be cutting things that are a lesser priority.

- Q15 **Mr Bradshaw:** On your first explanation, the Treasury is full of extremely intelligent people; they are supposed to be the brightest Department in Whitehall. Why don't they understand that, or why can't the Health Department persuade them of the lunacy of their current approach?

Sally Gainsbury: In essence, it is a hand-to-mouth situation. Last year, £1 billion extra was allocated to social care to cope with winter pressures. NHS Improvement reckons that saved £21 million in delayed—so you spend £1 billion and you save £21 million. Of course, in a situation where budgets all over the place have been squeezed, you are maybe not going to spend another billion. The timescale for the payback is too far off.

- Q16 **Mr Bradshaw:** If you had £1 billion now, would you put it into social care?

Sally Gainsbury: Yes.

- Q17 **Mr Bradshaw:** You would. What is the impact going to be on the NHS of the ongoing future cuts to social care in terms of the NHS being able to deliver?

Richard Murray: The point of funding social care is that it is for people who need social care services. One of the things we get trapped in is the question of how much bang for your buck spending on social care can give the NHS. It focuses you back on to the A&E department. Older people who may be struggling to live a reasonable life really need social care. It is not just a means to help the NHS. I wanted to say that before going on.

It is quite difficult specifically to identify how cuts in social care hit the health service. I do not think anybody doubts that they do, but, in the short term, carers try to step in; they take the stress and the burden, and the health service might not see it immediately. When people arrive in A&E, it can be difficult to know why they got there. How can you track back what might be quite a complicated pathway of care? Although most people in the service absolutely believe in the link, it is tricky, I think, if you are sitting in the Treasury, to work out exactly how much it is worth if what you are focusing on is, "I just want to save the NHS; I am actually not that bothered about social care."



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As we have done with mental health, we have to raise the visibility of how important social care is, not only because of its links to the health service but because it is an end in itself. If you keep cutting it, and you keep cutting public health, we will continue to see emergency admissions to hospital rise. They will always rise, but you will get extra admissions to hospital because of that, even if it is not always easy to say whether it will be this year, next year or the year after; you get caught in the system on a treadmill.

It is not only about social care. We have seen staff levels in community health services shrink; we have seen the number of GPs shrink. Eventually, the system will give all the resource to the acute hospitals and you cannot cut them: their beds and the A&Es are full. It is trying to run a little bit faster to get ahead of the rise in demand.

Q18 Johnny Mercer: Can I challenge that briefly? I am sorry to jump in. I was up at my local hospital about three weeks ago and they gather all this data. In terms of, for example, the over-65s, they have seen a 14% increase just this summer. Concomitantly, we have seen the decline in social care. I think to say that the data is not available is slightly giving too much to the Treasury.

In layman's terms—Ben hit the nail on the head—where is the missing chip that says, actually, if you take all this money out of public funding, it is going to have a direct effect? You say admissions will go up. They will always go up, but they have never increased at the rate they are increasing now. Why are they still missing that pretty fundamental link? Is it a culture thing?

Richard Murray: I am sure it is partly a culture thing. It is partly about searching for the benefit for the NHS. You can quite easily make the case for the benefit of social care for social care. Again, at least at a statistical level in England, you get numbers like £1 billion in health generating £21 billion in savings. It does not really seem to stack up. It is quite a difficult piece of maths to do, even if everybody working in the service absolutely understands it.

The other tricky thing about social care—I am sure I am only telling you something you already know—is that a long-term solution to the funding of social care is quite hard. It has been elusive for more than one Government. If it was that easy, I am sure they would have done it. The temptation instead is just to top up each year, with £400 million here and £500 million there, to push the problem slightly down the road, but the problem, unfortunately, gets bigger.

Sally Gainsbury: The social care system we have is a social care system focused only on the most critical of needs. It is not a social care system that is preventive or looking at preventing loneliness or higher critical needs. That has been the case for the last decade.



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Anita Charlesworth: A really important point is that it is not just social care. Over the last few years, despite clear stated policy ambition to move all services to a more preventive, earlier intervention, community-based model, we have seen resources come away from primary care and move away from the community.

I am a former Treasury official, so, if I was thinking of one thing that my ex-colleagues were seeing, it would be that even if they gave money badged for prevention to try to rebalance that—they could argue that they led the way in the better care fund, for example—what would happen, even when they gave it in a dedicated way, would be that all the resource got sucked into acute. I do not think central Government are fully confident in the ability of the Department of Health and the NHS to direct any additional resource into the areas of service that they really need. The misalignment with workforce planning is one of the things that gives them anxiety, which I think is not completely unjustified.

Q19 **Dr Williams:** That brings us to public health funding. Isn't that a case for increasing the amount of money going to local authorities to deliver health visiting services, sexual health services and substance misuse services?

Anita Charlesworth: Yes. I think it clearly is. Richard's point is really important. Things like sexual health services and health visiting matter in their own right for the outcomes for people—the service users. They should not be measured purely in terms of their ability to reduce demand on the acute system. If we look at their cost-effectiveness, and the work of bodies such as NICE on the cost-effectiveness on public health services, it is very high. There is no logical basis for the scale of cuts that have been made to public health, and it is completely contrary to all the policy narrative that we have had for at least the last decade.

Q20 **Chair:** Let us bring in Richard and Sally as well.

Richard Murray: That is absolutely right. The only thing I would note is that when the Treasury has handed over the money, and the Department has hoped that some of it might go into better care or more preventive services, they have to meet the costs of the acute sector. To reflect the pain of the people who work in acute hospitals, they do not have their feet up on the table; they are deeply stressed and very busy.

Part of the problem is coming up with overly optimistic assumptions that the acute sector will suddenly be dramatically more efficient, and that one of the levers we pull in the community will suddenly cut the number of people going into hospital. They do not. They often take a bit more time to work; they are not quite as dramatic as that. You get presented with a slightly unreal set of numbers that assume the acute sector will shrink. It will not, and it has not. The money then gets drawn out of all the other pots to try to prop it up again.

Q21 **Dr Williams:** Of course, many of the benefits of public health spending



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are not felt in the acute sector, or indeed even in the health sector. My local chief constable tells me that money spent on substance misuse services makes the biggest impact on some of the levels of crime associated with substance dependency. What would need to happen for either the Treasury or the Department of Health to make that public health spend?

Sally Gainsbury: The overall budget needs to be larger, as Richard has just said. It is not that the acute sector has been particularly privileged. We have had almost a decade of hospitals being paid 4% less year after year in real terms. They have not been able to keep up with that. They have not been able to cut their costs by that amount, but that is what they have been trying to do, which is why they have ended up in deficit.

The reason why public health and social care, community services and primary care are underfunded is that the overall pot has not been big enough. It is not that there is a load of fat stuck in acute hospitals.

Richard Murray: You could meet the legitimate costs of the acute sector but then ensure that absolutely everything else gets swept into the community into the more preventive services, but if you met demand in the acute sector there is a risk that it will keep going. More additional services and more high-quality services are wonderful in their own right, absolutely; but once the core costs have been met, so that they can meet the demands of today, we should try to make sure that all the additional money and all the additional workforce go into trying to protect the future.

Q22 **Dr Williams:** Sally, do you think it is possible for the NHS to meet its stated aim of reducing demand through prevention before we know what the public health settlement is going to be for the next few years?

Sally Gainsbury: There are no funds for investing in that prevention. It does not make sense to reduce the demand curve without investing in that first.

Q23 **Dr Williams:** The Government have just announced their prevention strategy; we had a big statement last week or the week before. Is the problem that it is largely secondary prevention, or early detection, rather than primary prevention?

Anita Charlesworth: Yes. Among the biggest drivers of ill health, as the strategy recognised, are wider social determinants, so the relevant thing is not just spending on things that are badged as health, but spending on education and on community infrastructure.

You were talking about the issues for your chief constable. There is an impact from things like cuts to youth services. All those different activities shape the health need that presents itself. It is interesting, and a weakness in some of our debate and the way we do public spending reviews in the UK, that we conflate the NHS and health; we do not have a wide enough conceptualisation of health. In things such as the spending



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review, we do not think properly about all the different contributors to health and how our health needs are changing, and what that means for public services and welfare as a whole.

One of the things on which one could challenge the Department of Health and Social Care is that, although it has always been responsible for social care but it was not necessarily always very visible, it is a different thing to be a Department of Health as opposed to a department for the NHS. It has been a better department for the NHS than a Department of Health.

Q24 Dr Williams: On that note, thinking about the wider determinants of health, particularly the impact of income and of poverty on health, are there ways that the Chancellor could be better using the tax system to improve public health?

Richard Murray: One of the most impactful things on people's health has been the reduction in the use of tobacco. I am sure NHS stop-smoking services were helpful in that, but so was punitive taxation and steadily tightening regulation, which, to some extent, do not cost the public sector at all, and, if done right, can also be light touch on the private sector, although we do not always like regulation. It is opening out the conversation to say that there are some levers around spending.

Anita is absolutely right: the Department has been the department of the NHS. The mindset is, "How can I use NHS staff to impact on prevention?" They should think that, but they do not always think about the full range of levers, many of which are held by the Treasury or other Government Departments. Let's face it: the impressive success of the sugary drinks levy has not forced people to think through difficult decisions about changing their diet, although perhaps it is what we want them to do; it just led many of the companies to reformulate their drinks and nobody notices that the sugar content has gone down. That was quite an innovative policy.

What the Secretary of State said last week—the vision—is that a Green Paper is coming. What we really want in that Green Paper is thinking about some of the spending levers, and thinking about how other parts of the public sector think about health and how health thinks about them. We need those other levers, the things that really worked on tobacco and the things that appear to have worked on sugary drinks, so that we do not get trapped purely into a conversation on spending, partly because I fear that the NHS, where a lot of that money would get spent if you are using money, probably does not have the staff to do it anyway, not quickly.

Q25 Dr Williams: Some public health spend tries to alleviate health inequalities. What evidence is there that inequalities are fuelling the demand for NHS services?

Anita Charlesworth: There is a gap in life expectancy, obviously, between those in highest income groups and those in lowest income



groups, but the bigger gap is in healthy life expectancy. Healthy life expectancy for people in the lowest decile is something like 18 years below life expectancy—I will write to you with the right numbers—so a substantial group of people are living with multiple chronic conditions and very difficult social circumstances that make the delivery of care more challenging. We have a resource allocation formula in the NHS that tries to move money around to reflect that.

That is also one of the areas where thinking more broadly across Government is important, because the lowest in the income distribution, at least 30% or 40%, have a healthy life expectancy that is way below the pension age. You have the impact on the health service of higher need, but also people whose ability to work is affected, which impacts them now, and impacts the Treasury now, in benefit payments. It also means that they are not in a position to make provision for their own old age and retirement. That is lose-lose, very clearly.

There is a strong case to be made for a focus on inequalities, and we really hope that the new long-term plan will meet that. It is the right thing to do in terms of social justice and it makes absolute economic sense.

Sally Gainsbury: We have an allocation formula that will nominally send more money to areas of higher deprivation, or at least they have a higher allocation target, but the problem we have had in recent years is that, because the overall funding increases each year have been so small, it has not been possible to send more money to those poorer areas.

The only way you could do that would be to cut the allocations of areas that are nominally overfunded, and I do not think any of you would like your constituency to be one of the areas with actual cuts. There has been a principle that everyone has had a similar baseline uplift, and the extra headroom that was available for giving more to poorer areas, which are acknowledged as poorer and needing more funding, has not been there, so that has not happened.

Q26 **Chair:** Before we leave prevention, Richard, I know the King's Fund has done quite a lot on social prescribing, and I have just come from a meeting with a group called Dance in Devon that does fantastic work on falls prevention through exercises and dance. Where do you think the funding for social prescribing schemes, and voluntary services doing fantastic preventive work, should best come from? Should it come from CCG budgets or public health budgets? Where do you see the future for that?

Richard Murray: In a practical sense, it is probably only the CCGs that have the financial depth to do it at the moment. After all we have said about the problems in some of the public health budgets, looking to them to do it on their own is a big ask. We asked the Secretary of State whether he was happy to see NHS money going to help support those schemes, and he said, absolutely, yes. They probably do not need much



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money, but they need some. They need a bit of seed funding to get them off the ground, particularly given some of the real enthusiasm we have seen for them among GPs.

For many GPs, it ends up being very stressful having patients sitting in front of them whom they cannot help. They know patients are suffering from social isolation, and they are trying to medicalise something for which a medical solution is not necessarily the right thing. It needs a bit of seed funding to be confident that the programmes work, and confident that people are attending things that are okay and safe. I do not think it is much investment, but it needs to come, and at the moment only the CCGs have the room for manoeuvre.

Q27 **Chair:** You would like to see that happen as well.

Richard Murray: Yes.

Q28 **Andrew Selous:** We know the capital budget has been raided to balance the books in previous years. What is your assessment of the impact that has had on the NHS?

Richard Murray: If you only did it once, you could probably manage it. The problem with raiding the capital budget is when you do it too many years in a row, particularly when you then attempt to manage down capital spending in NHS Providers. For obvious reasons, you begin to build up a backlog of maintenance, and that begins to move into essential maintenance, so we have two things now. One is effectively a hygiene issue for some providers, so they really need the money spent. It is great having incentive schemes that try to support STPs and ICSs, but, if your hospital is falling down, there is a pretty clear case that you need to put some money into it.

The other thing, particularly for the long term, is that we need a bit more confidence about where the capital revenues, capital spending, are coming from, because at least some of the changes might need investment at local level, particularly in developing community services, which are often quite light on capital. It is not necessarily a very big number, but it might be more than we have at the moment.

The Naylor review pointed out that you could get it from more than one source—the taxpayer is one—but there are some more innovative schemes about making the most of the NHS estate. Don't just sell it: knock it down and build something really big that has a private sector tenant in it and use part of the building for the NHS. A bit more imagination around the use of the NHS estate could also generate large sums of money.

Q29 **Andrew Selous:** I note from our figures that there is an £800 million increase from 2018-19 to 2019-20, and a further £100 million from 2019-20 to 2020-21, which is good to see, so it is moving in the right direction. Do you think there is a case for ring-fencing it now that the backlog of maintenance and so on has become so significant? It has been



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an easy target, hasn't it, in previous years?

Richard Murray: The NHS cannot just move capital money to revenue. It needs Treasury permission, so it is not something the NHS has done that you could then ring-fence. The capital budget is ring-fenced, but the problem is that the ring fence keeps moving. If the Government move the ring fence, the NHS makes the most of the money.

I would like to think that that increase is there, but, looking back over the last five years at this point in the financial cycle, it was always there, and then it gets cut in-year, so it always looks like next year there is going to be a big increase in capital spending that in fact does not materialise and has not materialised now. So we need a bit more clarity that the money is there and to find a way to commit to it. As I said, the capital budget is supposed to be ring-fenced as it is, but it has not really materialised.

Q30 **Andrew Selous:** I do not quite understand that. For 2018-19, we have £5.9 billion of capital DEL spend, and that goes up to £6.7 billion for 2019-20. Are you saying that that may not materialise?

Richard Murray: Yes.

Anita Charlesworth: I think it means that they have shifted money from in-year if the day-to-day resource budget is under pressure. What the Treasury agrees to do to the Department of Health is take some of the money out of the capital budget and move it into the resource budget. We are not confident that it will not happen again next year.

Q31 **Andrew Selous:** It goes back to the ring fence really, doesn't it?

Anita Charlesworth: Yes.

Q32 **Andrew Selous:** You would be in favour of that, would you, given the backlogs?

Anita Charlesworth: Yes. It is also worth not just thinking about whether we can protect the overall capital budget; very importantly, there needs to be a capital plan to sit alongside, as part of the long-term plan. There needs to be a serious look at the way we allocate capital and at the priorities for investment in capital. There is a clear issue around maintenance, but often the places that most need some of the capital investment need relatively small-scale capital investment to unlock improvements in the way care is delivered.

To give you an example, lots of clinicians will say that there are many services delivered at the moment as day cases, which, if outpatient departments were configured differently, they could do on an outpatient basis. You need some money to reconfigure the outpatient department. The places that have access to the capital spending are not necessarily the places with the greatest need, so they need to look root and branch at how they allocate and prioritise capital.

Q33 **Andrew Selous:** What about borrowing to invest? We have some figures



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in our brief that the UK only has 9.5 CT scanners per million of population compared with an EU 15 average of 24.1, and so too for MRIs; we have 7.2 per million as opposed to 17.2 for the EU 15 average. If trusts were allowed to borrow to scale up, would there be an efficiency payback in relation to their tariff payments?

Richard Murray: The challenge has always been, "Borrow from whom?" If you attempted to get trusts borrowing from private banks, private banks would want security, and never in the NHS has anyone been willing to give them the security they would need to lend in the first place; they cannot come in and repossess NHS property.

The service has also struggled under PFI. The Government can borrow quite cheaply. Trusts are effectively part of the public sector; their borrowing scores against national spending and national debt, so it has been quite difficult not to use the publicly funded route. Yes, borrow to invest, but do not necessarily make each trust do it on their own.

Q34 **Andrew Selous:** You mentioned PFI, which I am going to come to next. I think, Anita, you expressed some worries that the freeze on PFI could present some challenges to the capital budget, but I note that the annual repayments are around £2 billion a year, so PFI has come at quite a significant annual cost, hasn't it? We were talking about a missing £1 billion earlier. We could do quite a lot with £2 billion a year to plug some of those holes. We got lots of shiny buildings in the past and we now have a significant annual price tag for them, don't we?

Anita Charlesworth: Yes, there are some hospitals, undoubtedly, whose PFI arrangement is a major challenge for them. NHS Improvement—I know Ian Dalton will be here afterwards—has been trying to work quite hard through the finance regime to provide solutions for some of those providers. This is a not very popular thing to say, but there are good and bad PFIs, and not all of them are a problem for the NHS. I would not argue necessarily that we should have a new big round of PFI, or that the Government's decision was wrong. I simply note that the capital plan was predicated on that, so we have to come up with an alternative.

Richard's earlier point cannot be stated too much. The NHS is being pushed to sell estate. I firmly think that the bigger issue is poor utilisation of estate. It is not clear that selling estate is always optimal. I used to be on the board of an NHS trust that is fairly close to central London, and, if you wanted to know which buildings we owned, you just had to walk around: we were the only single-storey buildings in our zone. As Richard was saying, you can redevelop. There are links to things that people have been talking about—using the asset base much better for things such as accommodation for staff. We need a much more imaginative approach to capital.

Q35 **Andrew Selous:** You think we are going to need those innovative approaches to plug the gap.



Anita Charlesworth: Absolutely. It is very difficult at the moment. For individual NHS boards, the expertise and the timelines you need to do those sorts of things are not easily available, so it is about how we get the capacity and capability to be really good at managing our estate.

Q36 **Andrew Selous:** You mentioned the Naylor review earlier. During the general election last year, there was some political controversy around Naylor, wasn't there? What you are suggesting sounds quite sensible. This is all money that comes back into the NHS. It is just an extra revenue stream from existing public estate, with the income coming back into the health service. You would not see that as politically contentious.

Sally Gainsbury: It sounds sensible as long as the Treasury agrees that it is additional cash. One of the reasons why this does not exist already—there are lots of other reasons—is that at the moment, if the NHS started earning a substantial income stream from its estate, the Treasury would say two years later, “Okay, we'll take that off what we give you,” because, after all, it is trying to save the taxpayer money. One way to incentivise it would be to ensure that it is additional cash. I do not know how you hardwire that into Treasury thinking.

Q37 **Johnny Mercer:** Can I talk about mental health briefly? This Government are committed to parity of esteem for physical and mental health spending. They say that, through the amount they are increasing physical health expenditure, they will also be increasing mental health expenditure. Do you think that is a good way of measuring mental health services, and, if not, what is a better way of doing so?

Richard Murray: I was around in the system as we brought in 18 weeks and the four-hour target. You did not ask providers how much money they had spent on it; you asked them whether they had done it. In mental health, we do not have a reasonable, broad-based measure of good-quality service. Without that, we fall back on to trying to measure the money, so you could put more money in and find that it was poorly spent.

Q38 **Johnny Mercer:** Why don't we have a good, qualitative marking system?

Richard Murray: It is harder. Mental illness is a long-term condition. It involves very different degrees of severity. I do not think it is impossible; it is just much more complicated. It has never been given the attention it needs to try to sort out how we would measure what is good and what is bad. It was done a bit under the national service framework, with big central budgets and a lot of experts running the system. You can do it that way, but it is not really the way we do things these days. Without that, measuring the money is a kind of second best. I would not say stop doing it, but you have to realise that it does not really say, “Are the costs of mental health going up quicker? What would be the right number for mental health?” If you have cut mental health for the last four years, perhaps the money should be going in faster.

Q39 **Johnny Mercer:** Exactly. In communities like mine in Plymouth, if you



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want to judge how the mental health service is doing and you start talking about how much money you are putting in, it makes the situation a bit worse for the mental health community because they feel, "You say you are putting this in, but it doesn't feel that way to me, trying to get increased access to psychological therapies for my schizophrenic son," or whatever it may be. How do we find a measure in the middle so that we can hold the Government to account on how far they have gone along that journey of parity of esteem?

Richard Murray: You could use a series of measures of access to psychological therapies. What you absolutely need alongside that is a robust measure, which again I do not think is impossible to do, for acute mental illness.

One of the problems with investing more in psychological therapies, which is a very good thing to do, is that the service did it by pinching money from other parts of mental health services; it recycled money within the system. It did not genuinely put more money into the service. You can see it through the workforce numbers; they tended to go down, although they are stable now.

Could I name what the outcome measures are at the moment? No. I could name some of them. We know things about out-of-area transfers. We know things about access to psychological therapies and—

Q40 **Johnny Mercer:** A transfer is a tangible, measurable output, isn't it? If people are travelling 600 miles from Plymouth to Leeds to get access to mental health treatment, clearly that is unacceptable. Anita, what would you say?

Anita Charlesworth: There are two things. It is important to challenge the Department on the priority it attaches to putting in place proper measures, because, as Richard points out, when the 18-week target was first introduced, we could not measure it. We did not have measures all along the pathway, and they had to be created. Establishment of the target was one of the things that led a push for much better measures of how long. We knew how many people were on the waiting lists and we knew bits of the pathway—how long they might be waiting from this bit to that bit—but a meaningful measure of their waiting time was not available.

Part of it is another reflection of our priorities. We just have not made tracking what is important to people in mental health a priority. When I look for the money, I cannot track it all through the system. I cannot see where all the money has gone on mental health. The thing that will be most important for really improving quality of care is the workforce. It is having the people there. In the medium term, I would put most effort into tracking the mental health workforce; if there are workers, you can deliver.

Q41 **Johnny Mercer:** There is one way of measuring it. When a young person



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reports to their GP with mental health problems, there is a way of measuring how long they have to wait for their first contact with the mental health system. Why are we not measuring that in terms of viable outcomes?

Richard Murray: I do not know why we are not measuring it. I think it is a great thing to do. More measures in mental health are better. Do make sure that the resourcing is there behind it, because if the resourcing is not there—

Q42 **Johnny Mercer:** You follow the data. This is basic stuff, and I have literally just thought of that. This is really basic stuff.

Richard Murray: It is, as long as the staff are there, as Anita said. If you push the service into trying to game the target, they will ultimately do it, and we know in some areas of mental health services, including for children, that, if you miss an appointment, they kick you right off the list and send you to the back again. There are ways to game targets. That is one of the problems with them; they are not a be-all and end-all. But, absolutely, I think—

Q43 **Johnny Mercer:** We as politicians are ultimately the ones who go out and get a hard time for there not being mental health services. Don't get me wrong. The people who really suffer in this are the users, but we get held to account for it as well. There could be something tangible like waiting times. The Government, rightly, will say "We are putting more money into this," but, if they are not meeting targets, it gives us an insight into how to do that. I do not understand. You have cancer waiting times—it is really basic stuff—so why do you not have mental health waiting times?

Richard Murray: Indeed, we are trying to develop them. They exist. The bit that we are missing is particularly around some of the more acute mental health conditions. I think they should be there.

Q44 **Johnny Mercer:** Sally, do you have anything to add?

Sally Gainsbury: I have nothing to add to what my colleagues have said.

Q45 **Johnny Mercer:** What do you think of ring-fencing mental health spending? Simon Stevens comes in here and says, "I do not want to ring-fence mental health spending because it is ultimately going to be detrimental to what we are trying to do." There are others who think we should, and then there are people like me who are fairly agnostic and in the middle. What is your view?

Anita Charlesworth: I am torn. The introduction of the IAPT programme almost certainly only made the progress it did by being ring-fenced very tightly and centrally driven. If that had not happened, there would have been change, but would there have been the same scale of change? Against that, one of the things that is so important in the debate about mental health is that we do not see mental health as a



separate, disconnected service. We want to integrate mental health services with physical health, so that we look at people and treat all their conditions as a whole. We want workers who think about the physical health of patients who appear to have presented with mental health problems, but equally people with long-term physical conditions often have a mental health problem, and we want them treated in an integrated way.

One risk with ring-fencing is that it moves back that agenda. There are probably ways, if you really pushed, to measure activity, outcomes and workforce properly, where you can achieve many of the objectives of ring-fencing without the downside of ring-fencing, but it means that you need concerted action on all those things, and absolute transparency. I commend to you an NAO report on mental health that shows how far we have to go on all of that.

Richard Murray: I am probably in the same place. My experience of ring-fencing if you are doing it in the NHS is that it can be a charter for accountants, and you will get endless battles over which side of the line the spending falls: is it really health, is it really mental health, or is it really social care? I get that the broad measure of the resources going in is particularly workforce—remember that in mental health the workforce is a much higher share of overall spending than it is in acute services. A measure of access and a measure of outcomes would be better than trying to invest in a really detailed system of ring-fencing.

Johnny Mercer: Thank you.

Q46 **Chair:** This is the final section. I want to ask you a bit more about workforce. I know Richard at the King's Fund has done quite a lot on this and has commented that the workforce crisis is more pressing than the financial crisis, if anything. When we are looking at the long-term plan and the money that is being invested from the Budget, how do you feel we can best spend it in terms of the workforce? Should we be focusing on retention or recruitment? Where do you feel the real gap is?

Richard Murray: My colleagues from the other two foundations think exactly the same as we do. It was a joint statement that workforce is the key. I would not pull one lever. We are in such a state on the workforce, particularly as more money comes into the system, that we need to pull all the levers at the same time. That should not be beyond the system. It has done it before.

It will be looking at training, which admittedly, is a fairly long-term play; and at recruitment. Why are so many people who qualify not showing up in either the NHS or private healthcare services with a job? It will look at retention. What can we do with the skill mix? Not every profession is in shortage. Particularly in primary care, there are pharmacists and physiotherapists we could use to take up some of the burden, which is absolutely within their skill set. We should be ready to do international recruitment. Many people do not like the international recruitment side,



but if you want to do something quickly, to take some of the pressure off existing staff and try to get their workloads manageable, it would be truly key in retention. We must be ready to use the international lever in a way we have not done for a while.

- Q47 **Chair:** Are you concerned about the Prime Minister's comments the other day about international recruitment and immigration? Clearly, if you cannot recruit from the EU so easily, you are adding huge bureaucratic costs. At the moment, there are relatively few bureaucratic costs in recruiting from the EU. What will be the impact on total costs for the NHS if those bureaucratic costs are increased following Britain's leaving the European Union?

Richard Murray: If we carry on with the present system, where each individual organisation largely has a go at international recruitment by itself—there are one or two exceptions where that is not what we do—you will find they do not do it. It is too expensive. It is difficult showing up in New Delhi or Manila to try to recruit staff. It is not an easy thing for each individual organisation to do.

I fear that the worst possible outcome is that we will choke off a lot of the potential supply that the United Kingdom could still get. It is about finding an easy way through the existing system of migration rules, immigration rules and visas, being clear with the professional regulators as to how they handle some of the migrants coming in and helping NHS employers to do it. Expecting each individual organisation largely to have a go at it themselves is not the way to bring people in.

- Q48 **Chair:** Should there be central recruitment?

Richard Murray: It could be centrally supported. It could be regionally run. We know that Andrew Foster in the north of England runs it on a bigger footprint and is very successful at bringing in staff, and has the expertise and resource to do it. It is not easy but you can bring in people quite quickly.

- Q49 **Chair:** In looking at the extra costs, not just financial but bureaucratic, could you give us an idea of how much more expensive it is to recruit someone from outside the European Union than it currently is within the European Union, and what that will add if all the current EU staff, in future, have to go through those bureaucratic hurdles? Can you give us an idea of the extra cost?

Richard Murray: We would have to look at that. We have a number for the average cost, but I do not have the breakdown. We would have to write to you with that information.

- Q50 **Chair:** I would find that very helpful because it is a concern, not just physically getting out there and doing it, but the extra bureaucracy and the issue around the £30,000 threshold.

Richard Murray: That won't work.



Q51 **Chair:** Certainly for social care staff. Let me bring in Sally and Anita on that point.

Sally Gainsbury: Anita, you are the co-author of the report.

Anita Charlesworth: Yes. An awful lot of the staff we have at the moment in both NHS and social care would not be earning £30,000 on arrival. It is not the case in the NHS that pay exactly maps to skills shortages, which is the underlying ethos. We have some key skill shortages below £30,000. That threshold would undoubtedly be problematic.

To add to what Richard said, beyond the individual measures, which are really important, it is clear that for at least the next decade—I struggle to think of a scenario for health and social care where this is not true—we will have to be incredibly good at workforce planning, deployment and strategy at the national level and locally. Our system for doing that, our capability, skills and capacity, is nowhere near strong enough at any level of the system. Clearly, the long-term plan needs to think about individual policy areas and coherence within the workforce, but it also needs to look across the system at how we manage the vital area of health service policy and delivery.

Q52 **Chair:** The impact on the HEE budget will be significant if it is cut to top up NHS England.

Anita Charlesworth: Yes.

Q53 **Dr Williams:** On international recruitment, you talked about NHS Providers, but I presume you were not talking about general practice. There was a plan to bring in 5,000 extra GPs. Would you like to reflect on that?

Richard Murray: You could bring in 5,000 GPs if you made the timescale incredibly long. It is turning out to be very difficult to bring in large numbers of GPs, partly because we are targeting countries whose GPs, frankly, do not wish to come here. They are more nested in their community, their English language skills have to be very high and there is something about the cultural understanding of the people you are working with. It is completely unfair, but some surgeons do not need as many of those communication skills.

People are leaving general practice. The inflow is not too bad at the moment, but people are leaving because the workload appears to have become too difficult. Even though the international recruitment lever is harder to pull in general practice than it is in some other areas, there are other professions in primary care that you could use quite quickly. Even now, a large part of a GP's workload is on medicines. Some of that could go to pharmacists. About 20% of a GP's workload is musculoskeletal, and some of that could go to physiotherapists. Fortunately for us, those are large professions that are not in quite such short supply. You are absolutely right: we need to get GP workforce modelling correct. The



slight danger with looking to NHS Providers is that they will not look at private care. It just is not in their scope. If they do not do that, you need to know who will.

Chair: Thank you very much for coming this afternoon. We really appreciate it.

Examination of witnesses

Witnesses: Jeanelle de Gruchy, Ian Dalton and Glen Garrod.

Q54 **Chair:** Welcome to our second panel. Thank you for being so patient with us. For those following from outside the room, could I ask you to introduce yourselves and say who you represent?

Ian Dalton: I am Ian Dalton. I am the chief executive of NHS Improvement.

Jeanelle de Gruchy: I am Jeanelle de Gruchy. I am director of public health in Tameside, Greater Manchester, and I am president of the Association of Directors of Public Health.

Glen Garrod: My name is Glen Garrod. My national role is as president of the Association of Directors of Adult Social Services. My day job is responsibility for social care and public health in Lincolnshire.

Chair: Thank you. Ben Bradshaw will open the questioning.

Q55 **Mr Bradshaw:** The Government have chosen to focus increased funding on NHS England. Do you think there is a case that it would be better to use some of that extra funding for public health and social care instead?

Jeanelle de Gruchy: The short answer is yes. We certainly welcome the increased funding to the NHS. You heard colleagues on the previous panel talk about the importance of funding to the NHS. Unfortunately, public health delivered through local government and directors of public health has had to cope with an immense amount of cuts—£700 million—since 2014-15 to 2019-20. That is a large amount of money.

A large number of the services we fund and commission are actually NHS services, which I do not think was brought out earlier. There is also a slight doublespeak about it because those are the sexual health services, health visiting services, drug services and so on. They are NHS services that our grant is funding. Those are being cut. The previous panel talked about the real cost-effectiveness of public health services, and there is no logical reason to cut the grant, particularly at the same time as talking about the importance of prevention.

Glen Garrod: I take a slightly different tack. Some of my best lines have already been used by the previous panel members, but I will have a go at something extra. From a social care perspective, the narrative is a little unfortunate. In a local system, we should not be having discussions that say this is an NHS budget, this is a social care budget and this is a public



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health budget. Increasingly, most of the people we see nowadays have complex needs. They do not just have a social care need or a health need. In some respects, that mirrors the debate about mental health.

Social care deserves its own space and relevance in better meeting people's needs. If we rob Peter to pay Paul, we go nowhere. From the social care perspective, as we have heard, the NHS is not getting what it felt it needed. In fact, it is probably far less than it felt it needed in the first place. How it spends that money, and how the money is distributed and used, is critical to our future success if we are to leave a better legacy than the one we have.

My main point is to reference Sir Derek Wanless in 2002, when he said that, unless we spend more on prevention and community, bad things will happen. Bad things are happening. The public narrative does not necessarily reflect just how bad things are in local systems. If Simon Stevens and Ian do not spend the extra funds, however short of ideal, on primary and community, with more community nurses, more GPs and more prevention, we will be back here again in a few years' time saying that things are getting worse.

Q56 Mr Bradshaw: Mr Dalton, do you agree with your colleagues?

Ian Dalton: Yes and no. It is clear that the NHS has come through a very difficult period in its history when the rising budget each year for the NHS has been at a lower level than it has been used to. That has manifested itself in financial pressure across the system.

I disagree with Jeanelle that there is an argument that, within the 3.4% settlement that has been granted by the Government to the NHS for the next five years, there is scope to take some of that 3.4%, which will be very important in ensuring that we can look after an ageing population in hospital, in the community and in primary care, and giving it to other budgets. The yes element is that, for the NHS to be successful in looking after people, it should not exist in a bubble. Our 3.4% is also dependent on an appropriate set of investments, which I am sure we will talk about today, in public health and prevention, which I very strongly support—for instance, things like smoking cessation. These will be the patients of tomorrow. Therefore, getting upstream on that is important.

You had an extensive discussion about workforce and the budget for training members of staff so that we can generate over the period of the long-term plan. Moving from a deficit in staffing to a balance between supply and demand over that period is really important. The capital budget is also important, and I am sure we will be talking about that. I would not accept that the 3.4% allows us to take money away from the NHS and put it into those other areas, but I absolutely accept that those areas, and social care, are critical for the success of the NHS during the next period.

Q57 Mr Bradshaw: Could I ask you about the impact this is having on NHS



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performance? In last autumn's Budget, we were promised that significant inroads would be made into waiting times. The NHS plan in February said that waiting lists in March 2019 would not be higher than in March 2018, when they were about 3.8 million, and that the number of people waiting 52 weeks would be halved, from 2,755 to 1,378.

The current total of people on the waiting list is 4.1 million, so it has gone up, not down, and the number waiting more than 52 weeks has also gone up, to 3,150. All of those indicators are going in the wrong direction. The promises that were made about waiting times have been proved completely worthless, haven't they?

Ian Dalton: There are two points. I suspect that all three of us on this panel will agree on the first thing. We are seeing a continued rise in demand from urgent and emergency patients coming into our hospitals, and the long-term plan will need to deal with that. We have had that situation for several years. It has the continued effect of displacing within the hospital capacity care for patients who are clinically less urgent. It is right to see more urgent patients, but within our capacity, inevitably, that has to be prioritised.

We have not yet published our Q2 report, which will show the latest figures, but I can take you back to the quarter 1 report or the quarter 4 report in the year before that. I have talked to the Committee before about this. We are seeing a long-term rise in hospitalisation of an ageing population, typically coming in as urgent and emergency cases. Necessarily, that has an impact on elective waiting times.

The plan needs to be able to address the demands of urgent and emergency care patients and the legitimate demands of people who need elective surgery. Nobody in the NHS is comfortable about patients waiting longer than they have to for elective surgery. We all want to treat patients quickly. To do that, we have to invest our money, over the next years, in both new capacity and new ways in the community particularly of looking after frail older people.

Q58 Mr Bradshaw: Why make these promises? It was pretty clear to us at the time that they were not going to be met. It is now absolutely clear that they are not going to be met. What is the point of Ministers and officials coming to this Committee and making bold promises that are totally worthless? It damages the public's credibility in our whole system.

Ian Dalton: I would suggest, in relation to the 52-week waits, that we expect to see those numbers reduce—

Q59 Mr Bradshaw: By March?

Ian Dalton: By March. We are pushing hard for that. Clearly, we have a winter to deal with, but that would be an objective. Our aim is to treat every single elective patient we can within the capacity, but, as I am sure the Committee understands, it is inevitable that the rise in emergency demand has to be met first.



Q60 Mr Bradshaw: Mr Garrod, can you give us examples of some of the difficult decisions that directors of social care are having to make at local level to deal with the current situation they face?

Glen Garrod: Thank you for the question. In September, we conducted a national survey of my colleagues. The results from that survey are quite clear: the concentration on delayed transfers of care has had a direct effect on A&E admissions for non-electives, unnecessary admissions to hospital. It has also had a material effect on the number of people entering residential care and not going back home. Personally, I feel that is a moral issue. It is also something that the Competition and Markets Authority, the King's Fund and the National Audit Office have commented on.

In addition, what is not happening in the community is not where the public narrative or the policy rhetoric is taking us. The public narrative is all around performance on detox, yet I have colleagues in this country who have a waiting list of over four figures for assessments of new people. I have people waiting months and months. There are 125,000 people not receiving an assessment for deprivation of liberty. I will not tell you just how bad the level of provision is, but we have people getting smaller packages of care that are not getting to where it is needed. As Age UK rightly said, there are some 1.4 million people with an unmet need for social care.

Some of the consequences are clearly having an effect, although not on the back door of hospitals because our performance there is good and has become better. What is happening is that the front door, A&E, is facing crisis. Not too long ago, I sat in an A&E on a Monday afternoon with an acute trust chief executive and counted the people who should not have been there, but were there because there were no GPs, no community hospitals or social care in the community. We are looking at the wrong end of the telescope in dealing with something that is far bigger, and the narrative for that is not there at the moment.

Q61 Diana Johnson: I would like to move on to public health. These are mainly questions for you, Jeanelle. What effect do you expect the funding for public health to have on the ability of the NHS to spend its uplift over the next few years effectively?

Jeanelle de Gruchy: May I clarify my previous comments? It was not about wanting the NHS uplift. It was more the concern that was raised at the previous panel about pensions and potential further cuts. It also relates to your question. Glen, it is local systems, isn't it? At local level these systems all interconnect.

We need to see people in a place. People live in places. There is much about how we live our lives that is being impacted by austerity, or cuts more generally. It is about how we create healthy places, healthy people and a healthy society. The point was made earlier that if we just focus on the national health service we are missing a trick on health and the



health of people in our local populations. As a director of population health, or public health, that is what I have responsibility for.

Equally, while I am concerned about the public health grant being reduced, I am also concerned about local government funding being reduced more generally, because all those other services—whether leisure services, youth services, schools or our ability to support healthy workforce initiatives—are being impacted on in terms of health. We are particularly concerned about children. I know we are looking at adult social care and the impact on the NHS, but, if we are serious about prevention, it is from pre-conception and the early years. We need to ensure that we support the best start in life so that we prevent all those issues later on.

Q62 Diana Johnson: Perhaps you could tell us a little more about the preventive strategies that you think need to be in place to have an impact?

Jeanelle de Gruchy: Going back to local systems and local places, directors of public health are well placed. We are in local government but we are generally very familiar with the health service; I was a doctor in the NHS. We are familiar with NHS services and we can see across the system.

Our services need to tackle some of the trickiest public health issues of today. One is smoking—tobacco—which has a real impact on the NHS. We fund some of the smoking cessation services. We have modernised. We have transformed the way we are providing services. We are targeting the hardest to reach. We are targeting people with mental health issues who we know have very high smoking levels and poor healthy life expectancy as a consequence. We have those services.

There are also policies, such as the smoke-free workplace legislation, that need enforcement. Our teams work with those dealing with illicit tobacco. There is lots of work. There is responsible retailing, so that we do not sell to under-age children. We talk to our local politicians about having local smoke-free places. How do we get communities engaged with smoke-free places? How do we raise the importance of smoking? People living in more deprived areas have a higher proportion of people smoking, whereas in more affluent communities you hardly see it any more. Who raises that as an equality issue? That is our job, but we do it with partners.

The impact of the cuts is both to services, such as the smoking cessation services, and to us and our expertise, either advising the NHS around smoking, smoking cessation services and support, or across local systems, to see how the evidence supports the reduction of smoking in a place. It is hard to characterise, but that is our role. You can see that read-across in a whole range of public health issues where we are working locally.



Q63 Diana Johnson: When the Secretary of State came to the Committee earlier this year, I asked him about public health spend and he told me that there were very good examples where, despite the cuts, excellent work was going on in public health. He said he would write to me with details of where those areas were. Unfortunately, I have not had details of where the areas are, but perhaps you could highlight for me where, despite the cuts, there is really good public health work that you can point to and say will have an impact as we move down the years?

Jeanette de Gruchy: There are quite a number. We will provide the Committee with that written support. A large proportion of our budget is going to certain public health services, such as the health visiting service, the drug and alcohol services, in particular drugs, and sexual health services. There are numerous examples where, despite large cuts, we have transformed the way we have brought about delivery of those services. We have had to. At the same time, some of those treatment services have shifted more towards prevention.

We have had to make services more accessible, so we have been looking at digital. We have been innovating around digital. We have been looking at skill mix around health visiting. Perhaps other skill mixes can help to deliver those services, because of recruitment issues. We have had to innovate in all sorts of ways because we have had to deal with cuts in those services.

Our members are certainly getting to the point where we have done that, we have innovated and the cuts are real. As I said, a large proportion are NHS services that have reduced. We will now start to see a real reduction, potentially, in health visiting services, sexual health services and drug services, with consequent impacts. As regards drug services, mention has already been made of the impacts for police and crime. You can imagine the consequences over time in prevention. We have had to transform our sexual health services and deal with cuts while demand has gone up.

Despite all of that, there are some very good examples where we are trying to provide system leadership by working through and with the NHS, such as on social prescribing and people supporting themselves. But how does the money flow and how does our expertise support the NHS in spending that money well? That is another key message. Money for prevention is going to the NHS. Directors of public health and our teams have the expertise to look at the evidence and the evidence base, and commission services, whether from the voluntary sector or elsewhere, so that we can help to spend that money well.

Q64 Diana Johnson: Can I ask you about public health budgets and local government in particular? You said you have an overview of what is going on and where the money is being spent. There has always been concern that public health budgets might be used for spending on things that are not strictly public health. Do you think that is the case? Is money being diverted into types of activity that are not traditionally seen as public



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health but might have a public health benefit?

Jeanette de Gruchy: As I said before, local government has a major role in creating healthy places. That is an undersold but really important role for local government. As you know, councils are experiencing severe cuts in how they provide healthy places for people.

We have heard about the pressures on adult social care. The same applies to children's social care. Working closely with our directors of children's services and directors of adult services we have been trying, collectively together, to work out how we shift from high-end, high-need adult or children's social care to more prevention. Our services and funding are contributing to that wider piece.

There is a real challenge for councils to balance their budgets. We are trying to do a lot, given the large-scale cuts. It is a challenge and a tension, and will continue to be so. Concerns have been raised here about potential further cuts to the public health grant. We will struggle in both public health and councils to meet further cuts, if there are any.

Q65 **Dr Williams:** I do not understand the logic. Why cut sexual health services but not cut gynaecology? What is the logic in cutting health visiting but not cutting midwifery? Why are we cutting substance misuse services while investing in mental health services? What is the logic?

Jeanette de Gruchy: I do not think there is any logic. Directors of public health need to be in local government for all the other reasons I talked about, providing local system leadership. The services are commissioned by us. That has worked really well in terms of our ability to commission those services and commission them well. The difficulty is the false organisational boundary, isn't it? It is unbalancing the system. We want proper local systems working really well, but we have an imbalance and we are going to see it increase. You are right: it does not make sense. There is distortion in how we create healthy places and populations.

Ian Dalton: What is clear is that there is real benefit to people in places from expenditure through the public health grant. That is not an argument to take money off the NHS. That is the Peter and Paul argument, which does not stack up. It certainly benefits the health service as well as people in communities to have the areas of expenditure that we have talked about at an appropriate level. The future in the long-term plan will be very much about what takes place in places, and that absolutely means that we have to be there with the right model of acute, community and primary healthcare to cope with people's health needs.

Of course, there is real merit in making sure that the population's health is good, and that we prevent people from getting diseases that otherwise we would have to treat in the future. Regarding smoking cessation, for instance, we know that today's smokers will end up as patients and will need to be treated. If we can prevent people from becoming patients because they give up cigarettes, that is an advantage for the people



themselves and for the health service. I do not think it is an either/or. I am very supportive.

Q66 **Dr Williams:** But it could become an either/or. Patients do not care what the funding route or the commissioning route is. Most people do not even know. When a patient has something categorised as a sexual health problem, it is funded in one direction, and something categorised as a gynaecological problem is funded in a different direction.

Ian Dalton: I am not arguing with that. The point I made at the top of the discussion is that the settlement of 3.4% real will be needed to support the change we need to see in the NHS. That does not in any way undermine the importance of social care or public health.

Q67 **Andrew Selous:** I want to come on to capital investment, but before I do that I have a question for Glen and Jeanelle. I get all the points that Dr Williams and others have been making about public health. It strikes me that local government has a huge opportunity to design healthy environments. We are building a lot of new housing estates. They could all have cycleways and walking paths to schools. When we build new roads, we could have decent cycle and pedestrian lanes. I saw recently that the local authority in Canterbury had come up with good clean air strategies. Councils have planning powers about takeaways next to schools.

Money is one side of life—I absolutely get that—but it strikes me that you are quite underpowered, frankly, in seizing the initiative to design health into new environments in new housing and new roads. You probably share my frustration. What do we need to do to achieve that?

Glen Garrod: Frustration seems to be a central feature of my emotional state most of the time at present. There is something about coherence across national policies, if you will forgive me for pushing back a little. I have worked in the sector for 35 years and I have yet to see a coherent set of national policies that push in the same direction as experienced in local systems. You have given a good example between health and public health.

Some of the councils doing something remarkably good, despite the austerity they are facing, have recognised the contributory elements of all the things they have at their disposal. Housing is key. We have not talked about housing, but it is critical if we are better to meet people's needs. It is also critical if we are better to meet the requirements of the NHS, yet it has not really featured on the landscape in any major way. I take the point about housing, but there are some policy drives that take us in the wrong direction around some of that.

The Chancellor's announcement of £55 million for disabled facilities grants to be spent within the year in two-tier areas does not work, and will not necessarily help health and social care systems, yet it could. New housebuilding design standards are another opportunity, as are leisure services. We have an opportunity for digital innovation across health and



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social care. It is interesting that one of Jeanelle's colleagues in Wigan told me a few months ago that she does not have a public health budget; it is distributed across the council. Why? Because it adds to the other pots that might be shaped towards more preventive approaches.

If we just see public health in a preventive bubble and nobody else does it, frankly, that is a missed opportunity. By the same token, we have to recognise that just under 40% of council budgets have been cut in the last eight years. A lot of that has been back-office functions, the things that might have led to more creative thinking. By the same token, borrowing £10 million on a council's budget costs £1 million to serve the debt. Not many councils can afford a high borrowing ratio, given what is happening to their revenue spends. It is a really difficult situation to be in. We cannot just talk to DHSC; MHCLG is part of the equation as well, because it is funding some of the things that could make a difference.

Jeanelle de Gruchy: I reinforce that. It goes back to how we create healthy places. Essentially, we will not be able to treat our way out of the NHS crisis. We have to create a healthier population. To do that, we have to get people walking, cycling, eating better and not being lonely. Some new housing developments have been built for motorway access only; a report has been published recently on that. What kind of communities and societies are we creating?

I echo Glen in that there is some good innovative work happening at local levels to try to join things up and use the levers we have. If you cut council budgets by 40%, the wiggle room you have to innovate, your public health expertise around the evidence base and your ability to influence a wide range of partners to create healthier places are more limited than they could be. My pushback is that if we were adequately resourced—the Health Foundation says £3.2 billion for public health per year—what could we be doing?

Q68 Andrew Selous: I want to move on to capital with a series of questions for you, Ian. The maintenance backlog is £6 billion, having gone up from £5.5 billion last year. Will we stop seeing capital budgets raided to deal with that?

Ian Dalton: Ideally, yes. I certainly hope so. We need to take a step back, if we can. A significant capital issue needs to be addressed during the next period of the history of the NHS. We spend about 3.1% of total health expenditure on capital investment, compared with an OECD average across 34 countries of 5.6%. While it is great that we spend more than other large countries, such as Greece, Mexico and the Russian Federation, we are spending less than Sweden, France and Germany.

In relation to the specific point, as an NHS, we have, effectively, had to depress capital expenditure over the last five years to balance the books. I have talked to this Committee before about the importance of opening the taps on capital to support the backlog, and I will get to that, because it is a big issue, but it is by no means the only issue. One of the things



that needs to change when we see what is in the spending review is the building of new facilities both in hospital and, frankly, in the community.

On the backlog specifically, we have seen, over the years, looking at significant and high, which is probably better than looking at the total, an increase from 2013-14 of £1.374 billion, which has gone up to £3.077 billion. It has gone up from £1.374 billion to nearly £3.1 billion.

Q69 **Andrew Selous:** That is the highest need in the backlog.

Ian Dalton: It is significant and high—the top two categories, which are the ones that have, therefore, built up most rapidly during the past couple of years.

Q70 **Chair:** Is that spending on the backlog?

Ian Dalton: No. Spending is different. The demand, effectively, over the years 2013-14 to 2017-18, for significant and high, as we categorise it, has gone from just under £1.4 billion to close to £3.1 billion.

Q71 **Andrew Selous:** I want to ask about the impact of the backlog. I gave comparative figures on CT and MRI scanners earlier. To what extent are lack of equipment and some of the poor maintenance you have talked about holding back productivity and efficiency? What sort of gains would there be if we could make up that deficit?

Ian Dalton: There are disbenefits to the NHS, to staff working in it and to patients, from having buildings with high levels of maintenance problems. If a lift breaks down, for instance, because it needs replacing, and that lift is meant to take a patient to theatre, the physical act of getting the patient from the ward to the theatre becomes more difficult. The number of patients who can be treated becomes more difficult.

The reality is that we have a need for a significant capital injection through the spending review. Obviously, we do not know, over the next five years and preferably beyond, what the capital settlement for the NHS is. I hope that we can have a longer-term capital settlement because, by definition, investing in capital, whether or not it is sorting out the highest priority backlog, let alone building the new facilities, some of which are in the community and some of which are new hospitals, that we need to deal with the population over the next five to 10 years, is a long-term gain and does not lend itself to short-term injections of capital.

Q72 **Andrew Selous:** Can I focus on equipment for a moment? To what extent is the lower ratio of MRI and CT scanners causing a pinch-point in the process?

Ian Dalton: What we have seen, and will see over the next few years, is a very significant rise in demand for diagnostic tests. As we improve cancer services, more patients will need to be scanned. Most of them will not have cancer, but it is still important that they are scanned. It is absolutely true that we need the right number of machines, and they need to be scaled to demand, which will continue to increase.



Q73 Andrew Selous: To go back to the numbers, our 9.5 CT scanners per million compared with an EU average of 24.1 is a huge difference. How serious an issue is it for you and your top team that our numbers are so far out? Do the EU 15 have too many? Do they get wasted? Are we efficient with the ones we have, or are we being held back? There is a big disparity, but I do not yet get a sense from you as to what your view on that disparity is.

Ian Dalton: I do not have a numerical view on the distinction between us and Europe, although we could provide that if necessary. I am clear that we will need newer machines and more of them going forward. Demand for diagnostics is rising particularly fast and waiting times are getting longer. There is a need for significant improvement in diagnostics. Part of that is about staffing—we might talk about that—and part of it is about machines and making sure that those machines are well used.

Q74 Andrew Selous: Is there no part of NHSI that looks at international comparators to see how the NHS is doing in terms of capital?

Ian Dalton: We do that. More important, which is where the long-term plan will set out its stall, is what we need to cope with our population's need during the next five and 10 years. As I said, we need a significant increase in access to diagnostics. That will mean more machines.

Q75 Andrew Selous: That did not answer my question, with respect. My question is: what capacity do you have? This is a Government-wide problem; if you do not have it, you are not alone in Whitehall. I can give you that comfort. It strikes me that it would be useful to know what other countries are doing well and whether the extra number of machines is making a serious difference to their efficiency. I will not labour the point, but it is something to take back to Baroness Harding in your next conversation with her.

You talked about opening the taps, and you were quoted as saying that when you came to see us in July. I do not know if the changes to PFI in the Budget came as a surprise to you. NHS Providers told us that it thinks some trusts with onerous PFI contracts will need further financial support in the future. What is the extent of that further financial support? Is it an area that you are focused on? Is it a particular concern to you? Are you going to be plugging PFI annual costs for some time to come, in order to help trusts do what they need to do?

Ian Dalton: As one of the previous speakers said, there are PFI deals and PFI deals. The total unitary charge cost to the NHS last year was £1.9 billion, managed across 50 different organisations. The impact on those organisations is pretty differential. One of the things we have to do during the next five years, and we have not yet finalised how we will do it, is to have a look at the relatively small number of organisations that have a very high PFI cost that will make it more difficult for them to balance the books. At the moment, as you know, for reasons that have been rehearsed in this Committee before, the vast bulk of hospitals are in deficit. During the next five years, they need to balance the books. There



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will be a relatively small number that will need to have a particular look at the PFI. That is an ongoing conversation.

The other issue is how the non-use of PFI and PF2 during the next period, and the £3 billion that was meant to come from that, is to be replaced. The importance that the NHS attaches to that is that, if it is not coming through PFI, we need to see it replaced as part of the settlement.

Q76 Andrew Selous: I have a memory that a few years ago there was renegotiation of some PFI contracts in relation to the interest rate, which was thought to be unduly onerous. I am not quite sure how the Government managed to renegotiate some of the contracts. Is that a possibility, or are they totally legally fixed contracts that cannot be varied in any way?

Ian Dalton: A PFI contract is, by definition, a legally fixed contract.

Q77 Andrew Selous: This was a big issue that one of the current Transport Ministers took up when he was on the Back Benches a couple of years ago with some success.

Ian Dalton: The bigger issue—we are working to support trusts on this—is to make sure that the existing contracts are managed really well and value for money is delivered. Bear in mind that as a PFI contract typically includes facilities management services bundled in as part of the life cycle cost and the unitary payment, it is important that trusts deliver value from that. We are supporting that, and data is available to understand whether people are getting decent value. I am less excited about the prospect of wholesale renegotiation and refinancing, if I am honest.

Andrew Selous: Thank you.

Chair: We now come to mental health.

Q78 Dr Cameron: My question is to Ian. Is the current data available on spending and the performance of mental health services fit for purpose?

Ian Dalton: It is getting better, but there is more to do. Reflecting on some of the comments earlier, the NHS has been working very hard during the last couple of years, and will continue to do so in the long-term plan, to put more priority on mental health. That means more money going into mental health services. We have started working much more with NHS England to try to track the investment. There is real evidence that the investment going into mental health across the country, in terms of the mental health investment standard, is being met. That is NHS England's responsibility. It is tracking that. We also want to track where that money goes and that it is getting to the frontline. At the end of the day, it is what goes in at the top to commissioners and what comes out in terms of services. We are making progress on that.

There is evidence that that investment is starting to pay real dividends. There has been huge investment in things such as improving access to psychological therapies. Whether it is that or young people's mental



health services, it is very clear that there is more to do, and a significant focus of the long-term plan needs to be on continuing to do that. Alongside that, we must have metrics to understand where the money is going—to pick up on the point made earlier—where the workforce is for this and, therefore, whether patches are able to drive their services forward. Out of area placements are important as well. We are getting there.

Q79 Dr Cameron: The IAPT was not ring-fenced. Is that not a further argument for ring-fencing mental health funding?

Ian Dalton: What is probably more important than a ring fence—I noted Richard's comments about the consequences of ring-fencing—and will be a test for the long-term plan, is that we are clear and transparent about the investment in mental health services as a proportion of the overall NHS budget. That will feature in the long-term plan. I am strongly expecting that there will be a significant focus on mental health.

Q80 Dr Cameron: If we do not get to the stage when we are clear that the investment goes where it should, should there then be a ring fence?

Ian Dalton: The technical arguments about a ring fence are less important for me than which services are being bought, how long patients have to wait for them and what is the workforce delivering those services to patients. That is the guts of the argument.

Q81 Dr Cameron: I worked in the field of mental health for 20-odd years, and the money often does not come. It is promised and then it does not arrive. Doesn't there come a point, if all the other details do not add up, when you say, "We need to make sure the money is going where it should, to the frontline of mental health"?

Ian Dalton: As somebody who in their early career worked in mental health as well, I am naturally sympathetic to the argument that we need to make sure that the money gets through to the frontline. Ultimately, that is NHS England's responsibility, but we will work with them, and we are working with them, to track the cash through from the investment.

The fact that the mental health investment standard is now being met across the country is a start point. We are also tracking what that is spent on, so we can see the services that people who have needs are getting. The metrics around that, which we talked about earlier, will then give us a sense of how quickly they are getting those services. We should not underestimate the priority that will be attached to that.

Glen Garrod: In a local system, there are four contributors to the mental health fund that serves people across all ages. There is the NHS budget, which is typically the larger sum. Then there is adult social care, which is between 15% and 20%. Children's services put in another 5% to 10%, and then there is something from public health. If you think about the whole quantum available to a local population to meet all-age mental health services, it is important to understand how that works together.



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Take tiers 1 to 4 on CAMHS. Would you spend more on tier 1 or tier 4? Probably, tiers 4 and 3, the more preventive angle. You might bring in some public health money to do some of that, looking at whether children's centres could do some work that traditionally might not have been funded by public health but could be a very useful vehicle for better meeting children's and families' needs. Understanding how population level budgets meeting a particular need works is probably the ascendant ethic compared with what my data tells me and Ian's data tells him. I am not sure that that resonates any more.

Q82 Dr Cameron: Should we be doing a lot more on mental health for older adults in social care? It seems that services are so stretched that people are going in and out in 15 or 20 minutes. That is contributing to loneliness and eroding people's mental health. Other community services that used to cater for it have been eroded too.

Glen Garrod: Only a couple of weeks ago, the Prime Minister herself said that it was one of the greatest challenges currently facing colleagues in public health. That is true for us all, because we know there is a connection between loneliness and mental health. We know there is a connection between loneliness and requests for support and services that are not always necessary and are sometimes far more than is required. Where does the resource come to address that?

Q83 Dr Cameron: People used to have day centres and other places where they could socialise, which reduced loneliness, but those have all been closed. People are getting 15 or 20 minutes a day, which may cater for some physical needs but it is certainly not going to do very much for their mental health if they are sitting looking at four walls all day.

Glen Garrod: I could not agree more. If the Government were prepared to give us long-term sustainable funding beyond the short-term, temporary and, frankly, inadequate resourcing that next year probably looks like £2.35 billion, some of that might change. Until it does, in a number of cases, people will continue to get levels of service that you or I would not want ourselves, because councils are too far stretched.

Jeanette de Gruchy: I agree, so that makes three of us. Going back to Diana's request for innovative examples of where things have happened and my points about local systems and DPHs, for instance, being part of that, I chaired a group in London that we innovated called Good Thinking. We manage to get all CCGs funding it, and more than half of local government funding it. We had support from Public Health England and national NHS people. We developed an innovative digital-based mental health and wellbeing service to help people with low-grade anxiety and depression where they are, which means in their homes and on their laptops and phones.

We developed a platform with users, with all that expertise, in an innovative way of doing public services, to help people help themselves where they are, finding them and inviting them to a platform where there



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were NHS accredited apps that they could use. We are also developing peer support, so they can get help when they need it, in their home, for instance, at midnight when they cannot sleep, rather than always relying on a public sector service, their GP or the NHS. We know how high the level of need is with low-grade anxiety, depression, OCD and those types of problems. How do we innovate our public sector services to meet people where they are, and to be user-friendly and use digital in that way? It is very much about prevention, with people helping themselves and then bringing in peer support.

That whole approach is quite labour-intensive to get off the ground because there are so many organisations. It goes back to the silos. With proper system leadership bringing people together, and with willingness and funding, we can transform the way we are doing services and meeting people's needs. That is how we can try to help make the NHS sustainable, but it needs funding in other places to make it happen.

Q84 Chair: The final section is about the workforce. Starting with you, Ian, have you been given any steer on the scale of the transfers from Health Education England budgets to NHS England budgets? We have seen the wider gap between the budget going to NHS England and wider DH spend. Are you expecting to see a transfer out of HEE budgets for education and training?

Ian Dalton: We are expecting something a bit different. Our plan depends on having money in Health Education England to train the new and increased numbers of staff we need. We do not yet know what the Health Education England settlement will be. That is clearly important.

Q85 Chair: How difficult is it for you to make a long-term plan if you do not yet know what your budget is going to be?

Ian Dalton: Let's take a step back. We have around 100,000 vacancies in the NHS. From memory, at the Q1 period there were about 37,000 nursing vacancies. To be fair, the vast bulk of those shifts are being met but they are being met by temporary staffing, which is unsustainable. We know that over the next few years demand for staff, both in the community and in hospitals, will grow because an ageing population will need more healthcare. Therefore, the basis on which we are planning is to look at the actions we would need to take so that over the medium term we cease to have a deficit in staff in medicine and nursing—those are two examples, but there are other professions as well—and the actions we would then need to have in place.

We can get into some of those in a minute if that is where you want to take the conversation, but one clear assumption is that we have to increase the number of training opportunities for nurses, in particular, otherwise we will continue to have a deficit. The assumption we have to work on is that the costs of those training places, and the placements to support them, will need to be met. That is an important determinant, just as it is in social care and public health, in how we use the NHS settlement



over the next five years and the following five years. Otherwise, we will have to manage with an ongoing deficit. That is a big assumption, but I do not have clarity on what the HEE budget is going to be, which is important.

Q86 Chair: That makes it very difficult for you to plan how you are going to achieve that, doesn't?

Ian Dalton: It is the job of Simon Stevens and me to set out what we think the NHS needs. Of course, we are doing that in the absence of knowledge about how much money there will be in HEE.

Q87 Chair: The last time there was a big cut to HEE budgets, it was all taken out of bursaries—we saw an end to bursaries—and we are already seeing the impact that is having, particularly on mature students going into nursing, which is the group most likely to stay. It is a serious worry, isn't it, that you are not seeing the expected increase overall?

Ian Dalton: That budget is critically important to the NHS. The 3.4% and our ability to reshape the national health service, both to offer access in hospital where it is needed and, picking up on earlier comments, to invest in primary and community care and have the staff to do that, to say nothing of mental health and learning disabilities, is crucial. My first job was in learning disabilities.

That is dependent on us moving from a situation of deficit to a situation of balance, and preferably a small surplus, over a number of years. That is one critical component. In the intervening period, we need to take a whole range of other short-term actions to start making a difference. The HEE budget and its adequacy in supporting a new number of training places, certainly for nurses but also for doctors, is very important.

Q88 Chair: It is not just about training, is it? It is about retention. We held an inquiry into the nursing workforce, and one of the most critical points, which was hammered home to us, was about retaining existing staff. We are not doing a good enough job on that, particularly with the impact of things like continuing professional development. If, as we anticipate, you are faced with a cut to the Health Education England budget, will you use the wider NHSE budget to make up the shortfall? How are you going to make that work?

Ian Dalton: I guess I am sounding a bit like a broken record but I will say it again. The short answer is that that would not be our intent, for the same reasons as when we talked about social care and public health.

Q89 Chair: Aren't you likely to get yourself into a vicious cycle of having a further workforce shortfall and all the extra costs that will put on you from temporary and agency staff?

Ian Dalton: That would be a very undesirable place for us to be. I accept that. Our job in the long-term plan is to set out the numbers of staff we will need to run the NHS during the next five years, and to make an



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improvement in the staff deficit we have currently. That includes retention, but it requires more investment in training places. Retention, as you rightly said, also depends on the ability to develop your career. We have to take some actions to be a better employer and to help staff feel valued. We will need some international recruitment, and that will have to increase in the short term. Ultimately, we are going to have to train more.

I note, for instance, that 14,000 applicants for registered nursing degrees in the 2017 year were not successful in getting places. I think I am accurate in that number. The bottleneck of training places will be very important over the period. I do not want to sound at all like a broken record, but I come back to the fact that the NHS is going to need the 3.4%, and that was the basis on which the settlement was agreed. However, we also need, just as with capital, social care and public health, an adequate settlement for Health Education England.

Q90 Chair: I do not want to sound like a broken record either. You have indicated to us that you have not been told what the HEE budget will be, whether it will be cut and if so by how much. Surely, that makes it very difficult for you to make a long-term plan, when the long-term plan is so dependent on that, and the workforce is critical to that. Is that something you are making clear to those who are thinking of cutting the HEE budget?

Ian Dalton: I am making clear that the adequacy of the budget to train our people is very important to us. I am also clear that, in modelling the long-term plan, we have to ensure that the thing adds up financially, and in terms of capacity—thinking about Mr Bradshaw's question about capacity earlier—and workforce. Otherwise, it would be pretty incredible.

Q91 Chair: You are doing your modelling. Within that modelling, what assumptions are you making about what is happening to the HEE budget?

Ian Dalton: We are making an assumption that we will be able to increase the number of training places commensurate with need over the next five years.

Q92 Chair: You are making an assumption that you are not going to have cuts to HEE budgets.

Ian Dalton: That is the assumption we are making.

Q93 Chair: What if, next year, after you have launched your long-term plan, you find that there has been a cut to HEE budgets? What will happen then?

Ian Dalton: In the short term, if the budget for training was cut, arguably not too much in the plan for next year, because the plan for next year requires a range of activities that are necessarily shorter in length than the typical length of nurse training, let alone medical training. Over the period of the plan, if the number of places for training is not



enough, we will have to fill the gap through temporary staffing or even more international recruitment. We are already having to step up international recruitment in the short term anyway.

- Q94 **Chair:** Of course, your costs for international recruitment are about to get a lot greater if we are not able to recruit from the European Union, which is relatively low cost compared with recruiting from elsewhere. Are all of those aspects going to be set out clearly in the long-term plan? You may find that you have to rejig the entire plan if you end up with a huge workforce training gap.

Ian Dalton: The importance of the workforce to the plan is critical, as we have discussed.

- Q95 **Chair:** Do you have a plan B? You are proceeding as if there is not going to be a cut to HEE, but everyone expects that there will be a cut to HEE. Are you factoring in at this stage how it will look if there is a cut? I find it extraordinary that no one has given you a steer on that.

Ian Dalton: We will set out the number of nursing staff we need to do the work that we know we have coming through the door, and for the new models of care for patients in the community and in hospital. If it turns out that the number of training places is going to be inadequate, we will still need the same number of staff. We will have to source them from elsewhere, which will be more difficult.

Within the next five years anyway, we have to start eating into the nursing vacancy level, because the Health Foundation has set out a do-nothing option that is unattractive. We can talk about the numbers, but the direction is clear. We will have to recruit more staff from overseas over the next five years, including more nurses, under any scenario. Clearly, we potentially have to do more than that.

- Q96 **Chair:** It would be very helpful if you could set out a note for us about the extra costs of recruiting from outside the EU, and, indeed, if and when we leave, after the transition period, how much that will impact your costs, given the extra bureaucracy.

Going back to a point that Jeanelle made earlier about the loss of expertise in public health, is that something you are going to look at specifically in your workforce plan?

Ian Dalton: It is something that I am sure Health Education England will want to look at more generally. The public health workforce is an important component of that. There is a whole range of workforce professional issues. We could talk about nursing, certain specialities of medicine or any of those things.

- Q97 **Chair:** This is my final point, because I know that Lisa wants to come in on this as well. Will the enhanced joint working between NHSI and HEE involve any pooling of budgets or other resources?



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Ian Dalton: We are not at that stage. We are clear that the link between Health Education England, which has the expertise for commissioning training places, and NHSI needs to be much slicker, because there has been a disjoint between long-term workforce planning and long-term service planning.

We are talking about a long-term plan for the NHS, and the NHS and its people. It is a people-based business. Those two things need to be aligned so that we deal with them together. We are working very closely with HEE on looking at the necessity for staff over the next five years. I would imagine that that closeness will continue to increase.

Chair: I still find it extraordinary that you can go forward with a 10-year plan without understanding what your workforce budget is going to be.

Q98 **Dr Cameron:** Shouldn't we be asking for an increase in funding for training, rather than standing still? Drastically, the whole Brexit thing has shown how unself-sufficient the UK is in terms of the NHS and health and social care. There are so many good people who apply for medical training, who want to be nurses and do these jobs, who are refused. Shouldn't we be aspiring to something better than just running to stand still?

Ian Dalton: Yes. In a nutshell, we should. That is what I have been saying we need to look at for the next few years. We need to get to a situation where we train enough of our bright young and not so young people to be the healthcare professionals we need. In the short term, we shall have to use more international recruitment, but we need to move beyond that. One element of that, fundamentally, is that we need to grow our own.

The response to Dr Wollaston is to remember what the settlement is with the NHS. The NHS has had its settlement. It is our job to set out what we do with it. As we have heard over the last hour or so, the link between the settlement we have and the other budgets on which the health service depends is well made. I am not saying that it is in any way not important, because we need those budgets to be right.

Q99 **Chair:** Further to that, Glen, would you like to comment on the impact of the disparity in the pay awards for the social care workforce and particularly the nursing workforce in social care?

Glen Garrod: Indeed. You raised the point about how difficult it is to have a long-term plan. My colleagues this year will have to save £700 million, and next year they will have to save another £500 million, ongoing, as a result of austerity. That will have a bearing on how the services look, and the nature of those services over the coming two years, unless we get a long-term funding settlement. What we have today is nowhere near close enough.

We can look at three particular groups in our workforce. We know that a number of care workers will seek to go into healthcare work. If you have



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a better pay offer of some 29%, which is the consequence of Agenda for Change, where will you go? How can councils possibly compete with that unless there is parity of esteem? We have already heard that.

Retention is a major issue for colleagues providing homecare services, particularly younger people and particularly those who are male. Most of them want a career structure that looks better than the one they are currently offered. Unless we are able to put money into domiciliary care, we will start to lose more people, and the consequence will be felt in hospitals. We will not be serving people in the community, which is where the bulk of the service lies, not on the acute side.

A nurse can work in the community, a nursing home or a hospital. Some of the more advanced thinking suggests that, if you look at nurses as having placement opportunities across those three sectors, there is a better chance of retention; there is a better chance of a more rounded nurse offer in those local areas. Some systems, my own included, are beginning to look at the acute trust, the community trust and social care providers working together not only to recruit but to retain nurses on placement, because they can work across the three sectors.

Let us look at different skill mixes and nursing associates. What you need to do a nursing task is not necessarily a nurse, but you need a level of clinical oversight. It also provides, potentially, a career structure for people in the sector who are so desperately in need of one.

Q100 **Chair:** We are very supportive of nursing associates.

Glen Garrod: All you can do, Chair, to promulgate the importance of some of those overlaps will help all of us deliver something better than we have today.

Q101 **Chair:** Where is the barrier? We heard clearly that you could provide a better career structure with rotating placements across health and social care, but what is the barrier that stops that happening in practice?

Glen Garrod: Let me quote the CQC. The more successful systems are the ones where relationships are good and have a long-standing base, and where colleagues are prepared to look across the piece at how we improve systems for local populations. If we look in our particular bubbles at our particular issues, we will singularly fail. That is particularly true of the care workforce, which, let's face it, is bigger than the NHS. It just happens to be a distributed model, and you do not see them wearing kit that has a certain totemic value, but they do just as skilled and just as dedicated work.

Chair: When there is a lack of nurses working in district nursing and in the community, we end up with people in more expensive settings in hospitals, I guess. Thank you.

Are there any points that any of you want to make about the Budget that you have not been asked about this afternoon? In that case, thank you



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very much for coming.