

Health and Social Care Committee

Oral evidence: Budget and NHS long-term plan, HC 1712

Tuesday 15 January 2019

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Diana Johnson; Johnny Mercer; Derek Thomas; Martin Vickers; Dr Paul Williams.

Questions 123 - 214

Witnesses

[I](#): Dr Jennifer Dixon, Chief Executive, The Health Foundation; Nigel Edwards, Chief Executive, Nuffield Trust; Richard Murray, Chief Executive, The King's Fund; and Niall Dickson, Chief Executive, NHS Confederation.

[II](#): Chris Hopson, Chief Executive, NHS Providers; Julie Wood, Chief Executive, NHS Clinical Commissioners; Dr Nav Chana, Joint National Primary Care Home Clinical Director, National Association of Primary Care; and Councillor Ian Hudspeth, Chair of the Community Wellbeing Board, Local Government Association.

Examination of witnesses

Witnesses: Dr Dixon, Nigel Edwards, Richard Murray and Niall Dickson.

Q123 **Chair:** Good afternoon and thank you very much for coming. Welcome to this session of the Select Committee on the NHS long-term plan. For those following from outside the room, could I ask you to introduce yourselves and say who you represent?

Nigel Edwards: I am Nigel Edwards, chief executive of the Nuffield Trust. We are an independent think-tank and research organisation.

Richard Murray: I am Richard Murray, chief executive of the King's Fund.

Dr Dixon: I am Jennifer Dixon, chief executive of the Health Foundation.

Niall Dickson: I am Niall Dickson, chief executive of the NHS Confederation.

Chair: Thank you. Luciana Berger is opening the questioning today.

Q124 **Luciana Berger:** It is lovely to see you all and thank you so much for coming to join us a week after the publication of the long-term plan. Can you tell us in your opening remarks whether you believe that the long-term plan as it has now been published identifies the right priorities overall for the national health service? We would ask at this moment that you could be succinct because we are going to go on to very specific areas after this question. Are there any issues that you believe are missing that ought to be a priority set out in the long-term plan?

Nigel Edwards: I think I was nominated by my colleagues to go first. There is a broad feeling that the list—it is a very long list—of things in the long-term plan represents the right sorts of things. Maybe the focus on individual diseases, which is understandable, rather than looking at the growing problem of multimorbidity, is something that might be corrected by the very substantial investment in primary care that is promised.

The anxieties people have about it are the overall bandwidth of the system to do such a large number of tasks, the finances to support them and, probably most of all, whether there is a sufficient workforce available to deliver them. Broadly, it is contiguous with what we had before, so it does not represent a major shift, and, while there is a hint of some structural change down the track, it has avoided the temptation to mess about too much with the structures, although there is some.

In terms of whether there is anything missing, perhaps a little bit more on musculoskeletal health would have been useful, and a bit more focus on multimorbidity, but I have probably said enough and should let my colleagues tell me what I missed.



Richard Murray: We agreed to try not to repeat the things we all think are the same. It is a plan for the NHS, and very clearly Simon and others in NHS England have stuck within that boundary. If it deals with prevention it is only secondary prevention, and wider issues of public health are outside scope.

It is very light on workforce, although I know there is a workforce chapter. Part of that is because some of the budget for workforce comes in the spending review, but, even beyond that, it is still rather light. We need to remember that we are talking about the NHS as it currently exists as a treatment service and not a lot of the other things we worry about when we think about healthcare, and indeed of course when we think about social care. We need to remember that there is still a lot more to come.

People talk about deliverability. A key issue on deliverability is the waiting times target—the waiting times standards—and that is work in progress, so we will only find out about that sometime later in the year.

On the point around bandwidth, there is an awful lot in it—a lot of detail, which is both good and something of a hostage to fortune. It relies on a few delivery routes that are, frankly, untested, particularly on primary care networks; if you search the document on primary care networks, they are littered throughout the document. They do not exist yet, so some of the big pieces of the architecture are not in place yet.

Dr Dixon: It is a good plan overall. It is great to have a focus on health inequalities and prevention, and the shift in care is a really good emphasis, and tackling the big killers—certain big diseases. It mentions, of course, some of the enablers that others have mentioned, particularly workforce. Overall, it is a good plan and it is in the right direction. It fits in with previous plans. It is coherent.

On the gaps, in addition to what has been mentioned, there is quite a gap on productivity. Given that the money is tight, I would have expected to see far more on how the system is really going to become more productive than the 1.1% mentioned in the plan. How progress is going to be evaluated is also not there. Sure, management is going to do that, but what about external evaluation and what is built in? How do we know whether things are working to be able to course-correct? How change is going to happen, beyond some investment and more detailed planning, is also not there. What is the theory for trying to up the pace of change beyond what we have seen in the past?

The other bit that I think is missing is to sort out the accountability issue of STPs and ICSs in a way that can give much more clarity locally to who is in charge of what and when. Maybe those things are to be worked through, but those are my main comments.

Niall Dickson: I have now scored out just about everything I was going to say. In addition to agreeing with everything that has been said, there



is a fundamental tension at the heart of the plan: how do you keep on with the day job? How do you maintain the hospital sector and not allow it to deteriorate further, which it has done in the sense that more people are waiting, accident and emergency departments and the like are under enormous current pressure, and constitutional standards are not being met? How do you maintain all that while moving to a new system?

It is clear, I think for the first couple of years, that the plan envisages a bit more emphasis on getting the deficit sorted, trying to deal with the system. The danger of that is that we repeat the mistakes that we have made time and again, when we promised that we would put more into community and primary care services, and, frankly, we have not done it; we have not done it at pace.

The emphasis is probably right. Whether the balance is exactly right, I am not sure at this point. It is right to sort out the deficits and it is right that we continue to support the acute sector. Attempts in other countries—in Wales once—where they shifted money out of the acute sector, resulted in massively rising waiting lists and times and loss of public confidence. You have to be extremely careful how you go on that. If we are serious about this, we are suggesting something very different; they are talking about, first, putting more money over five years into community and primary services than they will into the acute sector—a firm promise, as it were—and, secondly, an extra £4.5 billion, which is not to be sneezed at.

The second missing thing for me is social care. It was a missed opportunity not to do the NHS and social care together as a single plan. I regret the fact that workforce, which was being done together, is now being done separately, and our plea would be—albeit that we may have a Green Paper, apparently before April, all other political things permitting—that we try to bring them back together at local level.

That picks up Jennifer's point about how real implementation is. I am not sure that there is an understandable theory of change behind this document, so it is about understanding how it will be implemented at local level. We will certainly be asking our members about how practical they feel it will be to take this stuff forward, particularly at system level. There are an awful lot of "musts" and "dos" at the centre of this, and, albeit that we fully support it, as everybody else has said—I think it is a good plan—I suppose if we had a concern it is that I am not sure that we really understand the relationship between the centre and the local. If we are going to move towards a very centralised command and control system, the experience of the past would suggest that it does not work.

Q125 Luciana Berger: Thank you very much. We will be going into greater detail on many of the issues you have touched on as the session progresses. A number of you alluded in your remarks to the wider political issues going on, and obviously we meet today while a very significant debate is going on in the Chamber about Brexit.



HOUSE OF COMMONS

Nigel, the Nuffield Trust, in its response to the long-term plan, was very specific about your concerns about the impact of Brexit on the delivery of the plan. Do you or anyone else want to raise any concerns you may or may not have about how Brexit will impact on the delivery of the NHS 10-year plan?

Nigel Edwards: Yes, thank you. We assume that some assumptions about the effect on the pound of the proposed deal have been factored into the forward assumptions on inflation, because the amount of money is a real-terms amount. If there is a major change in inflation, presumably the amount coming to the NHS in cash terms would change, but our anxiety is that a no-deal scenario has a very substantial negative impact and the requirement for additional cash to deal with the price moves that would follow from that would be very significant, in the region of over £2 billion.

There is also a workforce concern in terms of the environment for EU staff. Although commitments have been made to them, I think concern remains, particularly going forward, given some of the proposals in the current immigration White Paper. There are concerns not just for NHS staff but even more so perhaps for social care staff, many of whom would be below the line and would not get in.

Q126 **Chair:** On a point of clarification, Nigel, when you say £2 billion, over what time period is that?

Nigel Edwards: That is annually. It is a one-off. It is a sort of one-off shock, I think. It is hard to predict what other things might go on beyond that. As you know, it is a highly contested area and a lot of people do not agree with any analysis that one does, but there seems to be a fair consensus based on a fair independent analysis of the situation. From the NHS point of view, the phrase "No deal is better than a bad deal" is probably not true.

Niall Dickson: As some of you may know, I chair the Brexit Health Alliance, which brings together industry, the NHS and academia in this area. First, to endorse that point, there is no doubt in our minds from every quarter that no deal is a real disaster, certainly in the short to medium term. A lot of people have talked about the supply chain issues. We have never had a situation where supply chains were disrupted possibly for a period of up to, say, six months. You might have a short or limited restriction in supply, but this would be serious indeed.

On the individuals front, if you take the care sector, to look at health and care together, a third of the care sector in London are non-UK EU nationals. The kind of pressures that could put on the system are severe. Avoiding no deal, I think, would be a top priority for the NHS.

Dr Dixon: The other more general point is that, if the economy is really taking a hit, to what extent is the £20.5 billion safe? There are also ramifications for the critical bits of the budget that others have referred



HOUSE OF COMMONS

to, and which will be sorted out in the spending review, we hope—social care, public health and education and training capital, on which this plan depends. That is a more general point, but there is a very real live question about the extent to which the £20.5 billion is in the bag.

Q127 **Luciana Berger:** Do you want to add anything?

Richard Murray: All the things we have said assume that no deal does not happen. It is a bit of a blank piece of paper if it does.

As to risks in the supply chain, it is almost unbelievable that in an advanced economy we would face threats like that, so I will not add any more. If we are not going into detail, it is not because we do not think it is hugely important but that it is hard to know what to say about it, should it happen.

Q128 **Chair:** Have any of the panel particularly looked at the consultation process leading up to the plan, and would any of you like to comment on how effective it was?

Nigel Edwards: We did not look at it. The plan comments that there was a consultation process. I have to say, from my perspective, that it was not hugely visible. That may not mean that it did not happen, but it was done very quickly. I think you are seeing some of the patient groups later, who are probably in a better position to comment.

Q129 **Chair:** Yes. I just wondered whether any of you had looked at it.

Niall Dickson: We thought a ridiculous timetable was imposed by the needs of Government, because the argument was that they could not have a budget without a plan in order to justify the expenditure, and of course that was thrown out of the window because the plan followed the budget and did not precede it. At the outset, we had real concerns about dividing up and identifying, for example, single clinical pathways as the way to try to pull the plan together. In the initial discussions we had, when we raised the question that at the centre of this must be a new model of care that mitigates demand, we were told it would be dealt with in the frail elderly bit. That has actually been taken out. It is now front and centre of the plan.

To be fair, they have adapted and recognised that demand mitigation—how the service becomes sustainable—has to be at the centre of everything we do. They have involved quite a large number of people, but the real test will come at the next stage: how is the average consultant, ward sister or community nurse involved in helping to shape the plan locally and influencing it? If we do not bring our clinical staff along, it will become a bit like the five year forward view, something that, dare I say, the chattering classes talk about. It has to be a social movement; it has to be something that people believe in, because we are proposing, and the plan proposes, a fundamental shift in the way we deliver healthcare in this country.



HOUSE OF COMMONS

Q130 **Chair:** As head of the NHS Confederation, Niall, what is your view right now as to the level of buy-in across the NHS to the plan?

Niall Dickson: I would say it is limited. Those who have been involved in it will support the bit they have been involved in and so on. We were involved in six of the themes. I think they bent over backwards in a relatively short period of time. The key, going forward, is engaging at local level. That means that every STP/ICS and every organisation needs a genuine discussion with their staff. You can absolutely motivate people once they understand what the challenges are, but simply imposing this like a tablet of stone from Mount Sinai is not going to bring that about. I think that is recognised now, although—as I think was touched on by colleagues—there is an awful lot of content and quite a lot of expectation.

One of our biggest fears is that we make the same mistake again—that somebody will end up saying, “Well, you didn’t deliver on your bit of the bargain. We gave you the money and you haven’t done it.” We need to be very clear about what the NHS can and cannot do, and that there are tough choices ahead. This is not a land of milk and honey. We are going to face very significant challenges and we need discussions with our partners in social care, in local government, in the voluntary sector and the independent sector—all those who participate in this—so that they feel part of it as well.

Q131 **Chair:** That brings me to the next section, which is funding. Richard, how deliverable is this within the funding that has been promised?

Richard Murray: To start by making a comparison with previous plans, it is more than has been done before. I say that for a couple of reasons. The plan has avoided some of the traditional black holes. It has kept the productivity assumption down. In previous times, that number would get stretched and stretched; it was not deliverable and then the plans failed. They have been public at the 1.1%, so in some circumstances it almost feels under-ambitious, but I think that is pragmatic.

The other thing they have avoided is assumptions around new care models that are presumed in-year to deliver enormous reductions in demand that never materialise, and then the acute sector gets into difficulties on funding and productivity. Again, I think they have avoided all of those.

Uncertainties for me remain around waiting times. If you do not say what you are doing on waiting times, it is quite a hard question to answer because, for a lot of people out in the service, that is what they are being performance-managed on. If you do not know where that is going, it is difficult to say.

The money is what the money is. It is the workforce that is going to give you the answer on deliverability. There is room to stretch some of the commitments in the plan. There are an awful lot of them, and I do not want to get away from that; it is a very heavy read. For me, it is



HOUSE OF COMMONS

particularly around the workforce that this will trip up if it is going to trip up anywhere.

Q132 **Chair:** Jennifer, can you say what you think might have to be deprioritised in order to make this work?

Dr Dixon: That is quite tricky. If I can answer the first question you asked, in the work that we did with the IFS in the summer, which you will have seen, we predicted forward to 2023-24 how much the NHS would need just to stand still. We got to a figure of £20 billion, just to cope with increasing demand from ageing, chronic disease and so on, as well as to get trusts back into financial balance and to meet the targets, or at least to get back to the targets, the RTTs and so on. That does not leave very much room for manoeuvre, and we recommended that they should be higher to remodel.

It depends on quite significant productivity changes if we are to make progress, not least plugging the workforce. If not, the trade-offs come, and who is in a position to make those trade-offs? Nationally, it would be difficult to do that. It would largely be a local decision, although, as Niall said, one of the big priorities signalled is to shift money into primary community and mental health, which has to be a good thing, but you can only worry that that would be at stake, and first off the line, if the productivity could not be made and demand could not be quelled. The NHS does not have a history of reducing its benefits on offer. There is some of that around the margin, but it will not be a big issue.

Q133 **Chair:** Does anyone want to add to that?

Niall Dickson: First, the NHS generally accepts that we have no alternative. This is the amount of money we are going to get, irrespective of political change. I do not think anybody is expecting any large amount of money. The big concern in the service at the moment is around social care; the success of the plan is very much dependent on social care being remedied and, hopefully, given equal or similar parity to the NHS.

In terms of deprioritising anything, I agree with Jennifer. Some of the decisions will have to be made at local level. There is a question about return to constitutional standards in everything, and the Powis review is looking at that at the moment. It should be clinically based, but we have to be absolutely clear about what is affordable and what is not. Any of us would be very concerned at any slippage of constitutional standards from where they are now, but in getting them back up again there would be a question about the pace you wished to do that, given the obvious limitations of funding.

As Jennifer said, the report we commissioned the IFS and the Health Foundation to do talked about 4%. That was 4% of the whole NHS budget. What we are actually being offered is 3.4% of a much smaller bit—not much smaller, but a smaller proportion—of the NHS budget. This



HOUSE OF COMMONS

is going to be very difficult, although it is considerably more money than we have been used to for the last 10 years.

Q134 Chair: A final question from me is whether any of you have made an assessment of what will have to be delivered in the spending review on capital budgets in order to make this work. Do any of you want to comment on that?

Nigel Edwards: We have not done that. One of the issues with capital is that private capital is available for primary care development but it is not being spent, partly due to problems with the capital approval process, which is a bit clunky, but also because there is no spare revenue to service the new capital. Most new capital in primary care requires an addition to your costs, so you are often taking out inappropriate estate that is quite cheap to run and replacing it with something new and modern.

We should be paying attention not just to the capital budget but to the revenue consequences of capital spend, which was historically one of the reasons why it was difficult to get business cases approved. There is a very large number of business cases currently in the pipeline—a very small number, it has to be said, for primary and community care—but they are being approved at quite a slow rate due to that revenue problem and a number of other issues.

Dr Dixon: Anita has done those calculations, and if you look across the OECD they suggest that in healthcare the average is 0.5% of GDP devoted to capital expenditure on healthcare. We are not near that. We are 0.3%. If you take it up to 0.5%, it adds another £4 billion to 2023-24. We are happy to supply those figures to the Committee.

Chair: Thank you.

Richard Murray: The particular concern for us would be around the primary and community services estate. That has not been a primary focus for capital spending for a long time; the big business cases tend to be the acute sector. If you are putting up £4.5 billion through the revenue spending on community and primary care, you are going to need capital flow to go with it because I do not think the quality of the estate is sufficient to support that.

Q135 Chair: The issue of transformation funding has come up as well. There is not much mention of that specifically in the plan, or about the backlog of maintenance and the very significant impact that is having. Is that something any of you wish to comment on?

Dr Dixon: It is absent, as you say. The backlog has been estimated at about £2.8 billion, so it is significant. You cannot get the new models of care up and running without that kind of investment.

Niall Dickson: If we are serious about technology, it is going to require significant investment as well.



Q136 Derek Thomas: Dr Dixon, you mentioned the IFS and that the £20 billion would just stand still, looking at current demand. In the plan, there is emphasis, as has been referred to already, on greater expenditure on primary care. Do you see the possibility that that will reduce demand, so that we can get where we need to without the more than £20 billion, or whatever? Does what I am trying to get at make any sense?

Dr Dixon: Yes, it is a good question. If you look at demand-reducing initiatives that the NHS has employed over the last few years, the biggest demand reduction attempt is through integrated care and new models of care. There, it is a very mixed picture. As the NAO showed, the case is not proven yet, so to load everything on to integrated care, primary and community, is a tall order given the fact that we still do not know what the best kinds of new models are.

There is much stronger evidence about supporting care in care homes to offset or reduce the risk of further care downstream in hospital. It is an absolutely laudable aim, but I cannot at the moment point to an evidence base that will produce the level of demand reduction you need to fit in the money available.

Q137 Derek Thomas: Thank you for that. Do the panel generally believe that it is right to focus attention on primary care and that is where the emphasis of the extra money needs to be—on community care? Are you generally in support of that aim? You are nodding; that is great. What do you think the implications will be? What kind of campaigns do you see being launched in local communities because of the implications of moving more from urgent care to community and primary care?

Nigel Edwards: It is worth mentioning that the mechanism that is proposed is more one of differential growth. One of the reasons why this policy has been difficult to implement in the past is that the way hospitals are structured makes it very difficult to carve out bits of cost. You have to make very big changes to release funding. In fact, ideally, if you really want to release money from hospitals, you have to shut them completely because so many of their services are interrelated.

The proposal is to grow primary care at a faster rate than the hospital system. The challenge is not so much about shifting work but preventing the work that will otherwise come, given the growth in not just older people but a more significant group—the multimorbid patients who are surviving for longer; their life expectancy growth seems to have stalled, but, unfortunately, the period for which they are unwell is growing. We are expecting to see over the next 30 years a very substantial increase in the absolute number of deaths, which is a very major driver of hospital demand, so the proposal is to provide better care in community and primary care to reduce the need for future hospital expenditure.

That is probably more achievable than some of the models that try to use integrated care to reduce demand, as Jennifer says. They work in some circumstances, but they take quite a long time to develop. In a sense, the



HOUSE OF COMMONS

fact that we are now using this to obviate the need for future demand means that there is a little more time for people to learn how to do the quite difficult organisational task of reorganising care in a different way.

Richard Murray: The public absolutely will understand the problems of getting access to a GP and the problems of getting access to anybody in primary care; pharmacy may be the only exception. Although some of the investments in community health services probably do not resonate as obviously as sorting out waiting times in A&E, there are things that would resonate with people. They understand how difficult it is to get that access and absolutely will welcome it, as Nigel said. The problem we have had in the past is assuming that some of these investments reduce demand in-year and that they are so wonderful that they will pay for themselves. That is not the case. As Jennifer says, there is not really much evidence that they can do that. They need a bit more time to do it, and this time the plan is clear that it is not booking savings from reducing demand in that way; it will allow them to grow, develop and prove themselves.

Niall Dickson: I agree. The plan is explicitly cautious in saying that we are not suggesting a reduction in hospital demand. We have not done that; any subsequent reduction in demand should be a bonus for the system. That is a welcome caution compared with previous attempts. If there is no hard evidence in Jennifer's camp, there are some green shoots, in some of the vanguards and so forth, that appear to demonstrate it, as well as the nursing home stuff, which is much stronger. There have been reductions, for example, in emergency admissions.

We are moving in the right direction. I think it is recognised by providers in the community that it will require all these services to be joined up in a way they have not been joined up before. Primary care networks, which are suggested, are a new and uncertain model, but that has to be right. The important thing is that down at clinical level different groups of professionals are working as one, rather than working in their individual silos. That will make for much more effective care, and I think it is possible to identify specific interventions that will prevent people from escalating towards hospital.

The other thing that gives me a lot of hope is that we are moving into a data-rich age where it should be possible to segment populations much more effectively than in the past, and identify groups that can be targeted more effectively with interventions that would then prevent demand from rising on the other side.

Nigel Edwards: While there is very good international evidence that investing in primary care is the right thing to do in these circumstances, one thing to note about the plan is that there is a very long to-do list for primary and community care in terms of both organisational change and service delivery change. We will send you a list of the things that are in it



rather than me reading it out here. Suffice it to say that an awful lot is expected of it, so it will be very important that the promised investment is delivered and that some of the workforce problems are dealt with.

The upside is that it is likely that the public will notice that improvement much more quickly than they would, for example, changes in waiting times or A&E, simply because general practice and primary care is the bit of the NHS that people use most often, so it will become, hopefully, more apparent quite quickly that things are getting better, because they have been noticeably getting worse over the last couple of years.

Q138 Dr Williams: Following on from that, Nigel, the vanguards have been through quite a process, haven't they? There has been quite a lot of investment in process in order to get them from where they were to where they are now. Do you think the Government will have the right levers to get the change they want to see in primary care, or are they going to have to invest in process in order to get the primary care networks working in the way that they need to?

Nigel Edwards: Dr Nav Chana, who I think is coming later, would probably be a better source on that. You will not get the sorts of changes that are being looked for without both investment in direct staffing to support it and, because there is quite a lot of organisational change, the standardisation or adoption of new processes. Changing the way that primary care works with hospitals in the case of the very substantial change in outpatient care that is required is quite a big managerial task. GPs and other community staff are already very stretched, so how they are going to make such a major change as a small add-on to their existing job is hard to imagine.

Given that the plan also asks for substantial cuts in management costs in CCGs, there is a sort of unanswered question, which my colleagues referred to, about the how. The plan is strong on the what, but it leaves some substantial questions about how on earth all that very complex change will be delivered because, as you rightly say, the vanguards invested a lot of money in that. Not all of it went into that; there was a lot of performance management and oversight as well, but there was investment in change. A lesson that has come out of that is that the development of new relationships and new ways of working requires time and space for people to do it. It is difficult to do as an add-on to your existing job, and it requires managerial and other expert support.

Richard Murray: Absolutely. As I said, the primary care networks are all over this document. They are the key way NHS England and its partners see delivery of primary and community services. They do not exist in the form in which they are referred to in the plan. The contract that establishes them is not in the public domain and has not been finalised yet.

If you turn from this document to the planning guidance about what exactly the NHS is supposed to do this year, there are one or two



mentions of primary care networks that make you think there is a slight worry that all that development is at some point in the future. I think there is a gap in the delivery mechanism, and absolutely in the support to general practice and to community services, which have not been the focus of a lot of leadership development in the NHS. They have often been re-procured over and over again by CCGs.

Q139 Dr Williams: Does it matter that these primary care networks are not going to be NHS organisations, or would it help? As so much is being invested in them, do you think it is inevitable that at some point in the future they will become NHS organisations?

Richard Murray: They are not organisations. They cannot have a head office. They are a contract across multiple practices that all the practices will join and sign up to. To go back one step, could it be an NHS body or not? Can they do it without being a thing, without being an organisation? There is a lot of risk around that until we see how it materialises. If they take some form of organisational structure, which will be something for the future, not for now, that question is very relevant. For a lot of staff, there is access to the NHS pension, they are working in community services and most of that is an NHS body, so you raise a whole new level of questions about organisational churn at local level. At the moment, they are not even organisations, so we are one step further back from that.

Chair: Thank you. We come now to social care.

Q140 Diana Johnson: The Committee is particularly exercised by social care; we did a report on it last year. We have all been waiting, as Members of Parliament, for the Green Paper. Could you say how important you think it is that we see action on social care to enable the proposals in the long-term plan to happen?

Niall Dickson: I think Simon Stevens himself has said that it is critical. As I said earlier, it is a missed opportunity that the two were not harnessed in the first place. With the best will in the world, the NHS at the centre, once it gets going, thinks about social care and then forgets about it fairly quickly. If integration is at the centre of this plan, it seems odd that we are not thinking about integrating social care. That does not necessarily mean you have to put them in the same organisation. There are lots of examples of supply chains run by different kinds of organisation, but the important thing is that they are integrated into one thing so that, when users come across the service, they are not aware of the divisions between the different providers.

The extent to which social care has slipped even further behind the NHS over the last four years is very much outlined in the report that Jennifer and I mentioned earlier, which demonstrates that we need pretty much the same level of funding going into social care—3.94% per annum—if we are to try to catch up in social care. There are endless promises. We have had innumerable reports. The Wanless commission, which I



HOUSE OF COMMONS

commissioned when I was at the King's Fund in 2006, talked about the fact that social care was the poor relation of the health service at that time. It is now an even poorer relation, and there is a real sense that there have been promises after promises made in this regard and successive Governments have failed to tackle it.

What we are looking for this time around is not another bail-out for one or two years. Let's see if we can do the same for social care as we have done for health, with parity of esteem in funding and a commitment to fund over a long period of time, as well as sorting out the way it is funded—the eligibility criteria for the funding. There will probably be a longer-term solution that could be developed over time to help on the funding, but that will not solve the next five or 10 years. If the Government are keen on some sort of compulsory insurance model, that will not solve it for a period of time, and we have to be honest about saying that is for tomorrow—it is very important if we want to go down that route—but we absolutely need significant funding now.

Many people in the health service are saying that in a way that, frankly, they would not have done before. If you had talked to chief executives of acute trusts 10 or 15 years ago, they would not have said that. They say it now. They think that solving the social care issue is absolutely critical for their business, and for health and care in their own economies.

Dr Dixon: I have nothing much to add to that apart from the fact that you see the traces of the lack of social care funding on demand on the health service, particularly with the rise in what are called zero-day stays—people who turn up for emergency care, particularly older people, and do not need to be admitted. There is also a rise in the number of older people turning up at A&E with chronic conditions that could have been prevented through proper support at home. That is primary care as well as social care. You just see the traces everywhere, and that is well documented.

Richard Murray: I agree that it is difficult to write a long-term plan for the NHS without knowing what the long-term plan for social care is. What you see here is a brave attempt at doing it and ignoring the elephant in the room; it has to be ignored because it is not within the NHS's ability to sort it.

I hope it does not stop the NHS and local government trying to work together at local level. Even with all the difficulties of the current rules and all the difficulties around the funding decision, there are things they can do now about building relationships between local government, the NHS and NHS partners around the wider public health agenda, which often sits in local government. Accepting absolutely the strategic challenge that this places on them, I make a kind of plea that both sides do not down tools in the meantime.

Nigel Edwards: I have nothing to add.



HOUSE OF COMMONS

Q141 Diana Johnson: Can I ask a question about what Niall said at the beginning? If this plan is about the next 10 years of the NHS, are you saying that, if we do not get something sorted out in the next couple of years on how we deal with the short to medium-term problems around social care, we could be in real trouble in seeing some of what we want to achieve through the long-term plan? You are saying that we have a couple of years to sort it out. Is that what you are saying?

Niall Dickson: I am not even sure that we have a couple of years to sort it out. The sorting out is long overdue if we want to take the plan forward, as I think its architects absolutely recognise. The reason they do not control social care or social care funding is a political decision. This was a job the NHS was asked to fix. In our view, they should have been done together. They are not being done together. We will see what the Green Paper says, if it ever emerges. Remember that it is green, which means that it is not necessarily a set of firm proposals. There are lots of political headaches in social care. That is probably why successive Governments have not really grappled with it, but the imperative to grapple with it and to try to get a medium term—10-year—solution is really important, as well as the 20 or 30-year solution that we also require.

Dr Dixon: The other short-term issue is the workforce, with the Brexodus. The threshold for the wage cap of £30,000 is another issue affecting social care. In the next couple of years, that will be an issue.

Niall Dickson: The fact that the workforces were separated when they were together again is such a missed opportunity, and we have to bring them back together.

Chair: We are going to look at that. We are going to move on to prevention and health inequalities.

Q142 Dr Williams: The plan has quite a lot to say about reducing health inequalities. It particularly asks each area to develop a specific plan around reducing health inequalities. What do you think about what it has to say, Dr Dixon?

Dr Dixon: It is really good that it is played up so prominently, although, as others have said, it is also very clear that the NHS can only do so much and it depends on the settlement of funding for local government, because of the wider determinants of health, particularly on inequalities. The idea of local areas and a target for inequalities is a good one.

Redistributing £1 billion to the most deprived areas on top of the ACRA formula is another good idea. What they say about pace of change towards ACRA targets is also very good. What is missing, although you would not expect it to be in this plan because it is largely an NHS plan, is cross-Government action at national level to set a framework for tougher action on inequalities, the kind of thing that we saw with the spearhead



programme that ran from 1997 to 2010. Do you remember that programme?

Q143 **Dr Williams:** The health inequalities national support teams—HINST.

Dr Dixon: Yes, with the four themes of work and the 82 commitments across Government. That is what is missing. You cannot really expect the long-term plan to do that because it is the NHS, but a commitment to that is what we want to see in the spending review. The amount of money spent on the spearhead programme over that period of 13 years was £20 billion. It was a lot of money at a time when the economy was booming anyway. I do not think anyone is expecting that level of money, but it requires some kind of cross-Government action and a focus beyond what local places can craft to meet a target.

Q144 **Dr Williams:** Does anybody else want to say anything about health inequalities?

Niall Dickson: I endorse all that and the focus on it. That is great. We agree with the Secretary of State when he says there are things you can do in terms of nudge and identifying particular groups and big data. Again, data will help to identify groups.

If you look at some of the great public health successes, not least around maternity safety, which has increased, and smoking, the trouble is that we have not made anything like the progress we should have done among those in lower socioeconomic groups. Targeting help is legitimate, and the right thing to do. That said, there is also a place for wider public health campaigns. It is not just about targeting the people you think are falling a bit behind; it needs to be a combination of both.

I have two other points. One is—let's be honest—that public health spending has been slashed over the last period, so it is great if we are going to reverse that. It is fantastic, but we should recognise what has happened.

Q145 **Dr Williams:** Is there any indication that public health funding cuts are going to be reversed?

Niall Dickson: Presumably, we will have to see that in the spending review. There is the national funding, which is not clear, through Public Health England, and what will happen locally is not clear.

Q146 **Dr Williams:** Is the plan deliverable if public health continues to be cut? What will the impact be on the plan?

Niall Dickson: The health inequality stuff they focused on are things the NHS could do, but, if you want to look at the wider picture, you have to bring in all the work that local government is doing, now employing health visitors and so forth. You absolutely have to look at it in the round.

Q147 **Dr Williams:** There is an indication in the plan, though, that the NHS may look at taking responsibility again for health visitors, school nurses



HOUSE OF COMMONS

and sexual health services. I do not know if any members of the panel can answer, but is it the right direction of travel for those clinical public health services to come back into the NHS?

Richard Murray: I understand the frustration that these services were moved to local government and then promptly started to get cut, and now we are watching the NHS budget continuing to go up and we are discussing what it is going to do with its £20.5 billion. The problem is not so much that local government has been given them but that the budgets were cut. You have to remember that the budgets were cut partly because the Government quite rightly identified that, whenever the NHS is short of money, it cuts public health. Moving it to local government did not turn out to be the answer, and exactly the same thing has happened all over again. When the NHS is in trouble, it always cuts public health and training. That is exactly what happened.

The answer on health inequalities ultimately does not sit with the NHS. The plan says that you cannot treat your way out of health inequalities—I think it uses that phrase. You cannot. All the NHS can and absolutely should do, and I welcome what it is doing, is to try to repair the damage done to people's health from things that happen before they hit the health service.

If there is any optimism, it is binding in and working with local government at local level to bring in all the other powers that local government has. Part of that is about money. It is not all about money. We did not reduce smoking in this country through funding lots of stop-smoking services. We did partly, but there was also a lot of regulation, public health messages and taxation, so there is optimism.

I am not sure that another structural change in commissioning to move things between local government and the NHS is what is needed. What you want is the two sides working together more closely. To do that, there is possibly a case, which I hope to see in the prevention Green Paper, for a national target on health inequalities. It is great having each local area do it and trying to come up with the answer themselves, but a clearer framework from the centre would be helpful.

Nigel Edwards: Meanwhile, the drivers of health inequalities in wider society are pushing in the wrong direction. We see widening disparity in life expectancy on a regional basis, particularly between the north and the south and between the rich and the poor. There is a slight feeling that the NHS has its finger in the dyke while the water is spilling over the top.

Q148 **Dr Williams:** There is also something about the NHS, particularly in its primary and secondary prevention activities, often inadvertently widening health inequalities because of the inverse care law, and the plan specifically references that in a positive way, doesn't it?

Nigel Edwards: Yes. The inverse care law is certainly alive and well. Previous experience with changing the allocation formula does not fill me



HOUSE OF COMMONS

with a great deal of optimism, partly because this money is to be spent now. Part of the problem is that many of those patients are already ill; they are too ill or they are already dead. It is quite difficult for health systems to make long-term investments, which is what is required.

There is a much bigger opportunity for local government, local industrial strategy, the health service and education to work on really rethinking how local economies and local systems work. That is where much of the answer lies, as Richard says; otherwise we are simply patching up problems after they have occurred and having already lost the benefit of improving people's lives.

Dr Dixon: There is an irony if there is a Green Paper on prevention and yet the public health budget from 1 April is going to be cut by £85 million. That is a tart point that needs to be addressed if we are real about prevention.

Q149 **Dr Williams:** It does not seem to make strategic sense, does it?

Dr Dixon: No.

Q150 **Dr Williams:** Niall.

Niall Dickson: No. The other point I wanted to make is that the NHS has another role that is not always recognised, which is that in many communities it is by far the largest employer. It is probably the one large institution still left standing in many ways. There is pioneering work going on, but recognising the NHS's contribution to the local economy in that sense is important; it can be an anchor institution within communities.

Q151 **Dr Williams:** The plan does that a bit. There are nods to that.

Dr Dixon: It is more or less the last sentence in the last part of the appendix, but I do not think it mentions the social value Act.

Q152 **Dr Williams:** Although it mentions its role in protecting the environment in terms of the NHS fleet and its emissions.

Dr Dixon: Absolutely. I think the will is there; it is just how far it is going to be foregrounded.

Niall Dickson: We are working with a number of NHS organisations on just that issue. It is about raising awareness at local level. People get quite excited about it when they realise what the potential is, and there is still a lot of potential.

Q153 **Derek Thomas:** The 10-year plan for the NHS has loads of good things about it, but when you look at prevention and health inequalities and at what causes poor health—quality of homes, lack of education and empowering people to take better control of their health condition, with access to the right kind of support to do that—a lot of it is not necessarily the responsibility of the NHS. Have we lost something, or is there still time somehow to bring all those responsible people around the table to



HOUSE OF COMMONS

understand the nation's health? Probably only a small chunk of that will end up in the NHS—huge chunks of it have gone on long before. Is that a fair point to make, and what can we do to control that?

Dr Dixon: It is a fair point. It is what I was trying to say earlier about cross-governmental action. There needs to be a framework or strategy, and poverty reduction has to be part of it. It is a serious problem and is probably the single biggest element. There should be something akin to what was tried with the former spearhead programme, with a multi-pronged, cross-Government strategy and a serious amount of time with some investment. There is quite a lot of evidence on what works from that programme.

Nigel Edwards: I visited Wigan recently where local government and health have addressed some of those issues in the way you describe. It left me with a glimmer of hope that it can be done, but it has taken some real leadership and hard work to make it happen.

Q154 **Derek Thomas:** You are absolutely right. When you look at health inequalities and all the things I described, is it about devolution? I am a Cornish MP, and the one brilliant thing about Cornwall is that we have one local authority—it is an STP area—one commissioning group and one trust, so we actually could deliver. There is not a huge population, though, which might be a challenge. Is it about giving the whole problem to a region or an area and saying, "You need to work together to deliver the housing, the education and address the poverty issues," and, obviously, fund it? Is that the only way to do it rather than nationally?

Nigel Edwards: If we look internationally, I think the Institute for Government says that the UK is the most centralised country, apart from North Korea, which may be an exaggeration, but they are making a point. Most other NHS systems work on a regional basis; Spain, Portugal and the Scandinavian countries have a quasi NHS. There is something about the scale of a region that is more manageable. You need a national framework and you need to say, "This is the offer nationally in terms of what you could expect," but the actual driver of that and the initiative to make the change happen, when we look at other countries, seems to work better when the organisation is at a more human scale and the people doing it are closer to and more connected with the problems they are trying to solve.

Richard Murray: The plan, in theory, leaves some scope for that through ICSs—the vehicle through which it is being done—and even if we are a bit pessimistic, or have missed opportunities about health inequalities at national level, I hope that at local level local government brings its powers and reach, along with other parts of civil society, alongside the NHS. Wigan is a great example, but we have to remember that it was led by local government; they started it and the NHS came along.



HOUSE OF COMMONS

It needs national bodies to leave a bit of freedom at local level so that local NHS bodies are not forever chasing a set of nationally determined targets. I do not think you can set aside all national Government—tobacco policy or housing policy. There is a lot of power at local level but it is not completely there. We need only look at what was done recently on the tax on sugary drinks. It is not impossible for local government to do that, but it is not instantly easy for them to do it. There is still a place for national Government, but you are absolutely right that the heavy lifting is at local level.

Dr Dixon: And welfare policy. The Health Foundation has funded an evaluation of Manchester that we have been doing over three to five years, and there will be some quantitative results from that, particularly including health, in summer this year. We would be happy to share that.

Niall Dickson: There is not an awful lot about devo in the plan, interestingly enough, and how that works. The relationship between ICSs and the centre and the new regions that are being created will be determined by the behaviour of individuals. I am not saying that is wrong, but the success will be in the degree to which the centre can let go. That does not mean abandoning all national things.

I have one correction. I hope they meant England, not the UK, because obviously other parts of the UK are much smaller and are nearer a regional model. England is such a big country that it seems to us that you have to move towards something much more locally controlled. You set the framework at the national level and you set outcomes that you want—that's fine—but you have to give much more freedom than has been given in the past to local government.

Chair: Thank you. We have several areas to get through, if that is all right.

Q155 **Diana Johnson:** All members of the panel have mentioned the challenge of workforce. Is the plan setting the right direction for tackling the current workforce pressures? Could you in your answers say something about what you want to see in the implementation plan around workforce and what level of funding expenditure for the training that is required for Health Education England would need to be argued for in the comprehensive spending review?

Niall Dickson: First, we need some radical changes to education itself—the education of doctors, nurses and so forth—which trains people more for 21st century needs than 20th century needs. In medicine, for example, a greater emphasis on generalism has been talked about for a long time, but there is quite a lot of work to be done.

We need to move away from our over-reliance on overseas recruitment. We are very dependent on that and will be for a considerable period of time, but over time we ought to be moving away from it. That is not to say that health professionals should not be moving around the world—



that is absolutely right—but for us, as a developed country, to take people from less developed countries does not seem the right way forward.

There need to be new types of role so that it is not just about producing more doctors or more GPs and nurses. We have to look at needs and, again, probably people who cover health and social care. There will be individuals who do that, people who can care-navigate and so forth. We need to do some retraining of existing staff. If you are talking about new models of care, you have to assume that even in 10 years' time probably two thirds of the workforce is already there, so there is something about how we end up supporting them.

We certainly recognise that in our role as NHS employers we need to support organisations to improve retention, and again there is quite a lot of work going on in that, but it is no use if you just concentrate on the tap and do not deal with the plug.

Q156 Diana Johnson: Do you have a figure for how much money is needed to deal with the problem?

Nigel Edwards: To give you some context, in 2006-07 the training and education budget was 5% of the total NHS budget. It has now fallen to 3%. To put that back would take about £2 billion.

One of the most serious cuts recently has been in continuing professional education. We are continually hearing that nurses—particularly nurses, but other medical staff—cannot get released to continue training. That is a major issue of retention, potentially. While we have prioritised mental health and primary community care, the production of nurses, particularly in those areas, has fallen significantly behind demand, and in fact there has been a drop in whole-time equivalent nursing in mental health. It is a bit harder to tell what has happened in community services, because when community services are transferred to private sector providers we seem to lose count of the nurses, so we are not sure, but we think there has been a significant reduction.

The age of practice nurses and district nurses particularly is a concern. There is a big retirement bulge coming over the next few years, so, in addition to all the change management things that Niall mentioned, which I absolutely agree with, there is repairing the current deficit and then creating environments in which people want to stay and work. Across the world, burn-out of doctors, particularly generalist doctors, seems to be a developed world problem, but we seem to be suffering particularly badly from it at the moment.

Dr Dixon: We have said that the budget for HEE should at least mirror proportionately the increase that NHS England is getting over the next five years. The budget will be set in the spending review and we might not be clear about that until November. It takes time to train new people, so there is a short-run issue, and that is where the gaps are and where



HOUSE OF COMMONS

international recruitment is going to be an issue, as well as keeping people in the system. There is a short-run strategy and a longer-term strategy, as well as the extra money.

Richard Murray: To emphasise that, if you put new doctors into training now, they will not be there during the period of the 10-year plan. The training budget is important, but particularly for new medical students it is not relevant to this, because it is so far in the future that they will not have arrived. The words "implementation plan" make me worried if it is after the spending review, probably in October or November. Even if we were to get an implementation plan next year, that is looking ambitious. I would rather see implementation plans. Things around international recruitment, retention and what you can do on skill mix do not need to wait until the spending review.

There is a training element, absolutely, and CPD is the one to focus on, at least in the short term, but there is a lot that can be done well in advance of a spending review. Leaving it that late means that next year we will just be treading water and will not make any progress. Particularly in the short term, it might look fairly bleak.

There are things around international recruitment, for all that we do not want to do it. I know we do not, and that is what everybody in the NHS always says, but we always end up doing it. It should be ethical, and we should try to sort out a bit more national support and perhaps a bit of focus on where some of the assets sit.

We have a very deficits-based approach, so we are terribly anxious about nurses and GPs, as we absolutely should be, but there are probable surpluses in some other professions, such as pharmacists, and the supply of physios is rising sharply. We know how much work in primary care is taken up with musculoskeletal cases and we know how much is taken up around medication. It would not be that difficult to retrain some of those staff, to add a bit extra, so that they can take on wider duties to try to take a more actions-focused approach. That does not need to wait until the spending review. We would be very alarmed if we just stopped and waited until next October and then started thinking about a plan.

Q157 **Chair:** Thank you. There are an awful lot of questions we could ask about system change, but because time is short I would like to focus on some of the legislative tweaks that have been proposed and whether you agree with what is proposed on the list and the pathway going forward. Nigel, do you want to start?

Nigel Edwards: I am of the view that the NHS has tested to destruction the hypothesis that we know how to design a health system. I am nervous about that. It is very clear, however, that our current system has a number of rough edges that need to be sorted out. In particular, the relationship between NHS England and NHS Improvement needs putting on a more regular footing. The current dispensation means that the devolution of commissioning powers for primary care is not properly



HOUSE OF COMMONS

aligned with the way the system is going, and there are number of rules around competition and procurement that clearly get in the way of the direction of travel and need tidying up. The proposals look like a reasonable, relatively low-impact and low-disruptive approach.

The integrated care system specification on page 30 of the plan lists a number of characteristics of the ICSs and looks like the sort of vehicle that, if the law was to be changed, you would reasonably be able to create. There would, I hope, not be a huge structural shift of the type that we have seen quite destructively in previous reforms of the NHS. With that caveat, what is in the plan is reasonably sensible, yes.

Q158 **Chair:** Does anyone want to add to that or disagree with any of those points?

Niall Dickson: I agree with everything there, but it is quite difficult to see how they are going to get the stuff through in any reasonable timescale.

Dr Dixon: I still think they are probably marginal in the scheme of things. If you really want to up the pace of change, the legislation is not going to affect very much. It is tidying up.

Q159 **Chair:** Yes, because the system is working in spite of it rather than being helped by it, so it seems to me that they are sensible legislative tweaks, but I wonder if you disagree with any of the proposals on the list.

Nigel Edwards: There is a slight concern, which may be less about legislation, and may relate more to the points that Jennifer and others made about the theory of change. There is a retreat from some of the competitive spark that in some services has driven improvement. The danger of creating NHS monopolies of provision, which are unchallenged, without appropriate adjustment to the accountability system, has some risk, but that is less about the design of the legislation and more about how the system is run. It is quite helpful, particularly in diagnostic services, elective surgery and suchlike, to have a degree of competitive edge.

Q160 **Chair:** Yes. You do not want to return to the airless room, as some people have described it to us.

Nigel Edwards: Yes. There was a reason why we created those systems, and why many other health systems around the world have created some sort of division between the specification of services and their provision. A degree of contestability in those, if not outright competition, seems to bring some benefits if it is properly managed. We have not always managed to do that. That has been one of the difficulties.

Q161 **Chair:** You are saying that we have to get the balance right.

Nigel Edwards: Yes.

Q162 **Chair:** Jennifer, do you want to come back?



HOUSE OF COMMONS

Dr Dixon: The imprint I see in this plan is that those sorts of bites into the system to poke it to action are in abeyance, and, as you say, data and technology will do more heavy lifting in future, mixed with clinicians and patients. I think that hypothesis is interesting, personally; it is something to watch, with less concentration on the former managerial and payment reform, and markets and things like that.

Niall Dickson: I agree. The way you can hold to account will probably change as we get greater transparency around data, but the international evidence would suggest that having a variety of provision rather than a single monopolistic provision is the right answer. They talk in the document about involving a number of different partners. For us, that absolutely would include the voluntary sector community interest companies and the independent sector as well as local authorities. We need a bit of grit in the oyster. I am sorry to add to the airless room analogy.

Who provides the care is much less important, and the Government need to be much more open and honest about that; they are petrified of the privatisation charge, but we need to encourage different sorts of providers who will provide different kinds of things. The key is getting the supply chain into a state where the user does not feel the junction between them, and we allow the best possible people to provide care.

Q163 **Johnny Mercer:** Can I talk to you quickly about targets? When the plan came out, it said it was going to speed up access for the sickest patients, but it did not make any flagship commitments to some of the statutory targets that we have at the moment. What is your view on that? Do you think we need to grasp the nettle as a political system and say that as demand increases, and so on, these targets are going to be increasingly harder to hit, but at the same time perhaps they are not the best metric for measuring success? What would your view be, Nigel?

Nigel Edwards: There is some concern about whether they are absolutely the best metric. That is partly why there is a review, which I think someone referred to earlier, by Steve Powis, the medical director of NHS England, who is looking at the four-hour target and the referral to treatment time target.

We have discovered, not just in this country but elsewhere, that the over-zealous management of some of these targets produces dysfunctional consequences and behaviours that are not very helpful, but, if you have no targets at all or you do not manage them properly, you end up like Northern Ireland with extremely long waits. Getting the balancing act right between targets that are sufficiently challenging and that reflect what clinicians and patients regard as a priority is something that requires further work. While it is perhaps a shame that it is not in the plan, my understanding is that there is a process, which I think is signalled in the plan, to look at that.

Q164 **Johnny Mercer:** Starting in October, they will come up with some ideas.



HOUSE OF COMMONS

Nigel Edwards: There is a good case study, I think, of the way the ambulance access targets were revised on the basis of a quite rigorous research-based study to look at what would be a better and more reflective way of measuring. My understanding is that they are repeating that methodology and will, as you say, produce that.

Q165 **Johnny Mercer:** You would urge the public who are watching this not to read too much into that at this stage.

Nigel Edwards: No, I think we are clear, and all health systems across Europe take this view, that the amount of time you wait for surgery and investigation is a key indicator of the success of your system, and if you start giving up on that you are admitting defeat.

Q166 **Johnny Mercer:** We should find somewhere in the middle.

Nigel Edwards: Yes.

Q167 **Johnny Mercer:** Anyone else?

Richard Murray: Even with the existing targets, if you really wanted to, you could deliver them. It is not that we have suddenly become such an old population and demand has risen so quickly. It is not that long ago that they were all being hit: the 18 weeks we may have missed for a couple of years and A&E for a little bit longer, but against anything we did in the past, they are still very impressive.

I do not think it is a question of, "Can you do it?" I do not think there is a choice if we want to do it. There is a question particularly about the A&E target that the four hours was set quite a long time ago. The attention of organisations or bodies such as yourselves on things such as sepsis has moved our understanding from where it was at that time, so, as long as they are absolutely grounded in what looks to be clinically appropriate, it is fair to say, honestly, "Let us rethink them." You probably would not want to do it when you are short of money because you give rise to the instant suspicion that you are desperately trying to find a way of making them a bit easier, but, as Nigel said, as long as what comes out of the ambulance review looks like it was clinically based, then surely—

Johnny Mercer: That's okay.

Richard Murray: It is nearly 18 years since we set the A&E targets, which is a long time ago.

Johnny Mercer: It is.

Dr Dixon: It makes clinical sense, but whether it makes political sense is another matter—clinical because people are different and you can stratify need and adjust waiting according to need and be faster with some cases than others. That is what happens informally anyway. Politically, though, these targets are iconic, aren't they, and simple to understand? How that will be replaced is another question, but I think it makes clinical sense.



Q168 **Johnny Mercer:** Niall, do you agree with that?

Niall Dickson: I agree that they should be clinically based and then you have to present whatever the results are so that they are acceptable politically. That may be possible because the plan includes, for example, that, if you have been waiting six months, you can look for an alternative provider, which is a new thing put into the plan. I think it is possible.

There may be things that the public are more concerned about. For example, there is some evidence that the public are more concerned about the four-hour wait in A&E than necessarily 18 weeks exactly for all forms of elective care. I am not advocating a reduction, but we have to look at the clinical evidence around this, and if you can base it on clinical evidence, as Nigel and Richard said, the politicians should support it.

Johnny Mercer: Great. Thank you.

Chair: Our final question today is on technology. I turn to Paul.

Dr Williams: I wasn't prepared for that. I think we said—

Q169 **Chair:** I am sorry; let's leave that. Are there any final points that any of you have not been asked that you would like to comment on today?

Nigel Edwards: The capital is an issue. There is a bit of a danger of us being over-optimistic about the impact it is likely to make in the short term, but probably underestimating the impact it is likely to make in the longer term, so it would be about sticking with it, I think.

Dr Dixon: So much of this depends not on technology but on diffusion of technology. There is an issue about how the system is managed, what pressure people are under and how they are supported to adopt innovation. That is the issue. It is not something that is pushed on people. It must be 90% management and 10% innovation that has to be factored in. That goes back to our discussion about the theory of change and the support the system needs to take up innovation and work with it properly.

Niall Dickson: The health and care systems record in embracing technology has been mixed, frankly. I take the short and longer-term impact point, but we are on the verge, over the next 10 or 15 years, of very significant technological advances, which are already here; I am not talking about new things, although AI will undoubtedly develop. They could fundamentally change the way care is operating. Often, again, the chattering classes with arts backgrounds tend to underestimate the impact that will actually have on the way care is delivered. That will be significantly transformed by the digital revolution over the next period. It is important that support is given to the system in order to be able to embrace that change rather than regard it as frightening.

Q170 **Derek Thomas:** I want to mention the targeting of money at flash glucose monitoring for diabetes care. We are aware of the huge burden



on urgent care, and that is one example of where you can move people away by managing conditions better, avoiding some of the horrendous treatment later. Presumably we need something that can test but quickly embrace devices and technology that really transform people's care.

Richard Murray: Specific examples like that of a technology that we can roll out are welcome. The bit that may be bleak, as I looked at the plan, was the 30 million fewer outpatient appointments over the next five years—30 million. I really hope they have not booked that as a saving because it will be a tricky one to pull off. More granular, specific examples like that are absolutely great.

Chair: Thank you all very much for coming this afternoon.

Examination of witnesses

Witnesses: Chris Hopson, Julie Wood, Dr Chana and Councillor Hudspeth.

Q171 **Chair:** Good afternoon and welcome to our second panel. For those following from outside, could you start by introducing yourselves and say who you are representing?

Julie Wood: My name is Julie Wood. I am the chief executive of NHS Clinical Commissioners, the independent collective voice of clinical commissioning groups across England.

Chris Hopson: My name is Chris Hopson. I am chief executive of NHS Providers. We represent the 227 acute community mental health and ambulance trusts in England.

Councillor Hudspeth: I am Councillor Ian Hudspeth. I am chairman of the Community Wellbeing Board at the Local Government Association, representing local government.

Dr Chana: I am Nav Chana. I am a GP and clinical director for the National Association of Primary Care.

Chair: We are very grateful to you all for coming to share your expertise. Johnny Mercer is going to open the questioning.

Q172 **Johnny Mercer:** Nav, do you think the long-term plan identifies the right priorities overall, holistically? We are not looking for chapter and verse, but, in big handfuls, stuff that the public can understand. Do you think, as a GP, that it identifies the right priorities overall?

Dr Chana: In short, yes. There are an awful lot of priorities in the 10-year plan, as we have just heard. There is a strong rationale for a lot of them. From a general practice point of view, the focus on population health and integration of care, and the focus on improving, developing and strengthening primary and community care are welcome priorities in the 10-year plan. Obviously, we will come on to whether it is realistic and feasible in the way it has been set out, but, broadly, prevention,



HOUSE OF COMMONS

population health and integration of care are priorities that talk a lot to the world of general practice and primary care.

Q173 **Johnny Mercer:** Ian, what is your view from local councils—local government?

Councillor Hudspeth: In short, yes, I agree that the priorities there in a holistic way are very good, particularly talking about integration and looking at how social care can work with the NHS, because the two are not independent; they are intrinsically linked, and it is about making sure that we have a sustainable social care system.

One thing that perhaps we are disappointed about is that the opportunity for the Green Paper was not taken at the same time, so that we could look at them both together. The Local Government Association brought out our own consultation and Green Paper in the summer, which came back with results. We particularly like the idea of prevention because obviously it is far better to make sure that people do not get ill in the first place and therefore do not need to go into the acute sector, so it is about working in the community and making sure that people have a better quality of life.

Of course, public health is a local government function, and of the 112 objectives, 80% have been achieved since 2013, despite the funding cut of £531 million, or £700 million in real terms. That is where the challenge is. There are a lot of things in the plan that we like—digital, yes, and we would like more integration there.

Q174 **Johnny Mercer:** How do you square it with the public when you say, “We believe in prevention and public health,” and then reduce the grant?

Councillor Hudspeth: That is a difficulty, of course. We do not reduce the grant; it is what the Government have reduced to us in that grant. We have to work efficiently to make sure that, despite that reduction in public health, we are making local decisions and taking key local decisions. It is a holistic view because, with local government, obviously, we are not just talking about public health; we are talking about how we create better communities through planning developments to make sure that people can have better physical outcomes. While we acknowledge that it is difficult in a reducing budget situation, we have been very efficient in the last six years in making sure that we deliver those key outcomes.

Q175 **Johnny Mercer:** Chris, what are your views on identifying the right priorities overall?

Chris Hopson: It depends on what question you wanted the plan to answer. The Government set the NHS the test of coming up with a plan to release welcome extra investment, so the plan has been produced, the investment is being released—

Q176 **Johnny Mercer:** Do you think that came first? Do you think the money



HOUSE OF COMMONS

came first and then the plan?

Chris Hopson: That was explicitly what was said. At the time the funding announcement was made, it was explicitly said that the money would only be released on production of an NHS plan that the Government were prepared to sign off on. In a sense, the basic—

Q177 **Johnny Mercer:** It is a very strange way of doing business, isn't it?

Chris Hopson: There were a number of people who observed at the time that it was an interesting way round to put the money in first and the plan afterwards. There were those who believed that was an opportunity to be clear about what the NHS would produce and hold it to account. In terms of the basic test and question that was set, it seems to me that it has been achieved.

There were two other questions. The question that I think the members of the trust we represent were asking was, does it provide a clear path to enable us to recover the performance, the finances and the workforce shortages? It answers some of those questions, but it does not answer all of them.

Perhaps the most important question was whether it presents a compelling and convincing answer to the existential question that faces our health and care system: can we provide the right quality of care, given the rapidly rising demand we are going to have from an ageing population, and can we do it on a financial settlement that just returns us to long-term trend growth? I think the jury is still out on whether that question has been answered satisfactorily.

There are a lot of very good things in the plan, but does it answer the question of whether we can deliver the right quality of care for the money that is available? I am not sure of the answer.

Q178 **Johnny Mercer:** When will we find out? That is quite an important question. When are the public likely to find out?

Chris Hopson: The question we need to ask ourselves, which is a question that every single advanced western economy is grappling with, particularly those that have taxpayer-funded systems, is how you fund the need for improved and increasing healthcare, given an ageing population, when there is a natural limit to the tax base. You will know, as a Member of Parliament, that when the Chancellor made the announcement of the extra funding, it was greeted around the rest of the public service with, "Oh, well, we are now a national health service with the rest of the state attached," so I think there is a set of really big and difficult issues for us as a nation about how we afford the extra healthcare that we clearly want and need, when there is a natural limit to the amount of extra tax we can raise.

Clearly, we have a job to do as the NHS to be as efficient as possible and to move to new models of care, but the question that remains for me is:



HOUSE OF COMMONS

does this provide the model of how we are going to do that on the money available? As I said, it is a legitimate point to make, although it may be slightly challenging, but I think the jury is still out on that.

Q179 Johnny Mercer: Julie, what is your view on whether or not it attacks the right priorities?

Julie Wood: Generally, yes, it does, but there are gaps. Social care, as we heard from the last panel, is a big gap. Workforce is another big gap. If we do not sort out both those things, we will not be able to deliver on the ambitions of the plan.

The other question I would raise is about the bandwidth of the system to be able to deliver it all while balancing new developments across the country, coupled with the need to get the NHS on a sustainable footing and return to some of the access targets we talked about, the clinical standards we are looking at for our population. Getting that balance right will be a challenge, particularly in some years of the funding growth that we see.

The other bit from a clinical commissioning perspective is that clinical commissioners will need to do this within a 20% reduction in their own running costs. Looking at how the clinical commissioning system needs to operate at system and place level, and what it focuses its attentions and energy on to get the right investment for the right health improvement, will be fundamental.

Q180 Johnny Mercer: You have identified two clear issues that you think are missing, and I got that from you, Chris, as well. Ian, what do you think? You talked about social care and the Green Paper, and that being missing. Nav, what do you think are the glaring omissions in your view?

Dr Chana: Without repeating what colleagues have already said—

Q181 Johnny Mercer: Yes. Is there anything else?

Dr Chana: The social care workforce, and there is a public health issue as regards what is happening around the funding in public health, given the focus on prevention. That is really important. The only other thing I would note is to what extent patients, people or communities have been involved in setting some of the agenda on the plan, recognising the speed at which it has been developed. Those are some areas that perhaps need to be developed further.

Chris Hopson: I think there are two things missing, one of which the plan acknowledges. The first is that, when we talk to our members about what they think about it, they all say that they wholeheartedly agree with the vision that is set out, but what is completely lacking is an implementation plan, which is effectively the next stage of the process. Our members are saying, "I can see all of this; it all makes sense. I'd love to do all this, but I simply do not have the money, the workforce and the bandwidth to do it."



HOUSE OF COMMONS

For me, the key second bit, which is perhaps less acknowledged, is prioritisation. What can we deliver out of this? I can make a relatively confident prediction here today that everything in the plan is not going to be delivered. There is simply too much to do for the money and the workforce we have available.

We need real clarity in the implementation plan. This is what our members say they must have quickly: what do they need to do and when, and can it be clearly shown how that matches the money and the workforce available? That is what plans normally do, so the issue is how we move to that quickly, which the plan says it needs to do. How are we going to get to that prioritised list of what we are going to implement, when are we going to do it and how does the implementation work in practice?

Johnny Mercer: That is clear.

Q182 **Chair:** Thank you very much. Can I ask each of you how engaged your organisations were in the development of the plan?

Julie Wood: A number of our members were certainly engaged in the different themes and workstreams as they developed. Then there was a much broader prioritisation process that I think we were less sighted on—how everybody's individual list of priorities got turned into the overall blend of priorities that we see in the plan. I echo the points that Chris is making; we have got to where we are, but now we need much more engagement and involvement in how we turn that list of ambitions into something that is deliverable in each and every part of our system across England. That will need much more engagement and involvement.

It is not going to do away with the relentless prioritisation and focus on maximising value. Points that were made about productivity and efficiency still have to be made. We still have to make those decisions so that we spend 100% of the current NHS budget as well as the new funding to the very best effect to deliver the best.

Q183 **Chair:** On that point, we heard from our last panel that the 1.1% target for productivity gain was much more realistic this time round.

Julie Wood: Absolutely.

Q184 **Chair:** Would you agree that it is a realistic target?

Julie Wood: Yes, we agree with that, but it still does not take away the need to focus on discussions of value and making sure we are spending every pound wisely.

Q185 **Chair:** Thank you. Chris?

Chris Hopson: This is a good opportunity to say publicly that, given the constraints within which NHS England and NHS Improvement were working, and the pace at which this needed to be done and the complexity of the exercise, I personally think they did a good job of



HOUSE OF COMMONS

engaging the relevant sectors and patient organisations. To give you an example, between 30 and 35 of our trust chief executives were involved in each of the individual workstreams. They were involved right from the beginning. They have said to me that they can see the work that they undertook reflected in the plan.

We were also asked as an organisation to get involved in the process. I have to say, if you look at the constraints they were working under, that they did a pretty good job. However, exactly as both the previous panel and this panel are saying, there is now the next bit, which effectively is engaging clinicians and the public. Up to now, they have done a pretty good job.

Q186 Chair: Thank you. I realise from the local government point of view that this is a plan for the NHS, but it has often been a criticism of STPs and so forth that they simply have not properly engaged consistently or effectively with local government. Do you feel there has been any engagement or appropriate level of engagement with you?

Councillor Hudspeth: Yes, there has been in this case at national level. We have been engaged with all 14 streams. We are taking part and that has been reflected. However, this is just the beginning.

Picking up on the question Chris was asking, it is about the implementation next. We have to decide whether it is going to be top down, and by the time we wait for the top down to actually produce what needs to be done, it might be too late down the line. We should be looking at local areas to see how the STPs or ICSs can deliver local benefits in the area, working between social care and the national health system because, as I said earlier, the two are joined together and it is important to make sure that they are not seen as one over here and one over there. We need sustainability of social care, otherwise it will not assist the national health service in delivering this long-term plan.

Q187 Chair: Likewise, given how much community features in the plan, Nav, could you comment on what your level of engagement was as an organisation?

Dr Chana: Certainly. I was a member of an advisory group that looked particularly at the primary care section for the plan. There have also been a number of stakeholder groups involving the broader primary care family that are associated but linked, such as the GP partnership review, the GP forward view and other transformation areas within primary care, where there has been quite a lot of engagement with members of the different primary care organisations and patient groups. Again, caveated by the timescale in which this has been produced, one could argue that there could have been more engagement around some of those things, but, within that timeframe, it has certainly been very reasonable.

Picking up what Julie was saying earlier, I was aware that there were other parallel workstreams. It was difficult to know what was happening



HOUSE OF COMMONS

in some of those streams until the plan was produced, so the opportunity to influence or hear what was going on in the other sections was perhaps not as easy to find.

Chair: It is pretty encouraging, though, overall. You have all touched briefly on the financial aspects, and Derek will look specifically at funding and primary care.

Q188 **Derek Thomas:** This is probably a question for Julie. The challenge for you is, how do commissioning groups manage the bun fight between the pulling, the wanting the money in primary community care and in urgent care? How are you looking forward to that? Then for you, Nav, how excited are you to be getting all this money to suddenly be able to resolve all the problems of delayed transfers of care, or even admissions that should never have been? It would be quite interesting to know. The weight of responsibility on both ends of the panel is quite big.

Julie Wood: It has always been a responsibility of commissioners to manage that bun fight between all parts of the service, from primary care through to end-of-life care and everything in between. There is more money, which is great, but there will still be the bun fights.

For me, the trick and the key issue is about doing it together. It is about how we move towards an integrated care system so that across each of the however many footprints we will have—we may come back to that—we have a partnership board that has all the people who have an interest in the area around the same table. There will be primary care, acute trusts, mental health community trusts, local government and the voluntary sector. It needs to be a very transparent process by which that system and that place determine how it will allocate resources to the system, but where there is also place working with a focus on population health management and outcomes.

We need to make sure that the payment reform changes that we are seeing support integration so that we have perhaps less of a bun fight about, “Do we put it here and have more clicks at the turnstiles with PBR?” and look at what is the right population health budget that we need to allocate, and then get people, providers across a place, working together to say, “If we redesign care in this way, it will cost us X but we will deliver Y.”

It changes the conversation we have had up till now, but I would not like to underestimate the extent of the maturity you need to deliver that. In some places, where you have advanced STPs and ICSs, that maturity is developing. In others, it is not yet, so I am not sure we are going to go from here to there in three seconds. It will take time.

Dr Chana: The investment in primary and community care that has been set out in the plan is welcome, but that is against a backdrop of significant underfunding relative to other sectors in the NHS, over the last 10 years certainly. That is an important signal.



The issue is how the whole system architecture evolves, not just the primary care sector. As we have been saying, it is about how different providers come together and how health and social care, local government agencies and the voluntary sector come together to support the aspirations of population health that have been set out in the plan.

One of the key things is the general practice component of primary care. It is really important that that is properly resourced and funded, and that the workforce issues and other issues are addressed, as set out in the GP forward view and other commitments. It is important to get that platform stabilised and functioning well, so that the primary care networks that have been described in the plan, which build on flourishing general practice, can become local system integrators working across populations, bringing together networks of organisations and supporting the population health ambition.

It is important to get that sequencing right so that we get properly funded general practice in place, but not forgetting other primary care providers, such as community pharmacy and other first-point contact providers—community dentistry, sensory services and voluntary sector organisations—so that a system starts to come together across first-point contact provision, which arguably is what is needed to support some of the ambitions around population health that have been set out in the plan.

Chris Hopson: There is a wonderful phrase, “By their deeds shall you know them.” One of the things that has not been particularly focused on is that there were two documents issued last week: the NHS long-term plan and the 2019 planning guidance. The complexity of this is shown by the fact that we have different, potentially conflicting, objectives.

The key focus of the 2019-20 planning guidance—what is going to happen next year when the extra money starts flowing—has been on reducing financial deficits in the provider sector. Effectively, those deficits sit in the acute sector, so, if you look at how the 2019-20 money is going to flow, it will not flow in vast extra amounts to primary and community services. If anything, more money is going to flow into the acute sector as a means of reducing the provider sector deficits. All we are saying is that everybody—we represent community trusts as well—recognises the need to make this shift; however, it is not going to be easy, precisely because different objectives may require the money to flow in different ways. What will happen in 2019-20 is a great example of that fact.

Q189 **Chair:** That is the year of the biggest uplift, isn't it?

Chris Hopson: No. You may have seen that that has now changed as a result of the changes on inflation. In fact, the last year will be a 4.1% uplift, but, yes, you are right, it is the second largest year of the uplift. I am not criticising that and I can absolutely see the logic. If you look at the whole package, you can see why you would want to focus first on recovering finances and recovering performance, but if you want to



HOUSE OF COMMONS

recover finances you have to direct more money to the acute sector, because that is where the deficits sit, than, to be frank, you would if you were realising the vision of more money to primary and community. How that balance changes over time will be key, and part of it will be how fast we can recover the acute sector deficits and, therefore, enable more to be spent on that.

Q190 **Chair:** It is a point for us to raise with Simon Stevens and the Secretary of State when they come.

Chris Hopson: It is.

Councillor Hudspeth: Another key thing is how we save money in the future. It is not just about plugging the current deficits: we have to come up with a system where we provide an answer to people getting into the acute sector in the first place, and not spending all that money in the expensive acute sector. That is where public health, prevention, comes in, and local government. I can sit here and say we are going to have a deficit of 3.5—

Q191 **Derek Thomas:** Let me come back to the question. I hear what you are saying, Chris, but if we are working with the plan, £4 billion-plus extra money is going into your area, so perhaps I can talk about that. I think that is fair, isn't it?

Actually, what I want from you, Nav, is what thoughts you have had since this has been released and on the conversation beforehand. What are the implications? What can community and primary care do that provides something that at the moment might well be already provided in urgent care or, as you are saying, Ian, that will stop people getting to urgent care? In all our communities and surgeries, we are acutely aware that the need is to help people to manage their health and to meet them as close to home as possible with the best possible expertise, so that they do not end up in A&E, where they probably never needed to be, and certainly not in a bed there. What thoughts have you had about what you think the money could deliver? I hear all the things about the resources and the lack of GPs and various other things. Do you have some vision about that?

Dr Chana: Yes. It is about building on the strength of the history of primary care that has been developed in this country—high-quality, first-point contact care that is comprehensive from prevention through to end of life, and which is continuous when people want it and co-ordinated, as well as providing equitable access for people in need. Those are the principles of primary care.

Arguably, over the last few years, demand pressure, changes in the demographics of our population, workload pressures and some of the recruitment and retention issues have stopped some colleagues in primary care achieving the full breadth of that primary care ambition. The focus has generally been on reactive illness management, dealing with demand pressures from people, people not being able to get



HOUSE OF COMMONS

appointments and all the things people are hearing about the primary care sector.

Over the last three or four years, members of the National Association of Primary Care have been testing and developing a new model, which we call primary care home, as the home of care for a population, focused around populations of between 30,000 and 50,000 people, which in many ways is embraced by the 10-year plan. The reason for that was the growing recognition, particularly in localities, that health inequalities for those populations have worsened and not narrowed in certain parts of the country. There are some good examples in the plan. Part of the reason for that is the lack of multiagency working; each provider organisation is focusing on its own issues and its own agenda, and their workforces are not properly integrated.

We welcome the commitments that have been set out in the plan, provided they are realistic and feasible and subject to the implementation guidance that colleagues have been talking about, because that is what populations want and need. They want to feel better when they are well and they want preventive measures in place, not just a focus on people with the greatest health needs. Obviously, that is really important, but, as my colleague has been saying, there are a lot of people we could do stuff with now to prevent risk factors in the future. We need primary care and community services, mental health services and voluntary sector organisations to come together to support that agenda, so that it is not just the responsibility of general practice, but the responsibility of the system at that level to come together to support those issues.

Q192 Derek Thomas: In my experience, there is huge appetite for that, but there has never been the money to build something without taking it from the NHS.

Dr Chana: Exactly. As I said earlier, we have to get the components of the system built properly, and the resourcing and workforce issues properly sorted out. Then we can get colleagues and systems to start thinking about population health management in the way that is set out in the plan.

Chris Hopson: The £4.5 billion extra sounds great, doesn't it, and the extra money we are going to spend on mental health sounds great. It would be helpful if our colleagues at NHS England and NHS Improvement could set out how much extra those parts of the NHS budget would have risen as part of the overall £20.5 billion increasing, because what it sounds like is, "Oh, great, we're going to have £4.5 billion—lots of extra money," but if you look at how much the mental health budget will rise over the five years, and how much the primary and community care budget would rise if you just preserved their existing share, you will find that that is probably the vast majority of the £4.5 billion in terms of primary and community care, with a similar story for mental health spending.



HOUSE OF COMMONS

You will remember that the Government chose to release in advance and trail a series of different parts of the plan, and our colleagues in the think-tanks you had in earlier, after the third or fourth of those, were just saying, "Look, all you need to do is aggregate the share of the existing NHS budget these sectors get and add 0.1% on top and then, effectively, you can come up with a magic kind of announcement that you are devoting more to them."

Chair: Yes, we get that.

Chris Hopson: It would be really helpful to see what that would have been anyway.

Q193 **Derek Thomas:** What I was trying to get at was where the shift of care was going, not necessarily the money. The money is of less interest, but it is whether care is going to go closer to home, which I think you answered. I think we should move on. That is absolutely what I was trying to get to.

Dr Chana: I can take you to some of the emerging evidence from our primary care home programme, which is a form of primary care network. There is some evidence that it is starting to show some change in the way we would want to see things happening.

Derek Thomas: Good.

Chair: Thank you. We are going to move on to social care.

Q194 **Diana Johnson:** We have heard already how important social care is and that we need to get it right. Could people on the panel comment on how important action on social care is to deliver what is in the long-term plan? What do you want to see in any Green Paper, whenever it is produced? What will make it work?

Councillor Hudspeth: First is a sustainable future for social care. At the moment, while we appreciate the additional funds we got in the Budget, it does not mean that we can plan for the future and, therefore, we need the sustainable long-term plan that the NHS has, so that we can work together to make sure that we are part of that, working in the community, working with primary care and building that to make sure that people do not have to have interventions at a later stage, and have a better outcome at the end. It would be very easy simply to say that we will replace the £3.5 billion shortfall that we are going to have by 2025 or that a £700 million cut has come to public health since it came over to local government, but we need to look at the efficiencies that have come out of it. Although there has been a cut in public health funding, we are still delivering good public health outcomes, which is really important, because local government has always had the discipline that we have to produce a balanced budget.

When I present my budget in a few weeks' time, it will be balanced. There is no borrowing, there is no deficit, and that means that we have to



HOUSE OF COMMONS

make some very difficult and challenging decisions and some that perhaps are uncomfortable for all people, including myself, but we will produce a balanced budget so that there is no deficit to recover and we can start to build and plan for the future based on what we have, rather than having to back-fill, which is always one of the issues.

When we were talking about finance, we immediately sectioned it into different blocks. We should be talking about the system. It is the health system, not individual blocks, and it is about the best outcome for the patient, and, of course, we put the patient at the forefront of everything.

Q195 Diana Johnson: You are obviously talking about the need in local government to balance budgets, as you rightly say, but on the other side of that, although you might balance your budget, there is a lot of unmet need out there in the community. It is not that you are able just to balance your budget and it is all fine and everyone is getting what they need, because clearly they are not. What do you expect? What are you looking for in the Green Paper? You talked about sustainability.

Councillor Hudspeth: It is about sustainability and understanding where the financing comes from. Perhaps this has been the topic we all dance around. Governments of all political persuasions dance around the edge, saying, "Yes, we'll look at it," but at some stage we have to ask, "Are we going to produce a plan for the future sustainability of social care?" It could be through national taxation, national insurance, or a different sort of national insurance to provide social care. Central Government could even say, "Okay, you look after it," but give local government the ability to provide that funding. At the moment, we are under the constraints of having to deliver within very stringent increases in council tax, and we are not able to provide that.

That would be the flexibility we are looking at. The extreme one is, "Okay, hand it over to us. We will have to find the solution." The difficulty there is that, in different areas of the country, there might be a postcode lottery. In some of the richer parts, there are more self-funders. All of that is in the system and we have to work through it. It is about grasping the nettle and saying, "Right, this is what we are going to do to provide long-term sustainability for social care."

Q196 Diana Johnson: If we do not get it right, will the proposals in the long-term plan fail?

Councillor Hudspeth: It would be very difficult for the system to work. While local government and social care are not recognised in the plan as much as we might like, you need to understand where the issues are coming from. Delayed transfers of care have been mentioned, where we have done very well, with a 37% reduction over the last few years, and that is a key system to help the acute sector and primary care as well, working together.

The other issue is the voluntary sector. We should not be scared of working with the voluntary sector. Some of the organisations are



HOUSE OF COMMONS

providing really good outcomes and really local ideas. We should be enhancing those and supporting the voluntary sector, not just seeing it as an add-on.

Chair: That is a very important point. We now come to prevention and health inequalities.

Q197 **Martin Vickers:** The old adage is that prevention is better than cure. How important are the actions of the NHS in prevention and health inequalities? How is the plan going to achieve that?

Councillor Hudspeth: I said right at the beginning that prevention absolutely has to be the focus. Over the years, when I have been making tough decisions, people have said to me, "Actually, this is going to have an added effect," but the budgets are in different areas of Government and local government. If we had one pot of money, we could look at that pool and see what the ultimate benefit across the area will be, rather than just whether we can manage our budget. That is a key thing.

The prevention mechanism has to be right there, to make sure that we do it. Are we providing enough funds for it? I would argue that, if we have cut the public health budget by £530 million over the last few years, that is not protecting it. We need to increase it. If public health had stayed with the NHS and had the same increase as the NHS, there would be an additional £2.4 billion in the system, which would be devoted to preventive medicine and would be providing good health outcomes.

Some of those preventive mechanisms might not be things we would initially think of as key. You can have simple things like a healthy new towns initiative, where blue lines are painted around a 5 km walk, so that people can walk and run on the blue lines. It is about getting interaction. Simple things can be done locally to provide integration and good health outcomes for everybody.

Q198 **Martin Vickers:** Dr Chana, I could see you nodding in agreement.

Dr Chana: Yes. It is about what we mean by prevention. Obviously, there is a lot of focus in the plan on lifestyle-related behaviours such as smoking, alcohol and obesity, and on air pollution. They are all really important things, but sometimes there is a reason why people smoke and drink. It is down to their housing, their employment and the broader determinants of health—education and health literacy. While I welcome attempts to change those lifestyle-related behaviours, there is also the ambition to improve the broader determinants of health, which picks up the points Ian Hudspeth was referring to.

In the practice where I work, 60% of the population is currently well. The key thing is to keep them well and make sure that we maintain the various initiatives that we need to keep a preventive focus, so that we do not focus just on those we naturally worry about—people with multiple comorbidities. We recognise that that is very important, but we must keep an eye on all the other elements of the population as well.



Chris Hopson: We talked with Johnny earlier about how you create a sustainable long-term health system. If we carry on along the current trajectory, we will need to build 40 more district general hospitals in five years' time to cope with the current level of demand. It is very clear that we need to do something pretty dramatically different pretty quickly in order to go down a different path. I think we all agree that prevention and turning the NHS into more of a national encouragement of health and wellbeing service is a key part of that.

If you do not mind my saying so, all of this has a terrible sense of déjà vu. We have been arguing this for 20 years, if not more.

Q199 **Johnny Mercer:** Welcome to Parliament.

Chris Hopson: I know. People on the earlier panel mentioned the Wanless review. The crux of Wanless was, how do we do this? The obvious question is, does what is in the plan represent a fundamentally different direction, with a real force and power behind it to get real change around prevention? The earlier panel argued, effectively, "It's got some good things, but it is just the NHS bit." To me, it does not add up to the real combination of national legislation that we need.

This Committee has been very powerful about the need to take more concerted action on high-fat, high-sugar, high-salt foods. We have been messing around with that for three, four or five years, if not longer. We have not done what we did on smoking. Probably the single biggest public health advance in this country was national legislation to ban smoking. We are cutting the public health budget and not getting the local government bit right. All I am saying—it is one of the arguments I was making to you—is that I do not see a sustainable health and wellbeing model in this plan. There is some good stuff in there, but it is just not going fast enough and wide enough.

Q200 **Martin Vickers:** Julia, you are going to give us the positives now.

Julie Wood: I was going to say that I agree. The point the earlier panel made about the need to join up across Government and to have a cross-Government focus on prevention and health inequalities is fundamentally important. Their prominence in the plan is great, but when you add them all together, it will not be sufficient to ameliorate the 40 DGHs that we might otherwise need. We have to do something fundamentally different. That is not very positive, I am afraid. I am sorry.

Q201 **Martin Vickers:** As we know, the NHS is going to have to work in partnership not just with local government but with the voluntary sector, as you mentioned in your answer to Diana's question, and, I would suggest, with the private sector. How are we going to combine all that? Partnerships are fine, but they tend to lead to wastage and inefficiency to some extent, because different organisations, inevitably, have their own direction of travel. Can I have your comments, please? How are we going to integrate it all?



HOUSE OF COMMONS

Julie Wood: I worry slightly about the size of the partnership board we will need to bring all the players around the table, particularly in the larger communities. Looking at the footprints of the current STPs, if STPs morph into ICSs, the smallest is 300,000 and the largest is 2.8 million. Getting all those players around the partnership board to own the issues and the agenda, to have sensible conversations and to make sensible single decisions will be quite a challenge. It is the right direction of travel, but we should not kid ourselves about how complex it is going to be. We need to learn from those who are further ahead about how they have done it.

We absolutely need to make sure that we do not think that it all happens at big-system level. Last week, I had the benefit of being on a panel at the Public Accounts Committee with some frontline CCG, ICS and STP leaders from clinical commissioning groups. They spoke very clearly about the importance of place on an ongoing basis, working with local government. It is not just saying, "We're all going to do it at a big-system level now. That will be fine." We have to do some things there, but, critically, we must continue to have good conversations with the right people at place level. There will be a number of places within each system.

Dr Chana: I totally understand that strategic planning at that level could be challenging. One of the advantages of thinking about populations of, say, 30,000 is that the number of actors in that scenario is proportionately lower and it is easier to build relationships and make some of the connections that benefit people at that level. We need system planning at the ICS level, but we must not forget that most of the action will happen in much more local neighbourhoods, where teams work across different provider organisations to support the particular local population.

Councillor Hudspeth: Picking up on that, it is about creating the places. You can have places that are very close to one another with completely different health outcomes—inequalities. As Nav said, it is about the ability to get in and understand how to make sure that everybody has a good home, so that they have the best start and we are providing a healthy atmosphere for them. It is also about design, so that we are looking to make sure that walking and cycling are prominent and are the default for everybody, rather than getting into their car. Air pollution is becoming more and more apparent, so moving modal shift towards walking, cycling and public transport has to be part of the answer. That is the place-shaping mechanism, which is best done locally.

Q202 **Martin Vickers:** With the spending review coming up, what sort of expenditure do you envisage? The follow-up question is this. Let us suppose that you get two thirds of what you want. How will you improve efficiency in order to deliver it for the two thirds?

Councillor Hudspeth: First, as I mentioned earlier, we are forecasting a £3.5 billion deficit by 2025, so we would be looking at that and saying,



HOUSE OF COMMONS

"Let's make sure that that isn't the situation." In local government over the last five or six years, there has been a £15 billion or £16 billion cut in our core funding, but we are still delivering and providing good-quality services, through efficiencies. Local government will adapt and change to make sure that we are delivering those services.

Chris Hopson: It is very important to recognise that successful delivery of the plan, as it says in several places, is dependent on three or four key decisions that will come out of the spending review. One will be on social care. The second will be what happens on public health. The third will be what happens to workforce budgets, which sit outside the ring fence.

You touched on the fourth a bit earlier, but, personally, I would have liked to hear a bit more about it. It is on capital. Look at what needs to be delivered in the plan. We know that there is a massive capital backlog. It is not just £2.8 billion—that is just the high and medium need. It is actually a £4 billion backlog. Then look at what is needed just to keep the general NHS estate up to scratch, for IT and for some of the changes in the models.

I will give you just two or three examples. We are talking about rolling out same-day emergency care right the way across the rest of the hospital base. If you talk to a hospital chief exec who does not have ambulatory care, the first thing they will say is, "Lots of capital needed." We talk about completing the creation of the urgent treatment centre network. That requires capital.

Diana, I visited your hospital 12 months ago. To be frank, I was extremely surprised to see how much they were struggling because of the lack of CT scanners. They were struggling to meet the current 50% requirement. This plan says that we are going to move to 75% stage 1 and 2 diagnosis. There is a very disturbing chart on page 60 of the plan that shows our current CT scanner take-up. If we are to get anywhere near that 75%, we will need a whole load of money spent on scanners.

Q203 **Chair:** Chris, can I have a quick point of clarification? One of the estimates we have been given about capital is that there is an estimated cost of £6 billion in 2017-18 to eradicate the maintenance backlog. Is that a figure you recognise?

Chris Hopson: I would need to double-check.

Q204 **Chair:** It is just that we have heard a number of different figures this afternoon for maintenance backlog costs.

Chris Hopson: It is one of those things that is drawn from a return that trusts put in, which is then aggregated. If you want me to drop you a quick note, I am happy to do that.

Q205 **Chair:** That would be very helpful. As you say, the figure we were given earlier was just for urgent maintenance.



Chris Hopson: Exactly.

Q206 **Chair:** It would be useful to have your thoughts.

Chris Hopson: This is one of the points I was trying to make earlier. What we have in here is a list of lots of things. I have heard nobody disagree with the direction of travel, but there are a number of constraints on what can actually be delivered that we are not currently taking into account: the revenue money, the capital money and the workforce shortages.

The one we have not really talked about, which is probably the biggest constraining factor, is leadership capacity. When I visit trusts these days, I see senior leadership teams spending probably 70% or 80% of their time just on ensuring that they have enough staff to continue to provide a safe service. If you added up all the different things that senior leadership teams in trusts would need to deliver, you would probably be spending that frontline leadership capacity four or five times over.

Chair: I am conscious that we have quite a few more areas to get through. Martin, are you happy for us to move on to workforce issues?

Martin Vickers: Yes.

Q207 **Diana Johnson:** Chris, the last point you made was about the workforce. Julie also made a point at the beginning. We have the direction that is set for us in the long-term plan. What do you want to see in the workforce implementation plan to deliver on what the long-term plan needs to do? How much money needs to be allocated in the comprehensive spending review around health education and training budgets if we are to deliver the number of new doctors, nurses and everybody else we will require?

Chris Hopson: In a generic way, there are two things the implementation plan needs to do. First, it needs to set out a very clear path for how, over the longer term, we are going to generate sufficient numbers of people to provide the extra demands that will be placed on the service. The bit that everybody seems to keep forgetting is that, when I talk to current trust chief executives, they say to me that their biggest problem today, yesterday, the day before and tomorrow is the current workforce shortages.

For me, the workforce implementation plan quickly has to do some things that will enable us to start closing those gaps now. We know that services across the country are becoming unsafe or are having to close because we do not have enough staff. There are quite a few things that we could do relatively quickly if we got all of Government working together and mobilised to start to address the issue. We could have a quick temporary expansion of overseas recruitment—it is talked about in the plan, to be fair—but that very much requires what will happen in the Immigration Bill that is coming up.



A second example is that we know that a bunch of new roles have been created, not just doctors and nurses. If we were to maximise the clinical permissions they have to do different tasks, that could make a significant dent. There is a whole bunch of different things. We know that the NHS is currently losing a whole bunch of senior consultants, and, indeed, GPs, because of the way the pension arrangements work. We need to get a move on and sort some of these things out quickly. That is what I would like in the workforce implementation plan.

I do not have a figure for what needs to be in the spending bid. There is deep nervousness around the NHS. Because we were seen, justifiably, to have been treated relatively generously—the phrase that is used—in terms of the ring-fenced budget, there is real nervousness that in the spending review we will not get what is needed.

Q208 **Chair:** That is right. Julie and Nav want to come in.

Julie Wood: As well as looking at what needs to happen in hospitals, we need to look at what happens out of hospitals. Boosting out-of-hospital care and having integrated multidisciplinary teams will have significant and profound workforce implications. We have to understand what that looks like.

If we are really to grasp the nettle, we need to look at health and care. We need to look at how we get much easier passporting of staff between health and care—what they do and how they share information, all that sort of stuff—so that we can really deliver integrated health and care at a local, place-based, neighbourhood level.

Dr Chana: In addition to what colleagues have already said, workforce planning needs to be configured much more around how the population looks and will change over the next five years, or the 10 years of the duration of the plan. As we know, as people develop more comorbidities, we might need a different skillset to look after them properly. That is not always driven by having more doctors or more nurses; it may be through other types of roles that we would not think of traditionally. I back up absolutely what Chris and other colleagues have said. We need the numbers to meet critical workforce shortages. As well as that, we need to be thinking about how we develop a skill mix solution that addresses the needs of people in the challenges they will face.

The other bit I want to highlight is that there needs to be a much greater focus on the education and training of our existing workforce—to pick up comments that were made by the earlier panel about CPD—and on interprofessional working, so that people understand what other people can do to help to solve a problem, rather than thinking about it from their own particular perspective. Those are critical factors for solving some of the workforce challenges we face.

Q209 **Diana Johnson:** I am a Member of Parliament in the north, in an area where it is very difficult to recruit. The long-term plan talks about



focusing “on reducing geographical and specialty imbalances.” From a primary care perspective, what does that mean? What will they do to get GPs to come to Hull, for example?

Dr Chana: That is not easy to say. It is not just about Hull, by the way; it is about other parts of the country. Today, a document was published by Nigel Watson—the GP partnership review. It highlights a number of issues around workload pressures, the workforce and recruitment and retention. In part, it is about trying to get doctors, when they have finished their training, to feel that working in primary and community care is the right place to be, so that they do not necessarily revert to being specialists in hospital.

We have to create a system that makes it fun for people to work there over the next four, five or 10 years of their emerging careers. Sometimes we see people, particularly in general practice, working in isolation, with heavy workloads. That model of care needs to change, so that we can attract doctors, following training, who want to work in that sort of setting.

Q210 **Diana Johnson:** It’s definitely fun in Hull.

Dr Chana: I’m sure it is. I’m sure it’s fun in Hull.

Councillor Hudspeth: To pick up on the workforce issues, social care is a fantastic occupation and is delivering some really good services, but we need to recognise that, and it has to be seen as a career. We need to make sure that we have a career pathway going into the NHS, but also back out, so that it is not seen as an add-on. We must make sure that we recognise the importance of the fantastic jobs that people do.

We must make sure that we multi-skill them. There is an awful lot that we demarcate. We say, “You are a social care worker. You can’t do that job.” Actually, they probably can do that job and provide that service, which means that another person can do something else. Multi-skilling is not necessarily downgrading jobs, or anything like that, but making sure that everybody is able to do the appropriate things at the appropriate time, which means that we do not have a care worker clashing with a district nurse about who has supremacy. That moves to the digital, to make sure that that never happens anyway, but we have to make sure that people in social care, in particular, which is sometimes not recognised as the fantastic job it is, have a career pathway.

Q211 **Chair:** I am conscious that we are losing some Committee members because of other business in the House today.

Councillor Hudspeth: Is there something else going on today?

Julie Wood: Surely not.

Q212 **Chair:** I am very keen to make sure that, if there is a particular point you want to make about the 10-year plan and that you have not been asked



HOUSE OF COMMONS

about specifically, you can let us know about it, so that we are conscious of it.

Dr Chana: This follows on a bit from what Chris said earlier about the implementation phase, certainly for the primary and community care elements. It is really important that, as the prioritised funding for primary and community care is identified, it lands where the pressures are, so that it hits frontline staff as quickly as possible and is not filtered out in parts of the system so that no one recognises where it is. It is really important that that lands, to drive the organisational development, leadership capacity and so on to make some of these things actually happen.

Councillor Hudspeth: We have not really touched on the digital. That is really important, to make sure not that we create a grand system that we spend decades producing and then doesn't work, but that we can talk to one another, so that the ambulance paramedic who arrives has a system to understand what the patient requires. That might mean that the intervention can be there, and they can be retained in their home.

Q213 **Chair:** There is quite a lot about that in the plan. Are you happy with what it says about that?

Councillor Hudspeth: Yes. It is about how we make sure that is implemented, so that we do not go for a grand plan, but make sure that, in areas where it can be done, we do it quickly and efficiently. Care homes should be involved as well, so that they have the appropriate access, to make sure that everybody can see what it is. There is a lot in there, but we must make sure that we really deliver it and do not over-complicate. I suppose that is what I am saying.

How can we get the systems to talk to one another, rather than designing a new, bespoke system, which would take some time? That will be really key, so that everybody understands. I spoke about the social care worker not arriving at the same time as the district nurse. It is about simple things like that, to make sure that we can do it. That is the advantage of the digital outcome.

Chris Hopson: For me, the key issue is this. Everybody we have spoken to supports the bold ambition in the plan, but plans do not really work unless they get delivered. There is a key issue around how we get from the ambition to something that is deliverable.

The only other thing that has not come up, which it would probably be good to have a quick run around, is the standards review. Johnny asked questions about how that works. I have one observation. We would draw a distinction as regards the need to have modern, up-to-date standards that reflect modern clinical practice. There is no doubt that both the RTT standard and the four-hour A&E standard could be updated to reflect modern clinical practice.



When we talk to our members, we find that many of them have spent 10 years working really hard to get performance levels up to the point they have reached. It would be a different issue if you were seeking to reduce the inherent performance levels within those standards. The answer is yes, modernise them and they might look different, but if a consensus is to be built, it must be around the fact that, effectively, the inherent performance levels are maintained. That is the key distinction: modernisation versus the inherent performance level in the standards.

Q214 **Chair:** Thank you for that point.

Julie Wood: We have not said too much about system architecture and the legislative asks. That is something I would like to flag up. When I was last giving evidence to this Committee, sitting at a different table, we were asked to come with the asks that our members would be looking to see delivered to support integration. We have done that. It is really pleasing that the eight things that the plan recognises need to happen are very consistent with what our members have been saying. That is fantastic. We feel we have been listened to.

However, my plea on behalf of our membership is that the mechanisms for delivering that change should be carefully considered. We are very concerned about whether hanging all our hopes on the forthcoming legislation is the right thing to do. We would like there to be a very thorough exploration of what the art of the possible is within the current legislative framework, and within regulations and guidance. We think there is more that you can deliver. Indeed, our members, providers and commissioners are willing to find workarounds.

We do not want workarounds to be perpetuated where they are very labour intensive. If there are ways to unlock those barriers, we need them to be unlocked, but please do not let us pin all our hopes on primary legislation, only to find that, if we cannot get it through, nothing changes. We have to be pragmatic and get the barriers unlocked, to deliver the change we are looking for.

The other thing, from a system architecture point of view, is that, typically, there will be one CCG per ICS. Earlier, I flagged up the very different sizes of current STPs and ICSs. I do not know how deliverable that is. Last week, at the Public Accounts Committee, Simon Stevens said that there was no declared end number for the number of systems that we have. We would like to work with NHS England and NHS Improvement to look at what the right end number should be to balance both big-system working and the place and neighbourhood working you have heard about from all my colleagues.

Chair: Thank you all for coming this afternoon. It has been really helpful.

Chris Hopson: Thank you for the opportunity.