

HOUSE OF LORDS

Select Committee on the
Long-term Sustainability of the NHS

Report of Session 2016–17

The Long-term Sustainability of the NHS and Adult Social Care

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Select Committee on the Long-term Sustainability of the NHS

The Select Committee on the Long-term Sustainability of the NHS was appointed by the House of Lords on 25 May 2016 to consider the long-term sustainability of the National Health Service.

Membership

The Members of the Select Committee on the Long-term Sustainability of the NHS are:

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Declarations of interest

See Appendix 1.

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Q in footnotes refers to a question in oral evidence.

SUMMARY

A culture of short-termism and an Office for Health and Care Sustainability

A culture of short-termism seems to prevail in the NHS and adult social care. The short-sightedness of successive governments is reflected in a Department of Health that is unable or unwilling to think beyond the next few years. The Department of Health, over a number of years, has failed in this regard. Almost everyone involved in the health service and social care system seems to be absorbed by the day-to-day struggles, leaving the future to ‘take care of itself’. A new political consensus on the future of the health and care system is desperately needed and this should emerge as a result of Government-initiated cross-party talks and a robust national conversation.

To build on this consensus, we recommend the establishment of an Office for Health and Care Sustainability. It should play no part in the operation of the health and care systems, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should look 15–20 years ahead and report to Parliament, initially focusing on: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. The body should be established in statute before the end of this Parliament.

Transforming services

Service transformation is at the heart of securing the long-term future of the health and care systems. It is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is badly needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made reform is needed to reduce fragmentation and the regulatory burden. Service transformation will be key to delivering a more integrated health and social care system and although there are some positive examples in some areas, there is more to be done. With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement are merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government.

Realistic and consistent funding for health and adult social care

We are clear that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for the delivery of sustainable health services. In coming years this will require a shift in government priorities or increases in taxation. We are also clear that health spending beyond 2020 needs to increase at least in line with growth in GDP in real-terms. We heard that publicly-funded adult social care is in crisis. The additional funding for social care announced in the 2017 Budget is welcome and means funding for social

care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system. The Government needs to provide further funding between now and 2020. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding.

Funding for health and adult social care over the past 25 years has been too volatile and poorly co-ordinated between the two systems, and this should be addressed as a matter of priority. We recommend that the budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the 'Department of Health and Care'. This should allow money and other resources to be marshalled within a unified policy setting at national level. We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen.

We support a funding system for social care that enables those who can afford it to pay for the care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission. We also call on the Government to implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms to make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs.

The absence of long-term workforce planning

We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10–15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Health Education England has been unable to deliver. It needs to be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care which should always look ten years ahead, on a rolling basis. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, which utilises a greater proportion of the domestic labour market. Health Education England's independence should be guaranteed, it should be supported by a protected budget and it should be given greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system.

The evidence was clear that too little attention has been paid to training the existing workforce and a radical reform of many training courses for medical recruits is desperately needed. Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical

and social care education and ongoing training courses can be reformed and streamlined. We also heard repeatedly of the linkage between over-burdensome regulation, unnecessary bureaucracy, a prolonged period of pay restraint, low levels of morale and retention problems. We call on the Government to bring forward legislation to urgently reform the system regulators and the system of regulation for health and social care professionals.

Innovation, technology and productivity

Currently, leaders in the NHS seem to be incapable of driving the much needed change in levels of productivity, uptake of innovation, effective use of data and the adoption of new technologies. Understandably, too much management and clinical attention is focussed on the here and now and there are too few incentives to look ahead to the longer term. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage.

Unwarranted levels of variations in patient outcomes are unacceptably undermining the effectiveness and efficiency of the NHS and there is no plan to bring about a greater consistency in levels of performance. The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance at a local level. There is an immediate opportunity in the implementation of Sustainability and Transformation Plans to take this forward. Greater levels of investment and service responsibility should be given to those who improve the most.

Public health, prevention and patient responsibility

We are of the firm opinion that continued cuts to the public health budget are not only short-sighted but counter-productive. There is a grave risk that the burden of disease will increase if these cuts continue, a trend which is bound to result in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets for at least the next 10 years. Governments should not cite unwillingness to behave as a ‘nanny state’ as an excuse for inaction on the major public health issues, including obesity. Importantly, the Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted and relaunched with a greater emphasis on these often overlooked individual responsibilities. The Government should also redouble its efforts to educate the public about the true costs to the NHS of poor lifestyle choices.

Time and resource constraints meant that we were not able to look at each and every issue in as much detail as they deserved. Nevertheless, we hope that our conclusions and recommendations, which can be found at the end of the report, will provide a starting point for others who continue to work to secure the long-term sustainability of both the NHS and adult social care.

The Long-term Sustainability of the NHS and Adult Social Care

CHAPTER 1: INTRODUCTION

Headline after headline

1. Our NHS, our ‘national religion’, is in crisis and the adult social care system is on the brink of collapse. No one who listened to the evidence presented by the vast array of expert witnesses who appeared before us can be in any doubt about this. Immediate measures are undisputedly needed to alleviate the situation in the short term. Our task, however, was different. We took—indeed our terms of reference stipulated that we should take—a longer-term view. The questions we asked were: How can we retain the basic principles of the NHS: healthcare largely free-at-the-point-of-use, for all citizens? How can we secure an adult social care system which meets the needs of a rapidly changing population? Ultimately can we get beyond today and envisage a long-term future for an integrated health and care service?
2. Our conclusion could not be clearer. Is the NHS and adult social care system sustainable? Yes, it is. Is it sustainable as it is today? No, it is not. Things need to change.
3. The NHS has been serving the nation well for almost 70 years. We were told that it is increasingly effective, affordable and a net asset for the country as a whole.¹ Remarkably, the founding principles which underpinned Aneurin Bevan’s pioneering NHS of 1948 are taken to be as valid today as they were then—that the NHS should provide a comprehensive service, available to all. The service one receives should depend on clinical need, not the ability to pay.²
4. The NHS has survived a long series of crises since its foundation. Accusations of underfunding, back-door privatisation and unnecessary reorganisations, together with claims that inefficient clinical and administrative practices prevail, have plagued successive Secretaries of State for Health. Many of our witnesses portrayed an NHS which is now at breaking point.
5. The House of Commons Public Accounts Committee (PAC) recently reported on the financial sustainability of the NHS. It found that the financial performance of NHS bodies had ‘worsened considerably’. NHS trusts’ deficits had reached £2.5 billion in 2015/16, up from an £859 million deficit in 2014/15. According to the PAC two-thirds of NHS trusts (65%) and NHS foundation trusts (66%) reported deficits in 2015/16, up from 44% of NHS trusts and 51% of NHS foundation trusts in the previous financial year.³ This downward spiral cannot continue.

1 Q 285 (Simon Stevens)

2 Department of Health, ‘The NHS Constitution for England’: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#principles-that-guide-the-nhs> [accessed 28 March 2017]

3 House of Commons Committee of Public Accounts, *Financial Sustainability of the NHS* (Forty Third Report, Session 2016–17, HC 887)

6. This, together with increased demand, is stretching the NHS's ability to cope. Headline after headline report that key NHS targets are being missed; performance against the four-hour Accident and Emergency (A&E) waiting time targets is worsening, as is performance against the ambulance response time standards and the target requiring patients to be treated within 18 weeks of referral.⁴
7. Increasing demand from an ageing population, when coupled with cuts to local authority funding, is placing immense pressure on adult social care services. Shortfalls in social care provision are placing an unprecedented and increasingly unmanageable strain on the NHS. A health service being forced to cope with higher demand and increasingly complex patient needs, as well as trying to secure its own financial sustainability, is being asked to achieve the impossible. The evidence we received was clear: a social care system in crisis will only exacerbate the funding and resource pressures on the health service, but a lasting settlement for social care has the potential to alleviate some of those pressures. The social care crisis is deepening, and unless it is tackled, the health service will not be able to survive in its present form.

Beyond the here and now

8. Beyond the immediate financial and operational pressures, we heard evidence of other challenges which, if left unaddressed, pose a serious threat to the long-term sustainability of the health and social care systems.
9. The UK has historically spent less on health when compared with the Organisation for Economic Co-operation and Development (OECD) averages. UK health spending per head is markedly lower than other countries such as France, Germany, Sweden and The Netherlands.⁵ The UK also performs poorly in comparison with other countries on many indicators of acute care, achieving worse outcomes for survival from stroke and heart attacks.⁶ It continues to lag behind comparable European counterparts for cancer survival over five years and 10 years.⁷ We heard that the UK also has fewer hospital beds, fewer doctors and fewer nurses per head than the OECD averages.⁸
10. Low productivity in the health and care systems remains an endemic problem and there are wide variations in provider performance. The Care Quality Commission's (CQC) latest report *The State of health care and adult social care in England 2015/16* concluded that the quality of care provided across England still varies considerably "both within and between different services."⁹ We heard that there is variation present in the system that is wholly unwarranted and which "cannot be explained by variation in need or explicit choice of populations or individuals."¹⁰ Action must be taken to change this.

4 House of Commons Committee of Public Accounts, *Financial Sustainability of the NHS* (Forty Third Report of Session 2016–17, HC 887)

5 The Health Foundation, 'How does the UK compare internationally for health funding, staffing and hospital beds?': <http://www.health.org.uk/chart-how-does-uk-compare-internationally-health-funding-staffing-and-hospital-beds> [accessed 28 March 2017]

6 Q 70 (Ian Forde)

7 Q 70 (Professor Alistair McGuire)

8 Q 70 (Ian Forde)

9 Care Quality Commission, *The state of health care and adult social care in England 2015/16* (12 October 2016): http://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf [accessed 28 March 2017]

10 Q 60 (Sir Muir Gray)

11. Significant health inequalities persist. This is felt markedly in the pronounced inequalities between the treatment of physical and mental health; people with severe and prolonged mental illness are at risk of dying, on average, 15 to 20 years earlier than others.¹¹ The reductions in health inequalities called for by the Marmot Review have yet to be realised.¹²
12. Innovative technologies can produce both large cost savings and more effective treatment. Yet the evidence highlighted that the NHS is often a slow adopter of new technologies. We heard that there is significant under-use of technology, data and digitisation, which slows innovation and reduces levels of productivity.¹³
13. The public is committed to the NHS as a service which is tax-funded and free-at-the-point-of-use. However, a recent opinion poll conducted by Ipsos MORI showed that the future of the NHS is an increasing concern, with 55% of people—the highest figure they have ever recorded—saying they expected the NHS to deteriorate over the longer term.¹⁴ There has been an entrenched reluctance to engage in a serious conversation with citizens about how the system they have grown used to will need to change to meet new challenges. People need to be educated to take responsibility for their own health. Politicians need to be honest that with patient rights come patient responsibilities.
14. We were afforded the rare opportunity to look beyond the immediate pressures facing the health and social care systems and instead focus on how to ensure they are sustained in the long term. We asked many of our witnesses what the perfect health system would look like in 10 to 15 years' time. The answers we received were consistent; fully integrated health and social care services, more care delivered in primary and community settings, a greater focus on prevention, supported by adequate and reliable funding—all of which should provide seamless, patient-centred care. Although there was widespread agreement on the vision for the health and social care system of the future, we are clear that this cannot be delivered as things stand.
15. Short-term funding fixes will not suffice. Neither will tinkering around the edges of service delivery. We believe that, in order to achieve long-term sustainability of the NHS, we need:
 - **Radical service transformation:** The needs of patients have changed and so the system needs to change with them. There is widespread agreement on the vision—integrated health and care services delivering more care in primary and community settings—but service fragmentation and volatile funding allocations are making the necessary service transformation difficult.
 - **Long-term funding solutions for the NHS and adult social care:** Funding for both health and social care needs to be more stable and predictable, with better alignment between the allocations for health and social care. This should help to support longer-term, strategic planning for both services.

11 Written evidence from Mind ([NHS0179](#))

12 [Q 322](#) (Professor Sir Michael Marmot) and The Marmot Review, *Fair Society Healthy Lives* (February 2010): <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf> [accessed 28 March 2017]; the report identified striking levels of health inequalities across the country.

13 [Q 72](#) (Professor Alistair McGuire)

14 [Q 105](#) (Ben Page)

- **Immediate and sustained action on adult social care:** The funding crisis in adult social care threatens to overwhelm the NHS and will undermine any efforts to transform the system as a whole. A long-term financial settlement—preferably one on which the political parties can agree—is needed to put social care on a sustainable footing. A long-term programme, with clear leadership, governance and accountability for the better integration of health and social care, is the single instrument that would do most to enable the NHS to break through to a sustainable future.
16. It is our firm belief that the NHS can be sustained and, indeed, that it should be sustained. However, unless the issues outlined above are addressed as a matter of urgency, there is a real danger that the NHS will be rendered incapable of delivering on its much-cherished foundational principles.
 17. This crisis is different from the other crises. Whatever short-term measures may be implemented to muddle through today, a better tomorrow is going to require a more radical change. Of course, more money will be required, but political and professional conservatism is as much a threat to long-term sustainability as a lack of funding. In this report we set out a holistic plan for long-term change that should deliver a flourishing health and care service not only for ourselves, but for our children and grandchildren.

The inquiry and the Committee's work

18. In March 2016 the Liaison Committee recommended that the House should appoint an *ad hoc* committee to consider the long-term sustainability of the NHS. On 25 May 2016 we were appointed and ordered to report by 31 March 2017.¹⁵ We started work in June 2016 and took the decision early on to focus on the following themes, structuring our Call for Evidence document accordingly:
 - (1) resource issues, including funding, productivity and demand management;
 - (2) workforce, especially supply, retention and skills;
 - (3) models of service delivery and integration;
 - (4) prevention and public engagement; and
 - (5) digitisation of big data, services and informatics.
19. The broad scope and relatively long timeframe for the inquiry afforded us the opportunity to examine cross-cutting issues such as planning, the quality of political leadership, and consensus-building, which have often been overlooked in other, more narrowly defined parliamentary inquiries or government-initiated reviews.
20. Although we were appointed with the clear remit of considering “the long-term sustainability of the National Health Service”, as the inquiry developed, we were struck by the inextricable link between the NHS and the provision of social care. The evidence we received was clear that a social care system in crisis would only exacerbate the funding and resource pressures on the

¹⁵ Liaison Committee, *New investigative committee activity* (3rd Report, Session 2015–16, HL Paper 113) and House of Lords Minutes of Proceedings, [25 May 2016](#)

health service, and that a lasting settlement for social care had the potential to alleviate some of those pressures. It would therefore have been impossible to carry out this task without investigating the inter-related nature of health and social care and the need for a lasting settlement for both. Consequently, much of our evidence-gathering and deliberations focused on this important issue.

21. We gathered a wide range of evidence from a large number of individuals and organisations. We received 192 written submissions and heard from well over 100 witnesses in oral evidence sessions between July and December 2016. The level of public engagement was noteworthy; members of the public submitted over 3,000 letters and emails in the final stages of the inquiry with many personal reflections and heartfelt opinions. We would like to place on the record our sincere thanks to all those who contributed to the inquiry by appearing before us in Westminster, by taking the time to submit written evidence or through sending personal correspondence.
22. Health is a devolved matter in the United Kingdom. Consequently, much of the evidence we received and the corresponding conclusions and recommendations we have drawn focus on the situation in England. It is our hope, however, that where applicable, the devolved administrations and those who work in and make use of the NHS throughout the entire United Kingdom may find in this report a set of worthwhile reflections on the future of health and social care provision in all four constituent nations.
23. The following six chapters contain conclusions and recommendations aimed not only at the UK Government, but politicians of all parties, those who work in the NHS, those who represent them and those who make use of its services. The report begins with a consideration of what service transformation is required to support the long-term sustainability of the NHS and adult social care systems (Chapter 2). The workforce is the lifeblood of the NHS and this is discussed in Chapter 3 before the controversial matter of funding for both the NHS and adult social care is considered in Chapter 4. Attention is then given to levels of productivity and the NHS's approach to innovation and the uptake of new technologies (Chapter 5). The move from an 'illness service' to a 'wellness service' and the role of the patient is considered next in Chapter 6. The report concludes with a discussion of political leadership, the need for a cross-party consensus on the way forward and a call for a longer-term solution to funding and planning (Chapter 7).
24. The members of the Committee are listed in Appendix 1, along with declared interests. The witnesses and those who submitted written evidence are listed in Appendix 2. The Call for Evidence is given in Appendix 3. All evidence is published online on the Committee's website.
25. We were ably assisted in our work by two specialist advisers. Anita Charlesworth, Chief Economist at the Health Foundation, was an invaluable aide as the inquiry progressed and Emma Norris, Programme Director at the Institute for Government, was particularly helpful with an audit of independent and semi-independent public bodies, details of which can be found in Appendix 5. We are deeply grateful to both of them. We are also grateful to the staff who worked on the Committee: Patrick Milner (Clerk); Emily Greenwood (Policy Analyst to October 2016); Beth Hooper (Policy Analyst from October 2016); Thomas Cheminais (Committee Assistant to November 2016); and Vivienne Roach (Committee Assistant from November 2016).

CHAPTER 2: SERVICE TRANSFORMATION

26. Increased longevity of life was one of the triumphs of the 20th century. The challenge for today is to ensure that those extra years are healthy years. The health service in this country—in common with most of those in the developed world—was designed primarily to treat short-term episodes of ill health and today continues to operate around individual conditions and body parts. Consequently, it is less adapted for frail, elderly people with multiple health conditions.
27. If the system is going to adapt to meet the patient needs and demands of the future, radical service transformation is required. There is wide agreement on the vision for the health system of the future—effective primary and community services, secondary services free from inappropriate use, and more joined-up working between health and social care services—but we were told repeatedly of the barriers that prevent this transformation. If the vision is to become a reality it will require clear direction from the centre but also strong support for local co-operation and place-based commissioning.
28. This chapter sets out the case for service transformation and explores some of the existing efforts. It considers how the different components of the system need to change, examines the progress of integration of the health and social care services and considers what barriers need to be overcome to support the system to adapt to meet demands over the next 10 to 15 years.

The case for service transformation

29. While the NHS has evolved considerably since its inception in 1948, the drivers of change—from demographic factors and changing disease patterns, to technological and medical advances, income effects and increasing relative health care costs—are intensifying at a relentless pace and fuelling rising public expectations. The system, which was originally designed to treat short-term episodes of ill health is now caring for a patient population with more long-term conditions, more co-morbidities and increasingly complex needs.

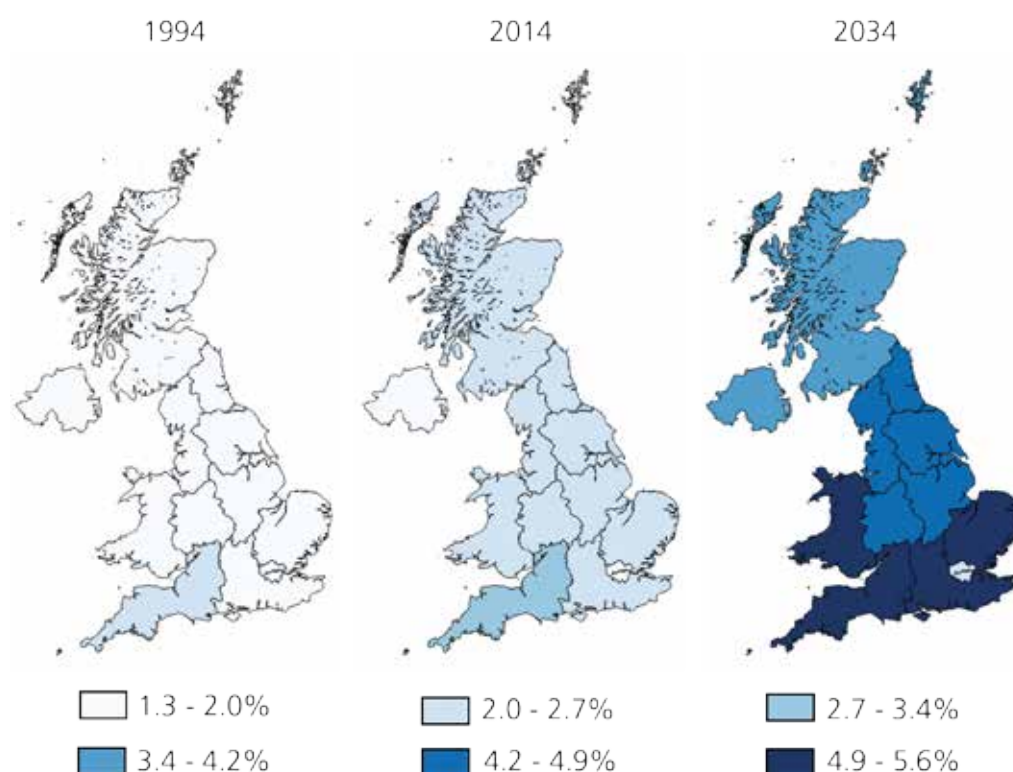
Box 1: Demographic and Disease Change

Demographic changes will contribute significantly to the levels of demand placed on health and care services over the next 10 to 15 years, and beyond. As the population ages, there will be a likely change to the prevalence of some major diseases and an increase in the number of people with more than one long-term condition.

An ageing population

The Office for National Statistics (ONS) forecasts that the proportion of individuals aged 65 years and over will increase from 18.0% of the population in 2016 to 26.1% in 2066. Growth will be particularly strong among the oldest individuals, with the share of the population aged 85 years and above set to increase from 2.4% to 7.1% over the same period. Figure 1 illustrates the historic and projected changes in the proportion of the population of people aged over 85.

Figure 1: Proportion of the population in the UK aged 85 in 1994, 2014 and (projected for) 2034



Source: ONS data cited in written evidence from Professor Chris Whitty ([NHS0194](#))

Changes to the burden of disease

Professor Chris Whitty, Chief Scientific Adviser at the Department of Health, detailed the likely change in disease mix expected over the next 20 years. In his view it was reasonable to expect the continuation of some of the trends seen in the last 30 years. For example, improvements in primary and secondary prevention mean that the incidence of cardiovascular disease (heart disease, acute stroke, some vascular dementia) and some major cancers (for example lung, cervical, gastric) will reduce.

Other diseases are likely to reduce in incidence but increase in prevalence due to better survival—stroke is an example. This will have significant implications for the skill mix needed in the professions 20 years on. Meanwhile some diseases will increase in prevalence due to successes in other areas (for example some infectious diseases and some cancers). Professor Whitty suggested that the most prominent of these will most likely be dementia.

Sources: ONS figures cited in Institute for Fiscal studies, *IFS Green Budget, UK health and social care spending* (7 February 2017): <https://www.ifs.org.uk/uploads/publications/budgets/gb2017/gb2017ch5.pdf> [accessed 28 March 2017] and written evidence from Professor Chris Whitty ([NHS0194](#))

30. There was widespread agreement throughout our evidence that the NHS's current delivery model was outdated and struggling to keep pace with the changes outlined in Box 1. Michael Macdonnell, Director of Strategy at NHS England, told us: "If we had to recreate the system, none of us would recreate what we currently have."¹⁶
31. The issue of whether the health system and the models of care within it reflect the needs of the patients it cares for is of central importance. Underpinning much of the evidence we received was a clear agreement that without the necessary service transformation, tantamount to a "fundamental reinvention of the delivery model",¹⁷ greater sustainability could not be achieved.

The vision

32. We asked many of our witnesses the same question—what does the healthcare system of 2030 look like and what do we need to get there? As a result, we were able to obtain a very clear articulation of what key components a sustainable system would need to include. A number of consistent themes emerged:
 - (1) The urgent need to shift more care away from the acute sector into primary and community settings;
 - (2) Widespread support for closer integration of health and social care services (as far as organisation and budgets are concerned); and
 - (3) The need to resolve the current fragmentation of the health system, which is making the provision of co-ordinated care impossible and frustrating efforts to move toward place-based systems of care.
33. A conclusive shift away from hospital-based care towards delivering care through primary and community-based services was perhaps the most prominent of the calls for service transformation. The Department of Health confirmed that: "Our focus and interest are in how you shift activity and resources from acute to community settings."¹⁸ Public Health England echoed this, stating that: "What we are looking for to happen over the next few years is new, more integrated services outside of the acute setting done at scale in primary and community settings."¹⁹
34. The evidence was also overwhelmingly in favour of the integration of health and social care services and budgets, with more of these services, including mental health services, provided on a community basis. The Royal College of Nursing was one of many witnesses that suggested that integration was central to the long-term sustainability of the health and care system, and critical to facilitating positive system change, stating that:

"The reality is that the failure to fund either effectively, or address people's needs through design and delivery of integrated services, is negatively impacting both funding and outcomes. We must consider these aspects of care and support as fundamentally connected and interdependent, rather than seeing them in isolation from one another."²⁰

16 [Q 47](#) (Michael Macdonnell)

17 [Q 128](#) (Tom Kibasi)

18 [Q 3](#) (Graham Duncan)

19 [Q 246](#) (Adrian Masters)

20 Written evidence from the Royal College of Nursing ([NHS0149](#))

Service transformation: the current situation

The Five Year Forward View

35. The current strategic vision for the NHS is set out in the Five Year Forward View which was published in October 2014. It was published under the leadership of its current Chief Executive, Simon Stevens of NHS England, and outlines a vision for the future of the NHS based around new models of care. It focuses on a number of themes such as the importance of public health and ill-health prevention, empowering patients and communities, strengthening primary care and making further efficiencies within the health service.
36. A core aim of the Five Year Forward View was to undertake “radical action to transform the way NHS care is provided.”²¹ To achieve this, it set out how NHS England would “support and stimulate the creation of a number of major new care models” to help meet the changing needs of patients.²² Some of the new models include:
 - Multispecialty Community Provider: This model permits groups of general practitioners to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care services to create integrated out-of-hospital care.
 - Primary and Acute Care Systems: This model combines, for the first time, general practice and hospital services, allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.
 - Urgent and emergency care networks: Under this model, the urgent and emergency care system will be simplified to provide more integration between A&E and other services. Changes include the development of hospital networks with access to specialist centres, new partnership options for smaller hospitals and a greater use of pharmacists.²³
37. These new models of care are being delivered through a series of ‘vanguard’ sites across the country. Michael Macdonnell told us that: “The new care models programme is based on a vision of where we want to get to.”²⁴
38. The general direction of travel set out in the Five Year Forward View was strongly supported as a basis for making the NHS more sustainable. Organisations including the Academy of Medical Royal Colleges, the Faculty of Public Health and the Shelford Group all indicated in their submissions that they agreed with the vision for service transformation outlined in the Forward View.²⁵

21 NHS England, *The Five Year Forward View* (October 2014), p 14: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 28 March 2017]

22 *Ibid.*

23 NHS England, ‘The Five Year Forward View—the executive summary’: <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/> [accessed 28 March 2017]

24 Q 44 (Michael Macdonnell)

25 Written evidence from the Academy of Medical Royal Colleges (NHS0139), the Faculty of Public Health (NHS0154) and the Shelford Group (NHS0134)

39. We were told that there were plans to extend the Five Year Forward View. Simon Stevens, told us that NHS England would publish a set of proposals, which would be “a manifesto if you like, for what going into the next Parliament it should look like over the medium term.” Mr Stevens indicated that it was likely that this would be published in the near future.²⁶
40. Despite the assurance that the Forward View would be revisited we were concerned that there appeared to be a significant lack of long-term thinking around how the momentum on service transformation will be maintained. As the Health Foundation emphasised:
- “Delivering the vision and funding set out in the Forward View is a necessary step towards a sustainable health care system but not a sufficient one. Beyond the Forward View, action will be needed to secure a high quality, sustainable health and care system for the 2020s.”²⁷
41. NHS Providers raised similar concerns and told us that:
- “... there is no clarity about how the government’s commitment to integrate care by 2020 will be delivered and a real lack of vision and strategy for integration or service reconfiguration beyond this period to 2035.”²⁸
42. It appears that in terms of service transformation (and in other areas we outline later in this report) the view of policymakers is set no further than 2020. Chris Wormald, Permanent Secretary at the Department of Health, confirmed that:
- “Of course like any Government department our primary focus is on delivering the manifesto right now. Our focus is unashamedly on the next five years delivering the five year forward view ... We are not in the business of publishing long term plans, future visions of the health service beyond the current Parliament but we are in the process of a constant horizon scanning.”²⁹
43. **Most people agree that key aspects of the service delivery model for the NHS need to change. There is also broad agreement on how this should happen. The general direction of NHS England’s Five Year Forward View commands widespread support and, if fully realised, will place the NHS on a far more sustainable footing, especially if greater public support can be achieved.**
44. **The Five Year Forward View appeared to be the only example of strategic planning for the future of the health service. This is clearly short-sighted. Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the Five Year Forward View will be put at risk.**
45. ***The Department of Health and NHS England, in partnership with the Department of Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services, should agree a medium-term plan that sets out the action required to deliver sustained service transformation at a local level. This plan should cover the period up to at least 2025, be supported by dedicated funds and be implemented following a full public consultation.***

26 [Q 278](#) (Simon Stevens)

27 Written evidence from the Health Foundation ([NHS0172](#))

28 Written evidence from NHS Providers ([NHS0110](#))

29 [Q 250](#) (Chris Wormald)

Sustainability and Transformation Plans

46. Sustainability and Transformation Plans (STPs) were announced in December 2015. As a result, NHS organisations and local authorities in different parts of England have been required to produce a multi-year ‘place-based plan’ showing how local services will evolve and become sustainable over the next five years—ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.
47. Final plans from the 44 STP areas were submitted in October 2016. The plans are likely to be assessed and approved in phases, depending on their quality. From April 2017, STPs will become the single application and approval process for accessing NHS transformation funding, with the best plans set to receive funds more quickly.³⁰ STPs were described by the Department of Health as a “genuine attempt to go for place-based commissioning ... trying to involve the local NHS plus social care plus public health, to bring them all together to plan on a five-year, more strategic basis.”³¹
48. We noted that the Department of Health and NHS England were clear that they saw STPs as a key way in which to tackle some of the system’s most significant pressures and were central to realising the vision set out in the Five Year Forward View. In November 2016, Simon Stevens said:

“The Five Year Forward View is a vitally important plan. It’s about the move to accountable care organisations, about the move to prevention and not cure. And it has the support of the NHS, and it is vital that we stick with that plan and implement it. And there will be lots of challenges and lots of bumps in the road but the sustainability and transformation plans are the way that we implement the Five Year Forward View and it is vital we stick with them.”³²
49. Amongst our witnesses, though there was broad support for STPs and their role in securing the sustainability of the NHS, some witnesses expressed concerns about the STP process.

Lack of governance

50. Currently, STPs have no statutory basis. However, several individual statutory organisations, such as clinical commissioning groups, will be involved in each Plan. There is, therefore, considerable ambiguity around the governance of STPs which threatens to undermine the ability of STP areas to drive changes to services. Sir Robert Naylor, former Chief Executive of the University College London Hospitals NHS Foundation Trust, said:

“There are, however, a number of challenges that STPs will need to overcome if they are to deliver the improvements that the NHS needs. The first is about governance and engagement. STPs have been set up relatively quickly, with multiple conflicts of interest and without a statutory basis. That will not give them the authority they will need to drive through difficult decisions about service changes and distribution of financial risks. They will be unable to deliver significant estate

30 The King’s Fund, ‘Sustainability and transformation plans (STPs) explained’: <https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained> [accessed 28 March 2017]

31 Q 13 (Dr Edward Scully)

32 GP Online, ‘STPs ‘vital’ for future of NHS, Jeremy Hunt MP has told health leaders’: <http://www.gponline.com/stps-vital-future-nhs-jeremy-hunt-tells-health-leaders/article/1415100> [accessed 28 March 2017]

changes, including investment in primary care, because the majority of assets are ‘owned’ by the acute foundation trusts who are not responsible for the whole patient pathway.”³³

Insufficient investment for both sustainability and transformation

51. The scale of the financial challenge facing both the health and care systems makes it extremely difficult to achieve the service transformation that so many agree is needed. Concerns were raised that, although STPs were regarded as an important mechanism to help transform the way care is delivered, without sufficient investment, they would not be able to achieve sustainable change.
52. When asked whether the transformation fund (the funding that has been made available to support the implementation of the Five Year Forward View through STPs) would be sufficient, Richard Murray, Director of Policy at The King’s Fund, told us: “At the moment, no. Much of the transformation funding that is available will end up being directed at deficits in the acute sector.”³⁴
53. In this year’s Budget, published on 8 March, the Chancellor of the Exchequer announced £325 million of new capital funding for STPs. The investment will be allocated to the ‘strongest’ STPs and will be spread over three years, with further funding to be considered in the autumn.³⁵ While this additional funding is welcome, we agree with those who have described this as falling short of what is required, given the significant amount of new capital investment that the plans are likely to need over the next five years, which has been estimated at around £10 billion.³⁶ There is a real risk that the funds which will be made available to STPs will be swallowed up by efforts to sustain local services instead of transforming them.
54. In its recent report on the progress of STPs, *Sustainability and transformation plans, from ambitious proposals to credible plans* (February 2017), The King’s Fund concluded that:

“The context in which STPs have emerged is much more challenging than when the Forward View was published, with the NHS now facing huge financial and operational pressures. The changes outlined in STPs could help address these pressures, but there is a risk that work to sustain services will crowd out efforts to transform care.”³⁷

33 Written evidence from Sir Robert Naylor ([NHS0181](#))

34 [Q 26](#) (Richard Murray)

35 HM Treasury, *Spring Budget 2017* (March 2017), p 48: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597467/spring_budget_2017_web.pdf [accessed 28 March 2017]

36 The Health Service Journal, ‘Leading STPs to get ‘very modest’ £325 million capital funding’ (8 March 2017): <https://www.hsj.co.uk/sectors/commissioning/leading-stps-to-get-very-modest-325m-capital-funding/7016338.article> [accessed 28 March 2017]

37 The King’s Fund, *Delivering sustainability and transformation plans From ambitious proposals to credible plans* (21 February 2017): https://www.kingsfund.org.uk/sites/files/kf/field/publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [accessed 28 March 2017]

Lack of engagement

55. For place-based commissioning to work, NHS organisations will need to work closely with local partners including local authorities, the voluntary sector and the public. The Local Government Association told us that “It is vital that time is invested in engaging councillors and MPs in the development stage of Sustainability and Transformation Plans, to ensure that communities’ wishes are understood, and to minimise the likelihood of challenge or delay to proposals.”³⁸
56. We were therefore concerned to hear reports that in some STPs areas there has been a lack of engagement with councillors and communities in the planning process. The King’s Fund research on the progress of STPs highlighted that engagement with local authorities had been patchy, stating that “The strength and depth of local authority involvement in the plans has varied between STP footprints, ranging from strong involvement in decision-making and planning to very weak involvement in all aspects of the process.”³⁹
57. We also received evidence demonstrating a lack of public involvement in these developments. The Chief Executive of the Patients Association, Katherine Murphy, told us that, regarding STPs:

“... the public were not consulted on what services should be provided in their local communities. The public are very willing to become involved. They want to be involved; they want to be consulted and talked to and given the correct information. They would like to be involved in an open, transparent and meaningful way. They understand the reasons why services have to be cut within the NHS. What they fail to understand is why such major plans are being drawn up without any consultation with patients and the public.”⁴⁰
58. **We applaud the move towards more place-based commissioning which delivers integrated health and social care services. At this early stage it would be premature to make a judgement about the current effectiveness of Sustainability and Transformation Plans but we doubt the ability of a non-statutory governance structure to secure sustainable change for the medium and longer term. NHS England, with the support of the Department of Health, should ensure that all 44 Sustainability and Transformation Plan areas have robust governance arrangements in place which include all stakeholders, including NHS organisations, local government, the voluntary sector and the public.**
59. **We are concerned by the reported lack of engagement with either local authorities or the wider public in the preparation of Sustainability and Transformation Plans. This will deter buy-in at a local level and jeopardise ongoing political support.**

38 Written evidence from the Local Government Association ([NHS0125](#))

39 The King’s Fund, *Sustainability and transformation plans in the NHS, How are they being developed in practice?* (November 2016), p 34: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_in_NHS_Kings_Fund_Nov_2016_final.pdf [accessed 28 March 2017]

40 [Q 179](#) (Katherine Murphy)

Devolution

60. In addition to STPs, we heard evidence about initiatives to devolve more responsibility for health and social care to local areas as another way of encouraging bespoke local solutions to service transformation. We heard evidence from individuals involved in perhaps the most high profile of these devolution projects—the devolution of health and social care spending to Greater Manchester—which is outlined in more detail in Box 2.

Box 2: Greater Manchester Health and Social Care Devolution

The Greater Manchester Agreement, signed in November 2014, set out new powers over transport, housing, planning and policing for the Greater Manchester Combined Authority.

In April 2016 the region became the first in the country to take control of its combined health and social care budgets. Following the signing of a memorandum of understanding Greater Manchester now controls the full devolution of a budget of around £6 billion in 2016/17.

A new strategic board, the Greater Manchester Health and Social Care Partnership, was created to take charge of the £6 billion health and social care budget. The Partnership comprises 37 NHS organisations and councils, including:

- 10 local authorities;
- 12 clinical commissioning groups; and
- 15 trusts and foundation trusts.

Source: Greater Manchester Health and Social Care Partnership, *Taking charge of our Health and Social Care in Greater Manchester* (December 2015): <http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Final.pdf> [accessed 28 March 2017]

61. Sir Howard Bernstein, Chief Executive of Manchester City Council, told us how devolution of health was working there:

“We are seeking to join up community services with social care, mental health and primary care in order to provide the integrated offer that is necessary, not only to support a transformation in our population’s health through prevention and early intervention but in effect, to reduce the demand for services in our hospitals. That is how we see this strategy.”⁴¹

62. There were, however, doubts expressed as to how well the Greater Manchester example could be rolled out in other areas⁴². Baroness Cavendish of Little Venice told us:

“Manchester is I’m afraid unique. I don’t think there is any other part of this country that has the same constellation of talent in terms of the NHS and local authorities. I don’t believe there is anywhere else that has the same political impetus because it is essentially a political construct so what we are doing at the moment is we are basing our aspiration for STPs upon a hope that politicians in local areas will be able to come together in a way they are doing in Manchester. I think it would be very foolish to expect anyone else to adopt the Manchester model.”⁴³

41 [Q 225](#) (Sir Howard Bernstein)

42 [Q 41](#) (Michael Macdonnell), [Q 251](#) (Chris Wormald), [Q 266](#) and [Q 269](#) (Baroness Cavendish of Little Venice), [Q 284](#) (Simon Stevens) and [Q 316](#) (Mark Britnell)

43 [Q 226](#) (Baroness Cavendish of Little Venice)

63. **The evidence was mixed on the contribution of devolution to the long-term sustainability of health and social care. There are undoubtedly lessons to be learnt from devolution, but the evidence was not clear on how well the model in Greater Manchester could be replicated nationally especially as many, if not most, of the Sustainability and Transformation Plans (STPs) are for much smaller populations than that of Greater Manchester.**

Achieving service transformation

64. Current efforts on service transformation have largely prioritised the changes which need to be made to ensure existing services in the community are used more effectively to moderate demand for hospital care,⁴⁴ and changes to improve the integration of health and social care services to provide more comprehensive and joined-up care to patients.
65. The necessary service transformation is happening but belatedly and, we fear, at an inadequate scale and pace. Efforts to transform the way care is delivered are being seriously hindered by the fragmented nature of the current governance system and a considerable degree of uncertainty over who is responsible for driving service transformation as distinct from current service delivery.

Changes to models of care

Primary and community care

66. The Five Year Forward View states that primary care will remain “the foundation of NHS care.”⁴⁵ However, we received a considerable amount of evidence on the current pressures within primary care, and the resulting impact of those pressures on other parts of the system.
67. The Royal College of General Practitioners highlighted the most pressing issues facing general practice:
- Despite an increase in demand, investment in general practice has declined. Since 2005/06 the level of investment in general practice as a proportion of the NHS budget has declined from 10.7% to a record low of 8.4% in 2011/12.
 - The failure of GP recruitment to keep pace with demand is set to leave a shortfall of 9,940 GPs across the UK by 2020.
 - Retention of GPs is also a problem. The College has identified 594 practices across the UK where 75% of the GPs are aged 55 and over—with the retirement of so many GPs a present danger for these practices, the College has identified them as being at risk of closure by 2020. Nationwide, the proportion of GPs aged 55 or over in 2015 was 20.8% in England, 19.9% in Scotland, 23% in Wales and 25.2% in Northern Ireland.

44 The King’s Fund, *Delivering sustainability and transformation plans, From ambitious proposals to credible plans* (February 2017): https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [accessed 28 March 2017]

45 NHS England, ‘Five Year Forward View’: <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-ch3/> [accessed 28 March 2017]

- The ratio of practice nurses is failing to keep pace with increased demand and complexity with 2.7 Full Time Equivalent nurses for every 10,000 patients in England in 2014/15, the same ratio as in 2010/11. As well as this, the practice nurse workforce is ageing, with 31% of practice nurses aged 55 or over in 2014/15.⁴⁶
68. These challenges are frustrating efforts to deliver more care in primary and community settings in order to reduce pressures in the acute sector. There were concerns that the current longstanding model of primary care is not fit for the purpose of delivering the desired shift away from the acute sector. We heard that there has been historic and damaging underfunding of the primary care sector, as highlighted in NHS England's *General Practice Forward View*, which stated that over the past ten years governments have "cut the share of funding for primary care and [grown] the number of hospital specialists three times faster than GPs." This has had an impact on GP workload and added to "growing patient concerns about convenient access."⁴⁷ A clear message from the evidence was that the model of primary care required urgent reform to deliver the required service transformation. The *General Practice Forward View* acknowledged this, highlighting a report by the Primary Care Foundation and the NHS Alliance, which stated that:
- "The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice."⁴⁸
69. We found broad support for the new Multispecialty Community Provider care model and, in particular, the move towards GP practices working at scale to deliver extended services through federations. Dame Julie Moore, Chief Executive of University Hospitals Birmingham NHS Foundation Trust, told us:
- "... the model that we expect them [GPs] to operate sometimes is no longer fit for this day and age. The demands placed on primary care are huge and demand is outstripping that. We need to look at new models of primary care and how we work more closely together in 24-hour services and actually relieve some of the pressure ... we can only do that by working in bigger centres, working together and providing round-the-clock access that patients now need. I think we need to look again at the whole model of provision."⁴⁹
70. Similarly, Chris Hopson, Chief Executive of NHS Providers, suggested that:
- "... there is a widespread agreement that the 1948-bequeathed structure of a bunch of single-handed practices led by individual GPs is unable to provide the kind and scale of primary care that we now need, and there is a rapidly growing development where people are coming together in GP federations which make it easier and more effective to then link up all these different parts of health and social care."⁵⁰

46 Written evidence from the Royal College of General Practitioners (NHS0078)

47 NHS England, *General Practice Forward View* (April 2017): <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf> [accessed 28 March 2017]

48 Primary Care Foundation and NHS Alliance, *Making Time in General Practice* (October 2015): <http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf> [accessed 28 March 2017]

49 Q 174 (Dame Julie Moore)

50 Q 92 (Chris Hopson)

71. The suitability of the current independent contractor status of most GPs was questioned. Dr Clare Gerada, General Practitioner and former Chair of the Royal College of General Practitioners, suggested this arrangement “was not fit for purpose.”⁵¹ Sir Sam Everington, Chair of the NHS Tower Hamlets clinical commissioning group, suggested that this could be resolved by considering local contracts: “If you are to shift that care out of hospital with ... different solutions around the country, you have to come up with locally sensitive contracts to make that happen.”⁵²
72. The Chair of the Royal College of General Practitioners, Dr Helen Stokes-Lampard, agreed: “We all have to be realistic about what the future holds, and, whilst personally I love the partnership-led model of general practice, I know it is not likely to be fit for the long-term future and that we have to have local solutions for local problems.”⁵³
73. Lord Darzi of Denham also commented on the contractual arrangements within general practice:

“What we got wrong in the original polyclinic ... is that we described what this looked like, a federation, but we never really looked at the business model. In the NHS we are not good at business model innovation. We look at technological process innovation, but there are many business models that you can use to ignite the interest in primary care, whether they are partnership or employment models. We have to understand that the primary care community and leadership are also very divided; we can stratify them into those who would like employment contracts and those who would like to build partnerships.”⁵⁴
74. Despite a clear move from GPs in some areas towards operating in federations, there appeared to be little support or direction from the centre to drive this agenda. Beyond the Five Year Forward View, clear and determined leadership from the centre is required to identify a process for adapting the primary care model and its contractual basis to ensure it has the flexibility to meet the needs of patients in the future. It was not obvious to us who is going to provide this leadership.
75. In addition, we heard that there is a clear case for reforming the primary care workforce so that a range of other healthcare professionals such as nurses, community pharmacists and mental health counsellors can work in a team alongside GPs to support their work. Professor Maureen Baker, Former Chair of the Royal College of General Practitioners, emphasised the need for “high-level nursing skills in the community” and highlighted the suggestion of “a model used in the US where you have colleagues who support the doctor in doing a lot of admin, form filling and basic clinical tasks.” Professor Baker stated that: “We are saying we need this range of skills, we need GPs—we need as many GPs as we can get—and we need other colleagues to work so that they have the right workforce with the skills that 21st century patients need in the community.”⁵⁵

51 [Q 187](#) (Dr Clare Gerada)

52 [Q 187](#) (Sir Sam Everington)

53 [Q 209](#) (Dr Helen Stokes-Lampard)

54 [Q 267](#) (Lord Darzi of Denham)

55 [Q 188](#) (Professor Maureen Baker)

76. ***The traditional small business model of general practice is no longer fit for purpose and is inhibiting change. NHS England, with the help of the Department of Health and the profession, should conduct a review to examine alternative models and their contractual implications. The review should assess the merits of engaging more GPs through direct employment which would reflect arrangements elsewhere in the NHS.***

Secondary care

77. Over-reliance on the acute sector is a serious threat to the financial sustainability of health and care services. NHS Clinical Commissioners told us: “We are concerned that without a significant reduction in expensive hospital activity and a transformation in health and care delivery that makes better use of available resources the NHS will be unable to adequately respond to changing population needs.”⁵⁶
78. Those secondary care hospitals which serve towns and small conurbations provide a range of services for their local populations and face different sets of problems from specialised hospitals or units. In providing acute surgical, orthopaedic, medical and obstetric care for seriously ill patients, many of whom enter through A&E Departments, their facilities are vulnerable to being overwhelmed by patients with long-term care needs that are not being met by community services. Such hospitals house expensive diagnostic and therapeutic resources, such as imaging and operating theatres, and these may be used inefficiently when patients remain in hospital unnecessarily, reducing the availability of beds for other patients in need. There is also ongoing concern around levels of productivity within this sector, as highlighted by the Carter Review.⁵⁷
79. The continued pressures on the acute hospital inpatient sector require a reshaping of secondary care to meet the needs of an increasingly ageing population. Many of these people live with multiple chronic conditions and are increasingly finding themselves being cared for in high-cost and inappropriate hospital settings.
80. ***We acknowledge that over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped in terms of service provision but changes to the number, size and distribution of secondary care services should always reflect the needs of the local population. Any changes should take place following a broad consultation.***

Specialised services

81. A number of witnesses highlighted examples in the NHS where some specialised services, such as for cancer or cardiac surgery, had been concentrated into fewer hospitals to improve the quality of care, efficiency and effectiveness. It was suggested that further consolidation of specialised services should be a key consideration for future service transformation.

⁵⁶ Written evidence from NHS Clinical Commissioners ([NHS0159](#))

⁵⁷ Lord Carter of Coles, *Operational productivity and performance in England NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health by Lord Carter of Coles* (February 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 28 March 2017]

82. Specialised and highly specialised hospitals tend to be found in large city conurbations. Although there is a danger of duplication from services located within relatively short distances of each other, there is little doubt that focusing such expensive specialised services in specific areas ensures high levels of expertise and care. The success of centralising services that dealt with stroke, trauma and heart attacks was highlighted. Sir Cyril Chantler, an eminent paediatrician, highlighted the provision of centralised, specialised services in London, stating that: “London has gone from being one of the more dangerous capital cities in which to have a stroke to perhaps the safest.”⁵⁸
83. Professor Andrew Street, from the Centre of Health Economics at the University of York, expressed disappointment that there had been a missed opportunity for further service transformation over the last 10 to 15 years, but cited the consolidation of specialised services as a success:
- “You mentioned in the previous session the development of treatment centres as a different model of delivering care; small, self-contained, specialising in particular treatments, and although they were expensive to set up in the first place, they now tend to deliver high-quality care at a lower cost, with lower lengths of stay and better outcomes for patients, than they would if they had gone through the normal run of the hospital sector.”⁵⁹
84. The Specialised Healthcare Alliance, however, warned that there was still work to be done and that further progress on consolidation of specialised services was being impeded by a number of issues:
- “... attempts to reconfigure specialised care provision have typically met competing provider interests, political interventions and regulatory barriers preventing service change. Challenges such as these have historically stymied progress towards specialised services consolidation.”⁶⁰
85. **The drive to consolidate specialised services is a necessary part of overall service transformation. However, as with primary care, we were left with no clear picture of how specialised service consolidation will be delivered in the medium and the longer term.**

Integrating health and social care

86. For the most part, in England, health and social care services are separate. NHS England is responsible for healthcare and local authorities are responsible for means-tested social care. With the population ageing and the prevalence of long-term conditions and co-morbidities increasing, more and more patients require both health and social care. The separation between the two is becoming increasingly problematic.
87. Improved integration between health and social care services is often put forward as a way of reducing costs, easing the pressure on commonly-used services and delivering a better overall experience for patients.⁶¹ NHS

58 Written evidence from Sir Cyril Chantler (NHS0187)

59 Q 80 (Professor Andrew Street)

60 Written evidence from the Specialised Healthcare Alliance (NHS0042)

61 National Collaboration for Integrated Care and Support, *Integrated Care and Support: Our Shared Commitment* (May 2013), p 1: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf [accessed 28 March 2017]

England's approach to integration policy uses the following definition of integrated care:

“... person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered.”⁶²

Progress on integration

88. In England, recent policy efforts have been focused on encouraging local areas to co-ordinate resources and enabling financial integration between health and social care services. In April 2015 the Government launched the Better Care Fund, a joint initiative between the Department of Health, the Department for Communities and Local Government, NHS England and the Local Government Association. The Fund requires local health bodies and local authorities in each area to pool funding, a minimum of £3.8 billion in 2015/16 and £3.9 billion in 2016/17. Local bodies are required to produce joint plans for integrating services and to submit these plans to NHS England. Many areas chose to go beyond the minimum pooled funding requirements, resulting in a total of £5.3 billion being pooled in 2015/16 and £5.8 billion in 2016/17.⁶³
89. A recent report by the National Audit Office (NAO) cast doubt on the effectiveness of the Government's plan for integrated health and social care services. While it acknowledged that the Fund had been successful in incentivising local areas to work together, with more than 90% of local areas agreeing or strongly agreeing that the delivery of their plan had improved joint working, the NAO report was clear that the Government's policy on integration had not delivered on its ambitions of releasing savings, reducing emergency admissions and delayed discharges and, crucially, delivering better outcomes for patients. The report concluded:

“... progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities. As a result, the government's plan for integrated health and social care services across England by 2020 is at significant risk.”⁶⁴
90. Although the NAO's report was published after we had finished taking evidence, many of the witnesses conveyed the same sense that, despite a long history of initiatives aimed at joining up health and social care services, progress had been incredibly slow. Some witnesses presented the difficulty of integrating budgets as almost insurmountable; system-wide integrated services were still very far from being a reality. Integration policy has been discussed for decades but it was clear from the evidence that there was a degree of frustration at the lack of progress on the integration of either funding or service delivery.

62 NHS England, 'Integrated care and support': <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/> [accessed 28 March 2017]

63 The National Audit Office, *Health and social care integration* (Session 2016–17, HC 1011)

64 National Audit Office, Press Release: 'Health and social care integration', 8 February 2017: <https://www.nao.org.uk/press-release/health-and-social-care-integration/> [accessed 28 March 2017]

91. Many of the sources of evidence were in agreement that better integration of health and social care services would support improved patient experience. Chris Hopson told us that: “What it [integration] does relatively quickly, it seems, is produce a better quality of patient and service-user experience.”⁶⁵ What was less clear was whether integration offered the potential for substantial cost savings. Dr Edward Scully, Deputy Director, Integrated Care at the Department of Health, told us:

“My own take is that the potential for savings through integration of health and social care is not what people have set out; it is more limited. It is not a utopia or a panacea for releasing savings.”⁶⁶

92. Despite the uncertainty over the direct financial savings that might be released through improved integration, it is nonetheless viewed as a vital element of service transformation. Overcoming the barriers to improved integration will be central to securing the long-term sustainability of both health and care services. Dr Sarah Wollaston MP, Chair of the House of Commons Health Select Committee, told us:

“I think that if we continue to have a very fragmented model we will be missing many opportunities to commission much more logically for health and social care ... By having separated, fragmented systems for health and social care, we are wasting energy and money and are not meeting people’s needs, so I think that should be a clear priority for the future.”⁶⁷

93. The complex and fragmented organisational arrangements of health and care services are making the integration of services much more difficult. With budgets and staff in different organisations, coherent governance of, and accountability for, service transformation is extremely challenging. Sir Cyril Chantler described an “overall strategic uncertainty” which was apparent to us in the lack of clarity over who was primarily responsible for securing service integration as part of wider service transformation.⁶⁸ For too long integration has seemed everybody’s responsibility and nobody’s responsibility.
94. **Although recent efforts to promote joined-up health and social care services have delivered mixed results, integrated health and social care with greater emphasis on primary and community services still presents the best model for delivering patient-centred, seamless care. Although there is disagreement on the financial gains to be derived from this integration, the benefits to patients are a clear justification for continuing to pursue this agenda.**

Challenges to integration

95. The Health and Social Care Act 2012 introduced wide-ranging reforms to the NHS which included a radical restructuring of the health system. The Act established a new executive non-departmental public body called NHS England, to oversee the budget, planning and delivery of the commissioning side of the NHS; clinically led statutory NHS bodies (clinical commissioning groups) responsible for planning and commissioning of health care services

65 [Q 96](#) (Chris Hopson)

66 [Q 13](#) (Dr Edward Scully)

67 [Q 291](#) (Dr Sarah Wollaston MP)

68 Written evidence from Sir Cyril Chantler ([NHS0187](#))

locally; established Public Health England and Healthwatch England; and introduced provider regulation on competition issues, overseen by Monitor, which was later merged with other organisations under an umbrella organisation as NHS Improvement.

96. Many witnesses suggested that the restructuring of the system by the Health and Social Care Act 2012 had resulted in an extensive fragmentation of services. This, witnesses argued, was continuing to act as a serious impediment to devolution, integration and new ways of working. The Centre for Health and the Public Interest suggested that the Act's provisions were frustrating the current efforts on service transformation, stating that:

“The Five Year Forward View's central aim is better integration of the NHS. But the provisions of the Health and Social Care Act of 2012 are aimed at promoting competition, the opposite of integration. In trying to achieve the aims of the [Five Year Forward View] commissioners and providers have to ‘work around’ the Act, working against its aims but in conformity with its legal provisions. Planning is thus being undertaken by ad hoc groups of local commissioners and providers working outside any legal framework and doing only what the Act does not explicitly forbid. Informal and unaccountable government of this kind tends to produce bad policies as well as being prone to conflicts of interest and corruption.”⁶⁹

97. Similarly the PHG Foundation suggested that the Health and Social Care Act 2012 had made service transformation and an integrated approach to delivering care harder to achieve, as:

“... the financial and organisational independence of hospital trusts (reinforced by the Health and Social Care Act 2012) results in misaligned incentives to compete, not co-operate and to a drive to develop ‘distinctive’ services rather than learn from and adopt best practice developed elsewhere.”⁷⁰

98. The King's Fund recently highlighted, in its report *Delivering sustainability and transformation plans*, that amendments were needed to the aspects of the Act that were not aligned with the aims of the Five Year Forward View and STPs. It suggested that:

“The sections of the Act relating to market regulation would particularly benefit from review, both in relation to the role of the CMA [Competition and Markets Authority] and requirements on commissioners to use competitive processes in procuring new care models. There is also a need to recognise more formally the role that STPs are expected to play alongside the boards of NHS organisations and local authorities.”⁷¹

99. **The Health and Social Care Act 2012 has created a fragmented system which is frustrating efforts to achieve further integration and the service transformation aims of the Five Year Forward View.**

69 Written evidence from the Centre for Health and the Public Interest ([NHS0050](#))

70 Written evidence from the PHG Foundation ([NHS0080](#))

71 The King's Fund, *Delivering sustainability and transformation plans From ambitious proposals to credible plans* (21 February 2017): https://www.kingsfund.org.uk/sites/files/kf/field/publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [accessed 28 March 2017]

100. *NHS England and the Department of Health should launch a public consultation on what legislative modifications could be made to the Health and Social Care Act 2012 which would remove the obstacles to new ways of working, accelerate the desired service transformation and secure better governance and accountability for achieving system-wide integrated services.*
101. **Service transformation is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is desperately needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made the national system is in need of reform to reduce fragmentation and the regulatory burden.**
102. *With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement should be merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government.*

CHAPTER 3: WORKFORCE

103. Those who work in the NHS and adult social care are the lifeblood of the organisations they serve. The NHS is dependent on a reliable supply of appropriately skilled and highly motivated individuals to meet the ever increasing demand for care. The NHS website described the scale of the current workforce of the NHS in England as follows:

“The NHS employs more than 1.5 million people, putting it in the top five of the world’s largest workforces ... The NHS in England is the biggest part of the system by far, catering to a population of 54.3 million and employing around 1.2 million people.”⁷²

It is estimated that some two-thirds of the health service budget goes on salaries and wages for staff.⁷³ However, the Association of Directors of Adult Social Services (ADASS) reminded us that there are more employed in adult social care than there are in the NHS.⁷⁴

104. Changing models of care require a flexible workforce that can adapt to new ways of working, but appropriate training and a healthy morale are critical if this workforce of the future is to be delivered. This chapter will look at issues such as planning, skill mix and training and the relationship between regulation, pay and morale.

Workforce strategy

The aspiration

105. Like any large organisation, workforce planning in the NHS is critical. The length of time and investment required to educate certain medical professionals means that this planning must take place over a long timeframe. An accurate estimation of future demand is also important. The Five Year Forward View summarises this critical requirement:

“Health care depends on people—nurses, porters, consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.”⁷⁵

106. The content relating to workforce in the Five Year Forward View is a positive step forward and the leadership shown by the Chief Executive of NHS England, Simon Stevens, should be applauded in this regard. The document speaks of moving away from a more specialised workforce towards a more holistic clinical approach and the need to move to more community-based working. It also acknowledges the need to plug the skills gap in the workforce, to invest more in training and to help employees work across organisational and sector boundaries. Future-proofing the workforce is also highlighted

72 NHS, ‘The NHS in England: About the National Health Service (NHS)’: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx> [accessed 28 March 2017]

73 NHS Improvement, *Submission to the NHS Pay Review Body and the Review on Doctors’ and Dentists’ Remuneration* (September 2016): https://improvement.nhs.uk/uploads/documents/NHS-Improvement_submission_to_DDRB_and_NHS_PRB_Sept_2016.pdf [accessed 28 March 2017]

74 Written evidence from The Association of Directors of Adult Social Services (ADASS) (NHS0072)

75 NHS England, *Five Year Forward View* (October 2014), pp 29–30: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 28 March 2017]

and the Five Year Forward View references the Shape of Training Review⁷⁶ for the medical profession and the Shape of Caring Review⁷⁷ for nursing, both of which sought to reform the way in which the workforce is trained.

A sound evidence base

107. A robust evidence base projecting future demand is required if workforce planning is to be carried out in a reliable manner. Gavin Larner, Director of Workforce at the Department of Health, described a piece of work called Horizon 2035⁷⁸ which was commissioned by the Department. He outlined the work of the project as follows:

“It has been trying to extend the global factors ... to see what the position will look like in the mid-2030s. A team of economists has been looking quite carefully at the evidence base. It concludes that, with the ageing population and the further spread of chronic disease through all age groups—beyond just older age groups—an estimated 3 billion extra care hours will be needed by 2035 and demand for care could rise twice as fast as population by that time. Its conclusion based on that is that you will need a lot more [lower paid staff] than we currently have, to cope ...”⁷⁹

108. The challenges posed by this demographic trend are well understood and reliable data to illustrate the ageing population is readily available, as described in Chapter 2. However, despite this, we were told that no workforce costings associated with this demographic trend had been calculated.⁸⁰ This compartmentalised and silo-thinking mentality emerged as a general theme from the evidence we received. The move to a unified vision for the medium-term in the Five Year Forward View was, undoubtedly, a positive development when it was published in 2014. But from the evidence we received, a longer-term, centralised strategy which joined-up workforce planning with other challenges faced by the NHS, such as financial sustainability and the adoption of new technologies, for example, appeared to be absent. In fact, we received no evidence to suggest that workforce planning was linked to financial planning in any meaningful way at all. This appeared to be because longer-term financial planning or service planning was not taking place at all or because there were conflicting interests within the bodies controlling the limited workforce planning that was taking place.⁸¹ For example, there was a clear conflict between the desire of Health Education England (HEE) to educate and train more staff and the opposing objective of NHS Improvement to seek cost reductions wherever possible.

76 The Shape of Training Review, also known as ‘The Greenaway Report’, looked at potential reforms to the structure of postgraduate medical education and training across the UK. Shape of Training, *Shape of Training: Securing the future of excellent patient care* (October 2013): http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf [accessed 28 March 2017]

77 The Shape of Caring Review, also known as ‘Raising the Bar’, looked at how to ensure that throughout their careers nurses and care assistants receive consistent high quality education and training to support high quality care. Health Education England, *Raising the Bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* (March 2015): <https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf> [accessed 28 March 2017]

78 This report highlighted interim findings from Horizon 2035, a piece of work commissioned by the Department of Health to consider how a series of challenges and opportunities may combine in the future and impact the health, public health and social care workforce. Centre for Workforce Intelligence, *Horizon 2035 – Future demand for skills: initial results* (August 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507498/CfWI_Horizon_2035_Future_demand_for_skills.pdf [accessed 28 March 2017]

79 [Q 4](#) (Gavin Larner)

80 [Q 7](#) (Gavin Larner)

81 [Q 26](#) (Dr Jennifer Dixon)

Health Education England

109. HEE is a non-departmental public body and its website describes its core purpose as follows:

“Health Education England (HEE) exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.”⁸²

110. Professor Ian Cumming, Chief Executive of HEE, told us about the importance of joined-up planning:

“... you need to make sure the service and workforce planning are properly joined-up, so we need commissioners’ intentions aligned with those who will be delivering the service, aligned with workforce planning. We also need to recognise that workforce planning has to be a very long-term strategy ... Of course, medical students entering university this year will become consultants in about 13 to 15 years, so the plans we are making at the moment on the numbers entering medical school will not have an impact on the workforce until 2030–31. We have produced a document called Framework 15, which takes a 15-year forward look, specifically designed around the medical workforce, to ask what we believe patients’ needs will be in 15 years’ time, and how we make sure that we are training doctors and other healthcare professionals to work in that timescale and not training people to work in the health service that we have today—because it will look very different.”⁸³

111. The evidence we received outlining the ongoing work within HEE was encouraging, but we were not presented with any examples of the body being able to influence a shift in the allocation of financial resources to make workforce planning a reality, or any evidence that the Department of Health was providing leadership in this area. Indeed, instead of workforce planning which was based on sound demographic data driving expenditure, short-term thinking seemed to be a real driver of supply. The Government frequently repeat that they have secured 9,500 more doctors and 6,900 more nurses since 2010, a flagship feature of the 2015 Conservative Party Manifesto,⁸⁴ but there is no evidence to suggest that these numbers were agreed to meet an identified demand based on specific demographic data or calculations. Dr Sarah Wollaston MP, the Chair of the House of Commons Health Select Committee, was disappointed to note that HEE’s budget had been cut in real terms, and we echo this sentiment.⁸⁵

82 Health Education England, ‘About us’: <https://www.hee.nhs.uk/about-us> [accessed 28 March 2017]

83 [Q 130](#) (Professor Ian Cumming)

84 The Conservative Party, *The Conservative Party Manifesto* (2015), p 38: <https://s3-cu-west-1.amazonaws.com/manifesto2015/ConservativeManifesto2015.pdf> [accessed 28 March 2017]

85 [Q 287](#) (Dr Sarah Wollaston MP)

112. The failure to prioritise workforce planning can result in gaps in the current workforce. Candace Imison, Director of Policy at the Nuffield Trust, told us that if this trend continued “there will be very obvious gaps in the medical workforce.”⁸⁶ The Royal College of Physicians told us of the increasing prevalence of consultants covering gaps in trainee rotas and that “together with a shortage of nurses, this has left our hospitals chronically understaffed. This increases pressure on NHS staff, impeding morale and puts patient care at risk.”⁸⁷ According to Mind, almost half of community mental health teams had staffing levels judged to be less than adequate in 2013–14.⁸⁸ The Royal College of Midwives told us that they have:

“... used the Birthrate Plus methodology to assess the adequacy of the size of the midwifery workforce; our current assessment is that midwifery services in England are 3,500 [whole time equivalent] midwives short of what would be needed to ensure that every woman could receive 1:1 midwifery care in labour, as clinically recommended.”⁸⁹

Workforce gaps are clearly a continuing case for concern, both in the NHS and in the adult social care sector. Skills for Care is an independent charity in receipt of public funds which is largely responsible for supporting organisations to develop their adult social care workforce in England. Care England argued that HEE should be given a role in social care workforce planning too: “In order to protect long-term NHS sustainability, HEE must start planning for the social care workforce now ...”⁹⁰

Overseas workers and Brexit

113. The NHS and social care workforce draws on global talent and relies on a steady stream of immigration. The Recruitment and Employment Confederation told us that:

“The latest data from the Health and Social Care Information Centre (June 2016) reports that 57,608 staff employed in NHS Trusts and Clinical Commissioning Groups in England declare their nationality to be from a European Union member state—71,510 staff are from non-EU member states; collectively accounting for around 11% of all staff ... A similar picture is found in social care—Skills for Care (2015): *The State of the Adult Social Care Sector and Workforce in England*—reports that 5% of adult social care staff are from EU countries and 11% are from non-EU countries.”⁹¹

114. Because of the long-established dependence on overseas recruitment, there was considerable anxiety expressed about the impact of the United Kingdom’s exit from the European Union and the prospect of tighter immigration rules.⁹² There is a strong case in the short term for the Government to do all it can to reassure those who may be affected by the United Kingdom’s exit from the

86 [Q 152](#) (Candace Imison)

87 Written evidence from the Royal College of Physicians ([NHS0065](#))

88 Written evidence from Mind ([NHS0179](#))

89 Written evidence from the Royal College of Midwives ([NHS0067](#))

90 Written evidence from Care England ([NHS0089](#))

91 Written evidence from the Recruitment and Employment Confederation ([NHS0052](#)) and Skills for Care, *The state of the adult social care sector and workforce in England* (March 2015): <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf> [accessed 28 March 2017]

92 [Q 132](#) (Danny Mortimer), [Q 160](#) (Dr Mark Porter), [Q 171](#) (Dame Julie Moore) and [Q 288](#) (Dr Sarah Wollaston MP)

European Union to mitigate against an exodus of overseas workers. In the longer term, the Government should go to greater lengths to secure a reliable supply of well-trained professionals and other health and social care workers from within this country.

115. Professor Ian Cumming told us about the reliance on overseas workers:

“From our perspective, we believe that, as the fifth-largest economy in the world, we have a moral duty to produce the healthcare workforce that we require for our National Health Service, and we should not be reliant on recruiting from other countries. That is absolutely not the same as saying that we do not welcome the opportunity for people from other countries to come and learn here and work with us.”⁹³

116. Independent Age called on the Government to ensure that all EEA migrants currently working in social care in the UK had the right to remain post-Brexit and that any future migrant social care workers were appropriately recognised in any new approach to migration. They outlined the potential consequences of a workforce gap in the social care sector:

“The implications of a social care workforce gap of between 350,000 and 1.1 million workers for older and disabled people are clear—far fewer will be able to access the care they need to live meaningful, independent lives.”⁹⁴

117. We were encouraged that this aspiration was expressed by the Secretary of State for Health:

“I would say that workforce planning is an area where we have failed, and successive governments have failed to get this right. Brexit will be a catalyst to get this right, because we are going to be standing on our own two feet and we will have to start thinking much harder without the automatic access to the European labour pool that we have taken for granted for many years. That is an area where we need to be much more strategic than we have been. Being able to announce 1,500 medical places is only a start, but that was four months after the Brexit vote. I think that shows there is a serious effort going into being more strategic in our workforce planning, but there is lots more to do.”⁹⁵

118. He also said:

“... if, as I suggest to you, over the coming decades we will need to spend a greater proportion of our GDP on health and social care, we will need more doctors and nurses. Doctors take six years to train and nurses take three years to train, and we need to start thinking about that now, because the truth is, even while we are in the EU and we can import as many doctors and nurses as we wish from EU countries without restrictions, we still have rota gaps; we still cannot find enough of them, because every country is facing the same problem. One of the most important reasons for taking a longer-term view is to be able to be more strategic about our workforce planning.”⁹⁶

93 [Q 132](#) (Professor Ian Cumming)

94 Written evidence from Independent Age ([NHS0053](#))

95 [Q 313](#) (Jeremy Hunt MP)

96 [Q 303](#) (Jeremy Hunt MP)

119. **We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10–15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Much of the work being carried out to reshape the workforce is fragmented across different bodies with little strategic direction from the Department of Health. Although we recognise that Health Education England has undertaken some work looking at long-term planning for the workforce, this is clearly not enough. Health Education England has been unable to deliver.**
120. *We recommend that, as a matter of urgency, the Government acknowledges the shortcomings of current workforce planning. Health Education England, both nationally and through the network of local education and training boards, should be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, and it should always look 10 years ahead, on a rolling basis. Consideration should be given to its name to better reflect its revised function.*
121. *Health Education England's independence should be guaranteed and supported by a protected budget with greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system.*
122. *Workforce strategy has been poor with too much reliance on overseas recruitment. The Government should outline its strategy for ensuring that a greater proportion of the health and care workforce comes from the domestic labour market and should report on progress against this target.*
123. *In the light of the result of the EU referendum, we recommend that the Government takes steps to reassure and retain overseas-trained staff working in the NHS and adult social care who are now understandably concerned about their future.*

Skill mix and training

Skill mix and evolving roles

124. Securing the right numbers of staff is not enough. Appropriately trained and skilled individuals are critical and, from the evidence we heard, there was broad agreement that more needed to be done to improve the education and training of the current workforce. Striking this balance between investing in a new workforce and developing the current workforce will be key. As we noted above with disappointment, the body charged with responsibility for this, HEE, has had its underlying budget cut in real terms.⁹⁷ The figures announced in the 2015 Spending Review redefined NHS spending, from what used to be the totality of the Department of Health's budget to mean NHS England's budget only. Other health spending not included in NHS England's budget—for example, spending on public health, education and

97 Written Answer, [HL 47397](#), Session 2016–17

training—was excluded. As The King’s Fund, the Nuffield Trust and the Health Foundation said at the time, HEE’s budget was likely to be frozen in real terms.⁹⁸

125. The way in which the workforce is trained has a direct impact on the way it functions. When questioned about the length of time it currently takes to train certain medical professionals, Professor Wendy Reid, Director of Education and Quality at HEE, spoke about work associated with the Shape of Training Review.⁹⁹ We heard from Dell EMC that some education providers required individuals to repeat training they had already completed elsewhere.¹⁰⁰ A number of organisations also highlighted the serious challenge posed by high attrition rates for trainee medical professionals.¹⁰¹ We were, therefore, pleased to hear that NHS Improvement was planning to conduct a review of the drivers of medical workforce attrition and how retention in general could be improved.¹⁰² There is also a strong case for appealing to those who have already left the workforce to return.
126. Overall, however, we were unconvinced that HEE’s work with the Royal Colleges, higher education providers and others involved in influencing the way in which the workforce is educated and continually trained was persuasive or strong enough and, from the evidence they provided, we were disappointed that they were not displaying a clear lead on radically changing the way the medical workforce is educated and trained.¹⁰³
127. We heard consistently that there was a skill mix problem with the current workforce. There was a broad recognition that the workforce of 2030 would need be different—that the skill mix would need to change—and some agreement that the NHS needed to get the balance right between generalists and specialists. Witnesses also highlighted that, in part, the workforce of 2030 was already in operation. Professor Ian Cumming told us that:

“... the majority of people who will be working for the NHS in 20 years’ time are in employment at the moment, so more than 50% of the people who we will have delivering care are actually our current employees. One mistake that we must not make is just to focus on the future workforce, and people coming through the education and training system. If we are to deliver transformation, we must focus on the people whom we currently employ, and I do not think we have given that enough attention. That is why perhaps the pace of change has not been as quick as we would like it to be.”¹⁰⁴

98 The King’s Fund, the Nuffield Trust and the Health Foundation, *The Spending Review: what does it mean for health and social care?* (December 2015): http://www.health.org.uk/sites/health/files/Spending-Review-Nuffield-Health-Kings-Fund-December-2015_spending_review_what_does_it_mean_for_health_and_social_care.pdf [accessed 28 March 2017] and also see Health Service Journal ‘Exclusive: HEE budget freeze will have ‘consequences’ for NHS’: <https://www.hsj.co.uk/topics/spending-review-2015/exclusive-hee-budget-freeze-will-have-consequences-for-nhs/7000603.article> [accessed 28 March 2017]

99 Q 130 (Professor Wendy Reid)

100 Written evidence from Dell EMC (NHS0070)

101 Written evidence from The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) (NHS0115), The Faculty of Public Health (NHS0154), The Royal College of Emergency Medicine (NHS0029), The Royal College of Midwives (NHS0067) and The Royal College of Paediatrics and Child Health (NHS0133)

102 Written evidence from NHS Improvement (NHS0107)

103 Q 130 (Professor Ian Cumming and Professor Wendy Reid)

104 Q 131 (Professor Ian Cumming)

128. Candace Imison, Director of Policy at the Nuffield Trust, described the current situation:

“The point I would like to get across about future sustainability to leave in the Committee’s heads is the degree of skills mismatch that we currently have in the workforce. A very powerful study was done across the whole OECD that showed that 51% of doctors and 43% of nurses felt they were underskilled for what they are currently doing, whilst 76% of doctors and 79% of nurses felt that elements of their role were overskilled. That tells us that our roles are not designed correctly for the skills of the staff that sit within them.”¹⁰⁵

129. Without sufficient flexibility, the way in which the workforce is educated and trained can limit the type of roles they are able to perform. Consequently, there were calls for greater flexibility and mobility between specialties in medicine and between different types of health care professionals, including the allied health professions. Richard Murray, Director of Policy at The King’s Fund, spoke about the challenges and opportunities created by new roles emerging within the workforce:

“The challenges as you look out into the future, alongside the demand and affordability piece, are particularly around new roles. We have an old model of consultants, nurses and more junior staff. As you look out—particularly reflecting the changing demographic needs of the population—is that appropriate? It is very difficult for a planner to know now, as some of the roles are nascent roles that are not with us yet.”¹⁰⁶

130. Ian Eardley, Vice-President of the Royal College of Surgeons, also pointed out the opportunity presented by new non-medical roles and suggested that the NHS needed to “take a longer-term view on workforce planning with a potentially increased role for a non-medical workforce to provide medical and social care.”¹⁰⁷ Professor Cathy Warwick, Chief Executive of the Royal College of Midwives, whilst acknowledging the proper role of medically trained professionals, argued that support roles were crucial:

“From my point of view, the greatest threat to maternity services is not having enough midwives. We now know from global research that if you are going to maintain the health and well-being of women and babies, they need midwifery input, and that is best delivered by midwives. It is not protectionism. The fact is that investing in midwives leads to higher-quality care. However, I would add that those midwives need to be well supported by highly qualified, well-trained, competent maternity support workers, and we need to focus on that workforce as well and help them reach the required standard. We also need to ensure that our maternity services have sufficient clerical support. Midwives are currently spending up to 50% of their time doing non-clinical duties, and that is absolutely shocking.”¹⁰⁸

We wholeheartedly endorse this view and would encourage all those in the health and care system to embrace the opportunities for different ways of working made possible by emerging workforce and support roles.

105 [Q 150](#) (Candace Imison)

106 [Q 24](#) (Richard Murray)

107 [Q 206](#) (Ian Eardley)

108 [Q 212](#) (Professor Cathy Warwick)

131. Natalie Beswetherick, Director of Practice & Development at the Chartered Society of Physiotherapy, saw these new roles as key to the sustainability of the workforce and told us that the Government must be held to account for its promise to deliver more of these new roles:

“... we need national accountability for the 10,000 workforce expansion for allied health professionals and nurses that was made in the last comprehensive spending review, and at the moment there is no accountability to deliver that. Without that workforce across allied health professions and nurses, we will not be able to get that sustainability in future.”¹⁰⁹

132. New roles can bring new challenges and require people to adapt the way they work. Gavin Larner, Director of Workforce at the Department of Health, told us about the reticence on the part of some to fully embrace these new roles:

“... there are strong culturally conservative parts of our healthcare system, where the different professional tribes see particular ways of delivering services. That is not necessarily always a self-regarding thing—it can be a genuine concern about what they feel is the best place to deliver the safest care.”¹¹⁰

133. Professor Sir John Bell, Regius Professor of Medicine at the University of Oxford, echoed this point:

“I am sorry to say the workforce in the healthcare system is hugely, in a sense, unionised; they are deeply conservative; they do not want to change what they do; they are dug in ... it is this heavily—”unionised” is probably the wrong word—consolidated view of healthcare workers who form groups and tribes within a healthcare system where they defend each other, defend their space, and they do not want to change. Worse than that, we train people to be highly focused on doing one thing and if we want them to be doing something else later in their careers, they will fight for their lives to stay doing what they were doing, even though we all know it is not cost-effective, so it is a real issue.”¹¹¹

We are clear that the current situation is totally unacceptable and will fail to deliver the services that patients will need in the future. This should be a major concern for all those working in the health service and those who represent them. The conservative culture which exists in some quarters should be challenged by political, professional and managerial leaders.

134. ***A transformed Health Education England should use its greater budgetary freedom to review current commissioning and funding mechanisms to explore how initial and ongoing education and training might achieve a more multi-professional skill mix among the workforce and be underpinned by a place-based approach.***
135. **There has been too great a reluctance by successive governments to address the changing skill mix required to respond to a changing patient population and too little attention paid to workforce planning, education and training, all of which are necessary for delivering efficiency, productivity and overall value for money.**

109 [Q 223](#) (Natalie Beswetherick)

110 [Q 11](#) (Gavin Larner)

111 [Q 238](#) (Professor Sir John Bell)

136. *Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical and social care education and ongoing training courses can be reformed. Many are too lengthy, involve unnecessary repetition and do not meet the needs of a workforce which will have to be more flexible, agile and responsive to changing need.*
137. *Given the move to a more localised and place-based approach to the provision of health and social care, a more flexible approach to the make-up of the workforce is required. Professional bodies, education providers and regulators should embrace the opportunities for different ways of working made possible by emerging, often non-medical, workforce roles and should not be afraid of challenging the traditional allocation of responsibilities within professions.*

Regulation, morale and pay

The role of regulation

138. Health and care provided through the NHS is regulated by two system regulators and nine main professional regulators.¹¹² We heard a great deal about the impact of over-burdensome regulation—both systemic and professional—on workforce morale and retention. The evidence we received suggested that out-of-date professional regulation hampered the development of new practitioners such as nurse associates and physician assistants, and that an overly interventionist approach to regulation was creating an unnecessary and restrictive administrative burden on other clinicians.
139. Professor Sir Mike Richards, Chief Inspector of Hospitals at the CQC, told us that the work of the CQC was more valued than one might expect. He admitted, however, that things needed to change:

“... even among general practitioners, going back to the question of whether we get good or bad press, 57% of them say that it has been beneficial and had a good impact, so it is not all that you may hear. What we will do at the end of our first round is look at the whole process of how we do general practice inspection. We have set out our new strategy overall for the CQC, which includes having a more targeted and tailored approach ... we will need to be lighter on our feet and we will need to target those places where the problems are greatest, but we will adapt so that we can inspect and regulate new models of care. With those new models of care, we are saying, ‘Please tell us what you are planning so that we can plan the regulation with you.’”¹¹³

112 The two system regulators are NHS Improvement and the Care Quality Commission (CQC). The nine health and care regulators register health and care professionals working in occupations that statute has said must be regulated. They are the General Chiropractic Council (GCC), the General Dental Council (GDC), the General Medical Council (GMC), the General Optical Council (GOC), the General Osteopathic Council (GOsC), the Health and Care Professions Council (HCPC), the Nursing and Midwifery Council (NMC), the General Pharmaceutical Council (GPhC) and the Pharmaceutical Society of Northern Ireland (PSNI).

113 [Q 262](#) (Professor Sir Mike Richards)

This approach is encouraging. It is our view that system regulators need to adapt to changing ways of working and develop the ability to engage with place-based care and not simply with fixed institutions and bodies. System regulators should be willing to adapt to the present reality of the way in which health and care is delivered.

140. Dr Clare Gerada, General Practitioner and former Chair of the Royal College of General Practitioners, told us about the effects of the Health and Social Care Act 2012:

“We live in a bureaucratic jungle. It is terrible. Every single day is full of box-ticking and reporting. Even I do not now know what I am meant to do. I discovered the other day that I have not done my heavy lifting training, which will make me non-CQC-compliant. I have to go and do it. It is dreadful in there. It certainly has not released us from the bureaucratic nightmare.”¹¹⁴

In fact, Professor Maureen Baker, former Chair of the Royal College of General Practitioners, argued that in recent years she had actually seen an increase in bureaucracy.¹¹⁵

141. A solution was proposed by Baroness Cavendish of Little Venice:

“One thing that could be done from the centre which is very simple, which I am always going on about, is to reduce bureaucracy. The amount of paperwork and pressure put on the front line by central government and the whole of this landscape of quangos is utterly unacceptable. I find that people in the centre of government or in the quangos have no understanding of that, have no overview of how the amount of data they require overlaps with the amount of data other people require. Other people have recommended endlessly that we need one single data set that should be required by all of these public agencies from all of these providers, whether they are in health or social care. I am not saying that that is the answer but I think you would find productivity would increase dramatically.”¹¹⁶

142. It is clear to us that such a simple development would radically change the workload of those struggling to comply with the many overlapping and competing requirements of different regulators. In a letter to the Chairman dated 15 February 2017, the Chief Executive of the CQC, Sir David Behan, told us that they intended to take steps to alleviate the pressure of regulation. These steps would include, among other things, reducing duplication, requiring only one data return from GPs and reducing the frequency of inspections for those GP practices rated good and outstanding.¹¹⁷ This was welcome news and we look forward to seeing these changes implemented.

114 Q 189 (Dr Clare Gerada)

115 Q 189 (Professor Maureen Baker)

116 Q 270 (Baroness Cavendish of Little Venice)

117 Letter from the Chief Executive of the CQC, Sir David Behan, to the Chairman, 15 February 2017: <https://www.parliament.uk/documents/lords-committees/NHS-Sustainability/CQC%20letter%20from%20Sir%20David%20Behan.pdf> [accessed 28 March 2017]

143. Another proposal was to reduce the number of regulators. Professor Dame Sue Bailey, Chair of the Academy of Medical Royal Colleges, argued:

“There are nine regulators and I do not see why they cannot go down to two. In terms of CQC, we need to move to an inspection of a whole system of care and place-based health ... We need a reduced number of professional regulators. For instance, if we are going to get physician associates up there and recognised, some of the big regulators need to decide who is going to do that. Inspections need to be separate but they need to work together better.”¹¹⁸

144. Professor Cathy Warwick, Chief Executive of the Royal College of Midwives, told us that:

“I think I would say we need far less constraints around the workforce; we need to enable our workforce to work in far more innovative, enterprising sorts of ways. At the moment the regulatory and government structures make that incredibly difficult ... We need a framework which is much looser and allows grass-roots innovation ...”¹¹⁹

145. The point was echoed by Sir Cyril Chantler, the eminent paediatrician:

“I am not against regulation; regulation is important. There are just too many of them all trying to do the same thing. There are too many agencies as part of the central system of the National Health Service now. I do not want them reorganised but a bit of rationalisation would be quite useful.”¹²⁰

He went on to speculate about the structural cause:

“... I think it comes from the nature of the top-down organisation of a healthcare system funded through taxation, which is what Beveridge and Bevan put in place. It is the right model but with it comes a responsibility upwards which leads to downward control.”¹²¹

146. In April 2014 the Law Commission, Scottish Law Commission and Northern Ireland Law Commission published their report *Regulation of Health Care Professionals: Regulation of Social Care Professionals in England*.¹²² The report included a draft bill to reform the legal framework around the regulation of health care professionals. The draft bill envisaged a single legal framework for all the regulators of health and social care professionals. The existing governing legislation (such as the Medical Act 1983, the Dentists Act 1984 and the Nursing and Midwifery Order 2001) would be repealed, and replaced with a single Act of Parliament to provide the legal framework for all regulated professionals. The Government has yet to bring a bill forward, though a Private Members’ Bill has been introduced in the House of Lords encouraging them to do so. The Regulation of Health and Social Care Professions Etc. Bill [HL] was introduced by Lord Hunt of Kings Heath and received its first reading in the House of Lords on 26 May 2016,

118 Q 202 (Professor Dame Sue Bailey)

119 Q 215 (Professor Cathy Warwick)

120 Q 270 (Sir Cyril Chantler)

121 Q 267 (Sir Cyril Chantler)

122 Law Commissions, *Regulation of Health Care Professionals: Regulation of Social Care Professionals in England*, Cm 8839 (April 2014): <http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345-regulation-of-healthcare-professionals.pdf> [accessed 28 March 2017]

and received its second reading on 3 February 2017. The Bill, if passed, would require the Government to bring forward legislation giving effect to the recommendations of the Law Commission, Scottish Law Commission and Northern Ireland Law Commission in their report. We wholeheartedly support the objectives of the Bill.

Morale, pay and retention

147. Dr Mark Britnell, Partner and Chairman at the Global Health Practice at KPMG, told us that one of the most important things for a sustainable health system was staff morale and he exhorted us to “love your workforce and motivate and direct it properly.”¹²³ Baroness Cavendish of Little Venice spoke at some length about the morale problems in the NHS:

“... we need to reignite enthusiasm, and there is a morale problem in the NHS. However, what I saw in No. 10 for the first time ever ... was a bunch of really talented people, clinicians and chief executives, who for the first time seemed to be genuinely determined to change things ... On the one hand, you have people who are extremely concerned—the financial situation is dire, people are in deficit, there is a concern that deficit will become normalised—and on the other hand there is a group of people who want to grab the opportunity to change. The gap is that we have not provided a sufficiently clear template to them for what to do, and there are some very bright people out there who are very busy, and they do not want to have to reinvent the entire wheel again in their patch.”¹²⁴

148. We were particularly concerned to hear from Sir Cyril Chantler that there was a climate of fear amongst the workforce which was being created by excessive levels of top-down accountability and over-regulation.¹²⁵
149. We received evidence on the lengthy period of pay restraint experienced by health and care staff and the consequential impact of this pay restraint on morale. This was a particular problem for those who were often at the lower end of the pay scale such as nurses, other healthcare workers and social care workers. It was clearly a relevant factor in the low levels of morale and significant staff retention problems we heard about. Sam Higginson, Director of Strategic Finance at NHS England, told us that the working efficiency calculations within the Department of Health assumed that pay restraint would continue up to 2019/20. Michael Macdonnell, Director of Strategy at NHS England conceded that in his opinion, 10 years of prolonged pay restraint were bound to have long-term effects on workforce morale.¹²⁶
150. Professor Alan Manning, Member of the Migration Advisory Committee, told us that:

“If one is focusing on long-term sustainability and the workforce side, I worry that pay gets determined as a residual. There is a bit of temptation to think, ‘This is the health service we would like to provide, this is the amount of money we have been given and, therefore, this is what we can afford to pay our workforce’. In the long run, you have to pay your workforce what makes these professions attractive to recruit and retain them, given the other choices that people have, and you cannot control how much those other choices pay.”¹²⁷

123 [Q 318](#) (Dr Mark Britnell)

124 [Q 267](#) (Baroness Cavendish of Little Venice)

125 [Q 266](#) (Sir Cyril Chantler)

126 [Q 32](#) (Sam Higginson and Michael Macdonnell)

127 [Q 134](#) (Professor Alan Manning)

151. There were concerns expressed about the capacity of the NHS to retain domestically-trained staff because of low pay and morale and the competitiveness of the international market for scarce clinical skills. The evidence suggested this was a particular issue in nursing, where the proportion of nurses leaving services increased from 6.8% in 2010–11 to 9.2% in 2014–15.¹²⁸ This link between pay and retention was developed by Dr Jennifer Dixon, Chief Executive of the Health Foundation:
- “Our work has shown that there are a lot of things that could be done locally to improve retention—not just for nursing staff but for others. HR management is a pretty underpowered profession. We just do not devote enough thinking in national or local policy to the wellbeing and motivation of staff, even though they are our biggest asset. Overall, if you look at the figures for staff joining and leaving the NHS, in some years the percentage joining and leaving is more or less the same, so you have a big leaky bucket.”¹²⁹
152. ADASS told us that retention in the adult social care workforce was also a problem: “Those who feel they are underpaid for difficult and often emotionally draining work are liable to seek alternative employment.”¹³⁰
153. **There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade.**
154. *We recommend that the Government commissions a formal independent review with the involvement of the Department of Health, the pay review bodies and health and care employers to review pay policy with a particular regard to its impact on the morale and retention of health and care staff.*
155. *The current regulatory landscape is not fit for purpose. In the short term, we urge the Government to bring forward legislation in this Parliament to modernise the system of regulation of health and social care professionals and place them under a single legal framework as envisaged by the 2014 draft Law Commission Bill. The Government should also introduce legislation to modernise the system regulators to take account of our recommendation that NHS England and NHS Improvement be merged and to reflect the clear move towards place-based care.*

128 Written evidence from UNISON ([NHS0081](#))

129 [Q 25](#) (Dr Jennifer Dixon)

130 Written evidence from The Association of Directors of Adult Social Services (ADASS) ([NHS0072](#))

CHAPTER 4: FUNDING THE NHS AND ADULT SOCIAL CARE

156. The issue of funding was, inevitably, a prominent theme within the evidence we received and getting this right will clearly be critical for the long-term sustainability of both the health and care systems.
157. The model of social care provision is very different from that of the NHS. Whereas NHS care is free-at-the-point-of-use, publically funded adult social care is means-tested and primarily funded through local government, through a mix of central government grants and local revenue. However, the inextricable link between the sustainability of the NHS and the adult social care system means that the financial provision for both systems cannot be considered in isolation from one another.
158. We were determined to hear and consider an extensive range of opinion about what level of funding the NHS and adult social care needs, how additional funding might be generated to help both services overcome the current financial strain, and how funding should be allocated to ensure the health and care systems remained sustainable in the long-term. This chapter sets out the range of options we heard in the evidence for how the NHS and adult social care could be placed on a more financially sustainable footing, before setting out our consideration on how health and social care funding might be better aligned to ease the pressures felt by both services.

NHS funding

159. We recognise that this is a period of extreme financial challenge for the health service and that this strain is being felt across the system. There is very real, very serious concern about the current state of NHS finances. Given the long-term focus of this inquiry, our examination of issues related to funding was not focused on the current funding envelope, but rather on whether the way in which the health service receives funding is conducive to the long-term sustainability of the system—in particular, have we got the right funding model and does the system receive funding in a way which will allow it to meet patient need over the longer-term?

NHS funding sources

160. The evidence to support the retention of general taxation as the principal method of funding the NHS was robust and consistent, leaving us in no doubt that this was the preferred approach for healthcare professionals, experts, parliamentarians and the public alike. We believe that it is also the right approach. Simon Stevens, Chief Executive of NHS England, echoed this:

“... a tax-funded National Health Service as a funding mechanism has served this country well since 1948. It has produced a steadily improving and expanding National Health Service and has done so in an equitable way that is highly valued by the people of this country.”

161. The Secretary of State for Health also confirmed his desire to see governments continue with the current model, which he described as “a sensible choice ... probably the choice that is closest to what most British people want.”¹³¹

131 [Q 302](#) (Jeremy Hunt MP)

162. We fully recognise that public support for a free-at-the-point-of-use service, funded through general taxation, is dedicated and unwavering—the public is, as Ben Page, Chief Executive of Ipsos MORI explained “... completely wedded to the idea of a free, universal NHS.”¹³² This support was clearly communicated through the substantial level of correspondence we received at the end of our inquiry.

Alternative funding models

163. We heard a range of evidence regarding the different funding models that were employed by different health systems around the world including: general taxation (UK); social insurance through employer/employee contributions (France, Germany); compulsory social insurance (Switzerland); and voluntary insurance (USA). We also received evidence about the options for mechanisms to raise additional funding.
164. The advantages and disadvantages of moving to an alternative funding model were explored over the course of the inquiry. However, there was general agreement that this would not be a viable solution for the UK. Lord Willets informed us that, in a previous role as a policy adviser to a past government, he had considered alternative arrangements for health funding including “co-payment, private insurance—all those conventional options” but concluded that: “a nationwide risk pool to fund healthcare was a perfectly reasonable arrangement, and that the costs of moving from what we had to some other system were very high.”¹³³
165. John Appleby, Director of Research and Chief Economist at the Nuffield Trust, also highlighted some of the issues related to alternative sources of funding for health, stating that:
- “If you want to switch the proportions of funding from different sources—from public to private, from collective to more individual—that raises a whole lot of distributional and equity issues. From the evidence and from looking at other countries, there is, in a sense, a trade-off between different sources of funding.”¹³⁴
166. The Department of Health was clear that it intended to continue with the current funding model—a view we wholeheartedly support. Andrew Baigent, Director of Finance at the Department of Health, explained that the Government was very clear that it saw health spending being tax-funded and was not exploring any other options at this time.¹³⁵ The evidence for maintaining general taxation as the principal funding source was reinforced by the lack of any evidence that made the case conclusively for any alternative funding models. A recent OECD report, which compared healthcare systems around the world stated:

“... there is no healthcare system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed. Both market-based and more centralised command-and-control systems show strengths and weaknesses.”¹³⁶

132 [Q 105](#) (Ben Page)

133 [Q 118](#) (Lord Willets)

134 [Q 55](#) (John Appleby)

135 [Q 2](#) (Andrew Baigent)

136 *OECD 2010, Health care systems: Getting more value for money*, OECD Economics Department Policy Notes, No. 2, p 3: <https://www.oecd.org/eco/growth/46508904.pdf> [accessed 28 March 2017]

167. In fact, there was nothing in the evidence that suggested any one system for funding health care was systematically better than another in terms of efficiency or performance. Dr Jennifer Dixon, Chief Executive of the Health Foundation, told us about:

“... a very good study by Mark Pearson, from the OECD, that clumped health systems into different archetypes: market-based systems, national health systems, Bismarckian systems and heterogeneous systems. When he looked at the performance of those systems, including efficiency measures, he found that no one archetype outperformed another and that there was more variation within archetypes than across them. His conclusion was that a health system that is seriously trying to improve performance should not necessarily look to any other system but should work with what it has.”¹³⁷

168. We were not persuaded of any link between the way you choose to collect the money to fund a health service and performance. Instead it seemed that, as Ian Forde from the OECD, explained “much more important is how you spend the money once you have collected it, which really determines performance and sustainability.” This view was supported by Nigel Edwards, Chief Executive of the Nuffield Trust, who said: “There is no immediate link between how you collect money and how efficiently it is disbursed.”¹³⁸ Similarly, John Appleby of the Nuffield Trust, explained that there are “probably 5 or 10 different factors that would explain relative performance between health systems, including their performance on productivity, but I would not lay much emphasis on the source of funding as driving that.”¹³⁹
169. **International evidence shows that a tax-funded, single payer model of paying for healthcare has substantial advantages in terms of universal coverage and overall efficiency. There was no evidence to suggest that alternative systems such as social insurance would deliver a more sustainable health service. Sustainability depends on the level of funding and, crucially, how those funds are used.**
170. *We strongly recommend that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for delivery of sustainable health services both now and in the future.*

Generating additional sources of funding

171. Despite the widespread support for maintaining the current funding model, we were also acutely aware of the concerns raised about the current financial pressures being felt by the health and care services. Many witnesses suggested that the current state of NHS finances was significantly worse than it had been in previous years. The Health Foundation highlighted that:

“The 2015 Comprehensive Spending Review confirmed that 2010/11 to 2020/21 will be the most austere decade for the NHS in its history. After accounting for inflation and population growth, spend per head for the English NHS will be similar in 2020/21 to what it was 2010/11 ... rising by an average of 0.2% a year in real-terms.”¹⁴⁰

137 [Q 23](#) (Dr Jennifer Dixon)

138 [Q 23](#) (Nigel Edwards)

139 [Q 56](#) (John Appleby)

140 Written evidence from the Health Foundation ([NHS0172](#))

172. This view was supported by the National Audit Office's (NAO) report *Financial Sustainability of the NHS*, which gave a summary of the financial position of NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts. The key findings in the NAO's analysis of the trends in the financial performance of NHS bodies were:
- In 2015–16, NHS commissioners, NHS trusts and NHS foundation trusts reported a combined deficit of £1.85 billion.
 - The financial position of NHS bodies overall had continued to decline.
 - The number of NHS bodies reporting a deficit rose significantly between 2014–15 and 2015–16.¹⁴¹
173. NHS England has suggested that the current financial envelope fell short of what was required. In evidence given to the House of Commons Health Select Committee, the Chief Executive, Simon Stevens, was asked if he felt that the “NHS has been given everything it has asked for” by the Chair, Dr Sarah Wollaston MP. Mr Stevens responded by saying:
- “For years 1 and 5, yes, you could say that we were kind of in the zone, but for the next three years we did not get the funding that the NHS had requested. This is not a controversial statement. It is what I have already said to the Public Accounts Committee, so it is not a new statement. As a result, we have a bigger hill to climb. It is going to be a more challenging 2017–18 and 2019–20.”¹⁴²
174. A recent report by the House of Commons Public Accounts Committee has also expressed concern over the use of capital budgets to fund day-to-day spending, which has happened for the second year in a row. The report stated that the Department of Health moved £950 million out of its separate £4.5 billion capital budget to its revenue budget in 2015–16, to fund day-to-day activities, and had confirmed that it would need to do so again to balance its budget in 2016/17 and in future years. The Committee stated that this could “result in ill-equipped and inefficient hospitals” and recommended that the Department of Health, NHS England and NHS Improvement should “call a halt to crisis driven transfers out of capital budgets.”¹⁴³
175. In recognition of the significant strain on finances, both in health and across all public services, we also sought views on the viability of generating additional funding for the NHS from alternative sources, to supplement the funding generated by general taxation.
176. The possibility of introducing additional charges for some procedures as a means of generating additional revenue for the NHS was discussed by several witnesses. However, amongst the evidence we received there was little to suggest that introducing further charges into the system would have much impact on the volume of resources available for healthcare.

141 National Audit Office, *Financial sustainability of the NHS* (Session 2016–17, HC 785)

142 Oral evidence taken before the Health Select Committee, 18 October 2016 (Session 2015–16), [Q 66](#) (Simon Stevens)

143 House of Commons Committee of Public Accounts, *Financial sustainability of the NHS* (Forty Third Report, Session 2016–17, HC 887)

177. Overwhelmingly the evidence weighed against the introduction of further charging. Of greatest concern was the risk that user charges could limit access and have a negative impact on efficiency and equity. The Barker Review, which was commissioned in 2013 to consider the sustainability of the NHS and social care models, noted that the international evidence on the impact of charging—how far it controls unnecessary demand—was “frustratingly weak.” However, it cited a study in the United States in the 1960s which found that charging had a serious adverse effect on those who were both poor and suffering from poor health. The Barker Review concluded that introducing further charges into the health system “would fail the criterion of equity”.¹⁴⁴
178. Much of the evidence reiterated this view. The Children and Young People’s Mental Health Coalition, the British Psychological Society and the Royal College of Ophthalmologists all expressed concerns that additional charges could create inequality between socio-economic groups and potentially mean that people would be unable to afford treatment.¹⁴⁵ Ian Forde, from the OECD, was equally critical about the possibility of the introduction of additional charges:
- “The evidence does not support that as a policy option. It is bad for equity, because it damages people on lower incomes, and it is bad for health, because in the long run it increases health costs because people forgo primary care and preventive care when they need it and wait till they are sicker further down the line and end up costing more money. There is good evidence that increasing dependence on out-of-pocket payments is not a good option.”¹⁴⁶
179. While there was little support for the notion of introducing additional charges for the health service as a way to raise additional revenue, we found there were a number of serious and considered calls to examine whether some form of hypothecated tax for the NHS would help to secure more long-term financial sustainability.
180. We heard a range of views on how hypothecation might work for the NHS. These ranged from suggestions for the introduction of a ‘soft’ hypothecation, using additional revenues from a given tax to supplement NHS funding, to a ‘hard’ approach, where all of the revenue from one tax (which some witnesses proposed could be National Insurance), would be used to fund the NHS.
181. The strongest advantage of hypothecation appeared to be the greater transparency it would provide of the link between taxation and government spending, which witnesses suggested could help improve the public’s understanding of expenditure on the NHS. This could help to facilitate a better debate about how much the electorate were willing to pay for the health service.¹⁴⁷ The key disadvantage we heard was that hypothecation could potentially undermine the ability of governments to deal with the economic

144 The King’s Fund, Commission on the Future of Health and Social care in England, *A new settlement for health and social care* (2014), p 25: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf [accessed 28 March 2017]

145 Written evidence from Children and Young People’s Mental Health Coalition (NHS0058); The British Psychological Society (NHS0057) and The Royal College of Ophthalmologists (NHS0032)

146 Q 70 (Ian Forde)

147 Written evidence from Lord Macpherson of Earl’s Court (NHS0177)

cycle, restricting the flexibility they have to allocate resources as they see fit.¹⁴⁸ This evidence is set out in more detail in Appendix 4.

182. ***We received some detailed analysis of how hypothecation might work for the NHS. Given the far-reaching implications of hypothecation for systems and services beyond the remit of our inquiry, we were not well-placed to make a firm conclusion on the issue. We recommend that hypothecation be given further consideration by ministers and policymakers.***
183. Although many people did not want to see significant change to the model of funding through taxation, there did need to be some recognition of the need for a debate on what the NHS was able to deliver in relation to the funding it received. Dame Julie Moore, Chief Executive of University Hospitals Birmingham NHS Foundation Trust, proposed: “a public debate about what the NHS is now coping with—the increased complexity, the increased demand—and ... what we are willing to pay for.”¹⁴⁹ Similarly, Mr Chris Hopson, Chief Executive of NHS Providers, stated that:
- “My view would be that we need to keep a taxpayer-funded system but increase the funding coming in, in which case we need to think much more carefully about how we build a national consensus around that increase in funding. That requires a much better quality of public debate about what the funding levels for the NHS should be and what the consequences of not increasing funding might be.”¹⁵⁰

NHS funding levels

184. Across countries, regardless of the health care funding model, populations have increasingly chosen to spend a growing share of national wealth on health.
185. Historically public funding for health care has increased faster than economic growth, with the share of UK GDP spent on health more than doubling from 3.5% in 1949/50 to 7.4% in 2015/16. On average, spending has risen by 3.7% a year in real terms (with periods of relatively high and low growth).¹⁵¹ However, the period 2010 to 2020 will see a marked divergence from that trend. The Health Foundation told us that “as part of the government’s priority to close the national fiscal deficit, funding for the UK NHS is currently growing at a slower rate than GDP.”¹⁵²
186. We recognise that growth in health spending has slowed across most of the OECD. Dr Jennifer Dixon told us: “Over the last 20 years, healthcare costs across OECD countries have outstripped GDP growth.”¹⁵³ However, the evidence suggested that the UK has seen a sharper retrenchment in health spending than most of its peers. The OBR projects, based on current spending plans, that UK spending on health and care as a percentage of GDP is due to drop from 7.4% in 2015–2016 to 6.8% in 2020–21.¹⁵⁴

148 *Ibid.*

149 [Q 177](#) (Dame Julie Moore)

150 [Q 97](#) (Chris Hopson)

151 The Health Foundation, ‘Health and social care funding explained’: <http://www.health.org.uk/health-and-social-care-funding-explained> [accessed 28 March 2017]

152 Written evidence from the Health Foundation ([NHS0172](#))

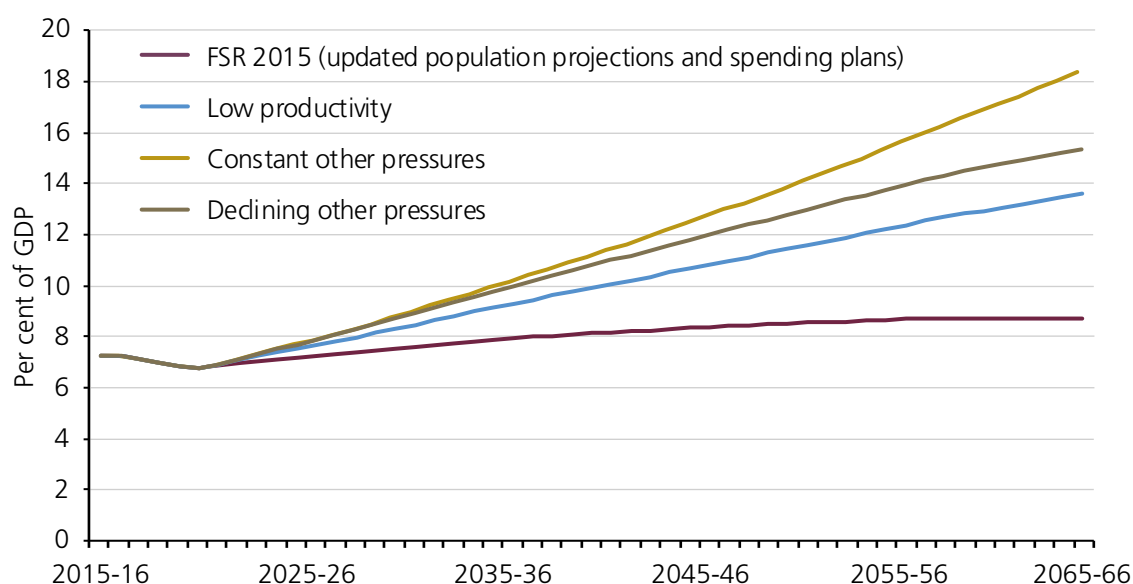
153 [Q 23](#) (Dr Jennifer Dixon)

154 Office for Budget Responsibility, *Fiscal sustainability analytical paper: Fiscal sustainability and public spending on health* (September 2016): http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf [accessed 28 March 2017]

Health spending beyond 2020

187. The Office for Budget Responsibility (OBR) produces periodic assessments of long-term fiscal sustainability based on projections of public spending and taxation revenues. The OBR's working paper on *Fiscal sustainability and public spending on health* showed that: "health spending has risen as a share of GDP in most OECD countries, including the UK over the past 40 years. Consistent with the projections of various international institutions, we project that health spending in the UK will continue to rise as a share of GDP in the future."¹⁵⁵
188. Figure 1 outlines the OBR's long-term projections for public spending on health based on its different assumptions for the impact of pressures on the health service.

Figure 2: Office for Budget Responsibility: Long-term projections for health spending (as a % of GDP)¹⁵⁶



Source: Office for Budget Responsibility, *Fiscal sustainability and public spending on health* (September 2016): http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf [accessed 28 March 2017]

¹⁵⁵ *Ibid.*

¹⁵⁶ The OBR's graph displays long-term projections on health spending using a number of different scenarios: FSR 2015; low productivity; constant other pressures; and declining other pressures. FSR 2015 (updated population and projections and spending plans) refers to the OBR's updated FSR (Fiscal sustainability report) health spending projection made on the basis of new population projections and detailed spending plans set out since its last report. The low productivity scenario assumes annual health care productivity growth of 1.2%. The OBR states that in order to account for other cost pressures (non-demographic pressures, for example increasing relative health costs and technological advancements) in its long-term spending, it has also used two variants: constant other pressures, which assumes that the additional pressures remain unchanged from 2021–22 onwards. In this scenario, primary and secondary health spending projections grow by 2.7% and 1.2% a year faster than OBR's central projection; and declining other pressures which assumes a linear convergence towards a 1% annual increase by the end of the projection period in each activity. This reflects the significant uncertainty over how pharmaceuticals, medical procedures and technology might evolve over the future. Office for Budget Responsibility, *Fiscal sustainability and public spending on health* (September 2016): http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf [accessed 28 March 2017]

189. The Nuffield Trust undertook some analysis of the OBR projections and highlighted the following points:

- The OBR's projections suggested that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8% and 8.9% by 2030/31.
- The projected figures were broadly equivalent to a real increase in health spending of just under £100 billion over the next 15 years (from £139 billion to £237 billion in 2015/16 prices).
- The OBR's longer-term projections of spending on health suggest increased spending over the next fifty years, but they varied widely—from just under 8% of GDP to between 15.5% and 18.5%.
- More than doubling the share of GDP devoted to health care spending over the next 50 years would mean further tough choices about how this should be funded—and what the public might be willing to forgo.¹⁵⁷

190. The views we heard on health spending beyond 2020 were fairly consistent, with broad agreement for the need to increase health funding to more closely match growing pressures and to bring it back more in line with the historic average (on average public spending has risen by 3.7% a year in real terms, but this has not been a continued steady increase over time¹⁵⁸). Richard Murray, Director of Policy at The King's Fund, said:

“If you are thinking about the long term, there are not many alternatives to paying, over time, to raise the share of GDP that goes on health and social care in the light of demographic change. As you look over long periods of time across the OECD and, of course, within the United Kingdom, that is exactly what you see.”¹⁵⁹

191. Similarly, Nigel Edwards, Chief Executive of the Nuffield Trust, stated that:

“If you add together the increasing complexity of the patients, the growth in the number of people who will die over the next five decades, the changes in the age structure and the increasing demands that will be made just because things are available, it will be very difficult to hold the line much below the historic trend, which has been about 4% growth in the UK. There may even be pressure to drive it above that.”¹⁶⁰

192. **The reduction in health spending as a share of GDP seen over this decade cannot continue beyond 2020 without seriously affecting the quality of and access to care, something which has not been made clear to the public or widely debated.**

193. ***To truly protect the sustainability of the NHS the Government needs to set out plans to increase health funding to match growing and foreseeable financial pressures more realistically. We recommend health spending beyond 2020 should increase at least in line with the growth of GDP and do so in a predictable way in that decade.***

157 The Nuffield Trust, *Is the NHS financially sustainable* (21 September 2016): <https://www.nuffieldtrust.org.uk/files/2017-01/is-the-nhs-financially-sustainable-web-final.pdf> [accessed 28 March 2017]

158 The Health Foundation, ‘Health and social care funding explained’: <http://www.health.org.uk/health-and-social-care-funding-explained#Historic> [accessed 28 March 2017]

159 [Q 23](#) (Richard Murray)

160 [Q 23](#) (Nigel Edwards)

Social care funding

194. The funding crisis in adult social care is worsening to the point of imminent breakdown. As mentioned in Chapter 1, although we were appointed with the explicit remit to examine issues pertaining to the long-term sustainability of the NHS, the sheer volume of evidence we received on the challenges facing adult social care and the impact it had on the NHS meant that our investigation widened in scope. This chapter outlines both a possible short-term and long-term solution.

The current situation

195. Pressures in social care are the greatest external threat to the long-term sustainability of the NHS; the urgent requirement to address the issues in social care is universally acknowledged, but action is needed now.
196. Social care is currently delivered through a combination of public and private providers but the publically funded care is financed from the Department of Communities and Local Government's allocations to local authorities and locally raised finance, principally from council tax. Christina McAnea, Head of Health at UNISON, explained the impact of cuts to local government budgets for the provision of social care:

“... it is not just about funding the NHS, as you have already said, but about funding social care as well to a level that means that you can actually meet need. Over the past few years we have seen a 25% cut in the funding for social care, a 25% reduction in people receiving social care, and an even greater cut in the actual overall budget that is going to local authorities. That has had an immediate impact and an ongoing impact on NHS services.”¹⁶¹

197. The pressures facing social care mean that more people who would otherwise be cared for in the community, in residential homes or in their own home are now presenting in NHS settings, often at GP surgeries or at A&E departments. The adverse impact on the functioning of acute services in hospitals is increasingly serious. In some cases acute services in hospitals are becoming the choice of last resort. The cuts to one public service are placing greater pressure on another.
198. We heard that disquiet about the situation is growing. The Greater Manchester Health and Social Care Partnership which we described in Chapter 2 is delivering real benefits, but even that endeavour is suffering as a result of social care funding pressures. Sir Howard Bernstein, explained that the Partnership had written a letter to the NHS and central Government explaining the severity of the situation:

“Jon Rouse, who is the chief officer for delegation, Lord Peter Smith, who chairs the Health and Social Care Partnership, and I wrote a joint letter to the Secretary of State for Health, copied to the Chancellor and elsewhere, particularly to Simon Stevens, explaining our particular challenges in social care funding, which, unless resolved, will gnaw away at our capability to create the sustainable funding platform that we have committed ourselves to within the next five years.”¹⁶²

161 [Q 159](#) (Christina McAnea)

162 [Q 225](#) (Sir Howard Bernstein)

199. There has been much commentary in the press about the exodus of care home providers and providers of other types of care from the sector. Limited public funds have meant that many have chosen to close. We heard that there is now the serious prospect of a further withdrawal of service providers from publicly-funded adult social care which is likely to damage the effectiveness and sustainability of the NHS.¹⁶³ Not only will this have an adverse effect on the staff who work in the care home sector, it will place greater pressures on families who care for their elderly relatives and confine those who need round-the-clock care in unsuitable settings at a greater cost to the taxpayer.
200. The Government has continually argued that the answer to the social care funding gap lies in the ability of councils to raise the Council Tax precept (the Adult Social Care Precept). In autumn 2016, the Government granted councils the flexibility to raise the precept by up to 3% for two years which would, they argued, provide a further £208 million to spend on adult social care in 2017/18 and £444 million in 2018/19.¹⁶⁴ The Association of Directors of Adult Social Services (ADASS) and UNISON welcomed this flexibility and the improved Better Care Fund, but argued that the Council Tax precept was worth less than the Government claimed.¹⁶⁵ ADASS went on to argue that “those councils least able to raise tax are those with the highest levels of people with social care needs” and that the improved Better Care Fund did not fully address this as “there is no extra money arriving in 2016/17, and [it] only reaches £1.5 billion in 2019/20.”¹⁶⁶ A number of witnesses expressed concern that this option would not produce sufficient resources to halt a further deterioration in services, especially in poorer local authority areas, and that both funding sources were too little, too late.¹⁶⁷
201. In fact, Andrew Haldenby, Director of Reform, argued that there might well be a change of thinking in Government on this issue: “I think the fact that the current Government introduced the new precept on social care in the Autumn Statement indicates that they know that cuts in social care funding have gone too far.”¹⁶⁸

Short-term responses

202. The evidence we received on the required short-term response to the funding crisis in adult social care was clear—the service needs more money. Whilst we acknowledge this is not a long-term solution, multiple witnesses warned that without a swift injection of public funds, the adult social care sector would be pushed to breaking point.
203. Witnesses, notably including Simon Stevens, the Chief Executive of NHS England, argued that increasing social care funding in the short term was a higher priority than providing more money for the NHS. Sir Howard Bernstein echoed this call for increased funding for adult social care¹⁶⁹ as did Professor Keith McNeil, Chief Clinical Information Officer for Health and Social Care and Head of IT for the NHS.¹⁷⁰

163 Q 99 (Sir Andrew Dilnot)

164 Department for Communities and Local Government, ‘Provisional local government finance settlement 2017 to 2018’: <https://www.gov.uk/government/speeches/provisional-local-government-finance-settlement-2017-to-2018> [accessed 28 March 2017]

165 Written evidence from the Association of Directors of Adult Social Services (NHS0072) and UNISON (NHS0081)

166 Written evidence from the Association of Directors of Adult Social Services (NHS0072)

167 Written evidence from the Association of Directors of Adult Social Services (NHS0072) and The Care and Support Alliance (NHS0097)

168 Q 79 (Andrew Haldenby)

169 Q 235 (Sir Howard Bernstein)

170 Q 242 (Professor Keith McNeil)

204. As part of the Spring Budget 2017, the Chancellor announced that councils would receive an extra £2 billion to fund social care over the next three years. £1 billion of this would be provided in 2017/18. The Budget also set out a commitment for the Government to publish a green paper, which would set out proposals to “put the system on a more secure and sustainable long term footing.”¹⁷¹
205. This funding has been welcomed by some in the sector and this lump sum could provide some short-term relief to the system. However, estimates have put the funding gap for adult social care by the end of the Parliament at more than the amount allocated by the Spring Budget. For example, analysis conducted by the Health Foundation, The King’s Fund and the Nuffield Trust, suggested that the social care funding gap could be between £2.8 billion and £3.5 billion by 2019/2020. More recently, the House of Commons Communities and Local Government Select Committee cited estimates which suggested the funding gap could be between £1.3 and £1.9 billion in 2017/18 alone.¹⁷² We remain unconvinced that the amount allocated so far for the period to 2020 is sufficient to provide a stable platform of adult social care services on which to build a longer-term funding solution.
206. **The additional funding for social care announced in the 2017 Budget is welcome and means funding for social care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system.**
207. *In order to stem the flow of providers leaving adult social care, meet rising need and help alleviate the crisis in NHS hospitals, the Government needs to provide further funding between now and 2020. This funding should be provided nationally as further increases in council tax to fund social care do not allow funding to be aligned with need. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding.*

Aligning health and social care funding

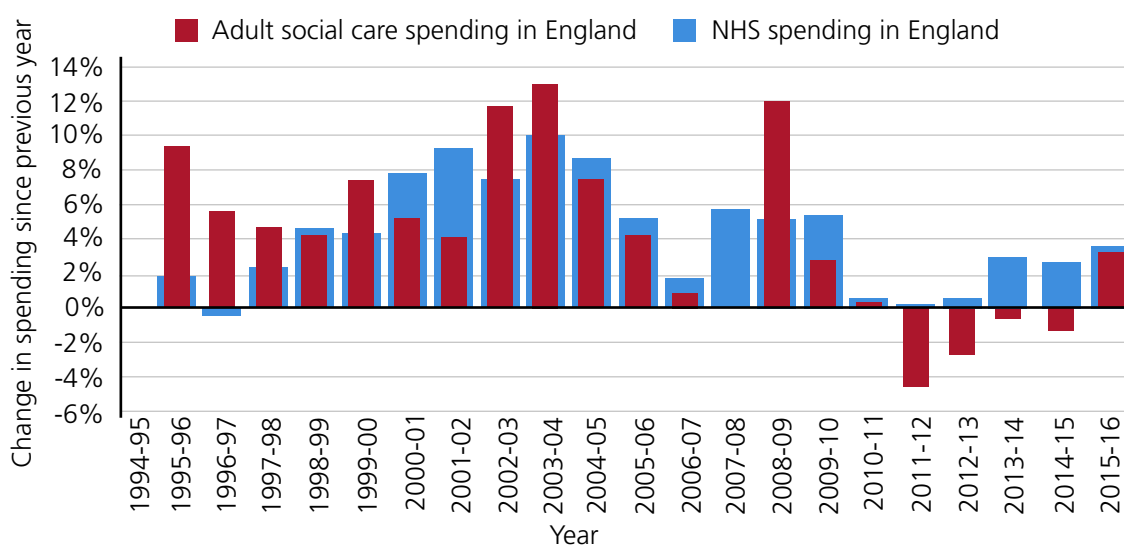
208. Additional funding for the NHS or adult social care alone will not guarantee sustainability. Both systems need immediate support to tackle the current financial difficulties but will also need to be able to undertake considered, longer-term planning to ensure the services can meet the changing needs and demands of the future patient population. We heard compelling evidence to suggest that neither service will be able to do this if two key funding issues are not resolved; the misalignment between the distribution of resources to the NHS and adult social care, and the volatility of funding allocations to both services.

171 HM Treasury, *Spring Budget 2017*, HC 10256, (March 2017), p 48: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597467/spring_budget_2017_web.pdf [accessed 28 March 2017]

172 House of Commons, Communities and Local Government Committee, *Adult social care: a pre-Budget report* (Eighth Report of Session 2016–17, HC 47)

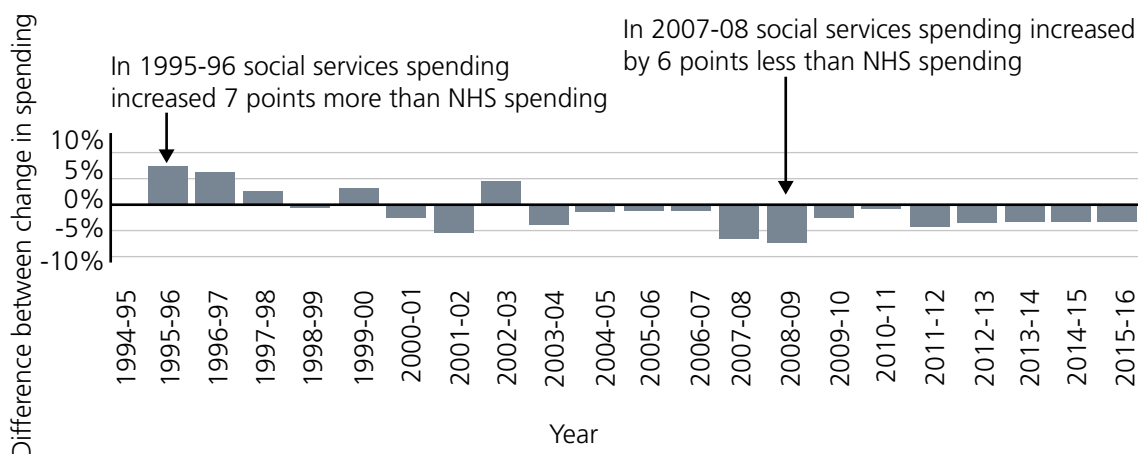
209. The way in which funding has been allocated to the NHS was seen as a key weakness of the UK's system because there was considerable volatility of spending growth for health due to it being tied to tax receipts, economic performance and political priorities. Figure 3 illustrates the historic volatility in the allocation of funding for the health system and the variation in social care spending.

Figure 3: Yearly change in real terms spending on the NHS and adult social care in England, 1994–2014¹⁷³



Source: Written evidence from the Health Foundation ([NHS0172](#)) and ([NHS0196](#))

Figure 4: Difference between percentage change in spending on the NHS and adult social care, 1994–2014



Source: Written evidence from the Health Foundation ([NHS0172](#)) and ([NHS0196](#))

210. The NHS appears to have gone through numerous cycles of boom-and-bust funding. Short-term financial pressures lead to short-term approaches elsewhere in the system (for example to workforce). We found agreement on this point from both the Department of Health and NHS England. Simon Stevens described how “we bounce off the backs between feast and famine, sugar high and starvation when it comes to the funding of the National Health Service.”¹⁷⁴ This ‘lumpiness’ was seen as detrimental to the efficient longer-term planning and use of taxpayer resources because of

¹⁷³ Figures 3 and 4 use 2017/18 prices and Her Majesty's Treasury's December 2016 GDP deflator.

¹⁷⁴ [Q 279](#) (Simon Stevens)

the uncertainty it creates. The Secretary of State for Health, acknowledged the issue, stating: “I think it has been particularly lumpy in the last six years because of the economic context we have been in, which has made it particularly challenging.”¹⁷⁵

211. Figure 4 highlights that the allocation of resources to the NHS and the amount local authorities have available to spend on adult social care has been historically very poorly synchronised. Given that both services continue to deal with very similar demographic and disease profiles, and the interdependent nature of the relationship between the NHS and adult social care services, this seems wholly counterproductive. It creates no stability for either service and prohibits effective long-term planning.
212. Some witnesses suggested that providing more funding certainty to the health system could result in a more effective allocation of resources. Lord Macpherson of Earl’s Court highlighted previous examples to secure greater funding certainty for the health service and other policy areas:

“Since inflation was brought under control in the 1990s, there has been a tendency to move away from annual spending reviews. For example, the 2015 spending review set budgets for the five years from 2016–17 to 2020–21. And there are a number of examples of governments singling out specific programmes for greater long term certainty. In his 2002 Budget, Gordon Brown set five year spending totals for the National Health Service, when other programmes were only settled for three years. There was also—briefly—a ten year transport plan. And more recently the defence equipment budget has been set for a ten year period, with varying degrees of certainty for the outlying years.”¹⁷⁶

213. Lord Macpherson of Earl’s Court went on to suggest that, providing it was underpinned by “end year flexibility” (the right to shift resources between financial years), he saw:

“... much to be said for agreeing funding for the NHS for a five year period at the beginning of each parliament, informed by manifesto commitments, tested by General Election debate and ideally by an independent assessment by the Office for Budgetary responsibility.”¹⁷⁷

214. Mr Stevens appeared supportive of the notion that action should be taken to reduce the volatility of the health funding allocations, stating that: “something that smoothed the funding increases, gave longer-term predictability and, more transparently for the public, connected what was being invested with the results they were getting in the NHS would be a great addition.”¹⁷⁸
215. Dr Sarah Wollaston MP told us that in her opinion this would be best co-ordinated in a unified policy setting in a single Government department.¹⁷⁹ There was also an argument for a unified budget. If the Government is serious about integrating health and social care, it should start at the top. A unified policy setting could also help to ensure that the funding allocated to local authorities is more consistent, given the vital role they play in the introduction of greater place-based approaches to health and care.

175 [Q 303](#) (Jeremy Hunt MP)

176 Written evidence from Lord Macpherson of Earl’s Court ([NHS0177](#))

177 *Ibid.*

178 [Q 279](#) (Simon Stevens)

179 [Q 289](#) (Dr Sarah Wollaston MP)

216. **Funding over the past 25 years has been too volatile and poorly co-ordinated between health and social care. This has resulted in poor value for money and resources being allocated in ways which are inconsistent with patient priorities and needs.**
217. *The budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the 'Department of Health and Care'. This should allow money and resources to be marshalled and used more effectively as part of an integrated approach to health and care.*
218. *We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen.*
219. *Regardless of this further work on integrating budgets, the Government should commit to (1) securing greater consistency in the allocation of funding to health and social care at least in line with growth in GDP and (2) reducing the volatility in the overall levels of funding allocated to health and care in order to better align the funding of both services.*
220. *We recommend that the current Government and any successive governments should agree financial settlements for an entire Parliament to improve planning and ensure the effective use of resources. 'Shadow' ten year allocations should also be agreed for certain expenditures, such as medical training or significant capital investment programmes that require longer-term planning horizons.*

Longer-term solutions for adult social care

221. The demographic and disease profile up to 2030 and beyond strongly suggested that the demand for adult social care (both publicly and privately funded) would continue to rise. If the funding of this sector becomes destabilised again, as has happened historically, we heard that this will place huge pressures on the NHS and threaten its sustainability.
222. The Prime Minister has acknowledged the need for a longer-term solution on a number of occasions. At Prime Minister's Questions on 8 February 2017, she said the following:

"As I have said before, we do need to find a long-term, sustainable solution for social care in this country. I recognise the short-term pressures. That is why we have enabled local authorities to put more money into social care ... But we also need to look long term."¹⁸⁰
223. Encouragingly, the Secretary of State for Health acknowledged that a longer-term solution for funding adult social care was required. He also spoke of the aspiration that people should save more for the costs of their own care in the longer term:

180 HC Deb, 8 February 2017, [cols 420–421](#)

“I think there is a real commitment in the Government to address the longer-term funding issues in the social care system during this parliament. I do not think we are saying that we want to wait until post-Brexit or until another Parliament. We recognise that this is a really serious issue that needs to be looked at sooner rather than later ... The reality is that putting in place longer-term incentives so that people save more for their social care costs will not make a material difference for decades, but it is still the right thing to do ... We need to find a way, through evening out the variations between different areas, pressing ahead faster with health and social care integration, doing what we can to relieve the pressure being felt everywhere, but I also think this is a time when we need to put in place a long-term settlement for the social care system, absolutely.”¹⁸¹

224. Simon Stevens advocated a much more holistic approach to the issue, drawing together the inter-related subjects of income, housing and care. He suggested that the idea of the pensions triple lock¹⁸² should be re-imagined:

“We need to go beyond just thinking about health and social care funding and think about what is happening in the benefits system, the pension system and so forth. Obviously, we have a triple lock until 2020, which is three different ways in which people’s pensions go up. A new way of thinking about that would be a triple guarantee for old people in this country that would be a guarantee of income, housing and care. I do not think you can think about any one of those in isolation from the other two.”¹⁸³

225. Lord Willetts, Chair of the Resolution Foundation, echoed this point:

“I would like to see a revised triple lock, which did not cover solely the pension and had some revised promise on the uprating of the pension, but included some commitment on the costs of social care. It would be a combination of a national insurance element plus private payment if you had significant assets on top.”¹⁸⁴

226. The traditional response to a funding shortfall in the provision of a public service has been to raise taxes. Dr Stephen Watkins from the Medical Practitioners’ Union Section at Unite argued for the increased taxation of individuals:

“There is no doubt that the introduction of free social care, which we strongly advocate, would necessitate increased taxation and it would necessitate increased taxation of individuals. But it must be noted that people deeply resent the risk to their savings involved in the current systems of social care charges. I think it ought to be possible to persuade people that they are getting good value for money out of the taxation that is necessary to pay for the introduction of free social care. That would be our response.”¹⁸⁵

181 [Q 305](#) (Jeremy Hunt MP)

182 The triple lock is the mechanism currently used by the Government for uprating the Basic State Pension (BSP). Under the triple lock, the BSP is increased each April by either the growth in average earnings, the Consumer Price Index (CPI), or 2.5%, whichever is highest.

183 [Q 281](#) (Simon Stevens)

184 [Q 118](#) (Lord Willetts)

185 [Q 159](#) (Dr Watkins)

People's ability to pay for care

227. There was debate over whether the limited provision of social care should continue to be means-tested. Evidence suggested that a means-tested system with adequate funding was sustainable on the condition that the Dilnot Report¹⁸⁶ proposals were swiftly implemented to provide a more realistic means-test and the capping of individuals' care costs at a sensible level.
228. The Care and Support Commission, led by Sir Andrew Dilnot, published its report in July 2011 (the 'Dilnot Report'). Its recommendations included the introduction of a cap on social care costs "to protect people from extreme care costs" in a range of £25,000 to £50,000, with a suggested rate of £35,000. It also proposed an increase in the upper capital limit for the means-test—below which people are eligible for local authority financial support towards their care costs—from £23,250 to £100,000. The Government accepted the recommendations, but later set the cap at £72,000 and the upper capital limit for the means test at £118,000.
229. Despite repeated assurances that Dilnot's proposals would be implemented, including through a commitment in the Conservative Party's 2015 manifesto,¹⁸⁷ on 17 July 2015, some two and a half months after the General Election, the Government announced a four-year delay in the introduction of the cap on social care costs.¹⁸⁸ In July 2015, Lord Prior of Brampton, Parliamentary Under Secretary of State for Health, cited a cost of £6 billion to implement the cap to care costs over the next 5 years as the reason behind the decision.¹⁸⁹
230. Many witnesses were disappointed at the failure to implement the duty under Section 18(3) of the Care Act 2014 that would have capped spiralling care costs, as proposed by the Dilnot Report. Again, some suggested that the Better Care Fund was alleviating the situation but most of the evidence did not support this assertion. Sir Andrew Dilnot told us that we should: "make sure that the Government introduce a cap on social care while at the same time properly funding the means-testing system. Those things were agreed, legislated for and in the Government's manifesto, so I am very much looking forward to seeing them done in 2020."¹⁹⁰
231. When asked about the future of the Dilnot proposals, Dr Sarah Wollaston MP, Chair of the House of Commons Health Select Committee, echoed Sir Andrew's call:

"[the provisions in the Care Act 2014 were] dumped in, I thought, a disgraceful fashion. Being snuck out as a Written Statement just before parliament rose, I thought, was the wrong way to do this. Even though there had been a clear call for it in response to the introduction of the living wage, it was clearly not going to be possible for them to do both. They have kicked it down the road a bit, but it is still there because we legislated for that ... They cannot keep ducking it ... They need to get

186 Commission on Funding of Care and Support, *Fairer Care Funding* (July 2011): <https://web.archive.org/web/20121019200932/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf> [accessed 28 March 2017]

187 The Conservative Party, *The Conservative Party Manifesto* (2015), p 38: <https://s3-eu-west-1.amazonaws.com/manifesto2015/ConservativeManifesto2015.pdf> [accessed 28 March 2017]

188 House of Commons Library, Social care: Announcement delaying introduction of funding reform (including the cap) and other changes until April 2020 (England), Briefing Paper, [No. 7265](#), 6 August 2015

189 Written Statement, [HLWS135](#), Session 2015–16

190 [Q 104](#) (Sir Andrew Dilnot)

to grips with this. Either they need to say, ‘It’s not affordable’ and be honest with the electorate, or they need to be setting out how they are going to fund it ...”¹⁹¹

232. Dame Kate Barker, Chair of the Commission on the Future of Health and Social Care England, argued that social care costs should not deprive people of all they have:

“We have to accept, as I say, that we probably cannot fund everything out of general taxation. People are going to have to cope with some of the ups and downs in their lives with social care, as they do with other things, but they should not have to cope with catastrophic costs, and people who do not have the resources to cope should not be left without any, as I think is happening too much today.”¹⁹²

Other funding streams

233. There were a number of ideas for how new funding streams could be developed to provide funding stability for social care. These included revisiting the pensions triple lock and converting it to a triple guarantee to cover pensions and care costs; incentives to individuals to save and invest to pay for care; a compulsory personal insurance-based system starting in middle age to cover care costs (as in Japan and Germany); and improved arrangements for accessing revenue from housing assets. We did not have the time or expertise to evaluate the merits of these ideas but note that the Government is considering all options and that the answer may lie in a combination of more than one of these.

234. The insurance option arose in evidence time and time again. Professor Julien Forder, Professor of Economics of Social Policy and Director of the Personal Social Services Research Unit at the University of Kent, told us: “it is time to look more seriously at statutory insurance and some form of hypothecation. Since the royal commission in 1999, there have been many attempts to reform social care. I think now is the time to look at statutory insurance very closely.”¹⁹³

235. Lord Willetts asked us to consider the systems in operation elsewhere in the world:

“Interested as I am in a fair deal between the generations, it is social care where we have a real muddle on our hands. I was on the Cabinet Committee that considered Sir Andrew Dilnot’s proposals, which of course have now been so watered down as to be barely happening. On social care, there is some scope for a combination of proper and distinctive public financing—perhaps doing as they did in Germany, with some national insurance element dedicated to covering the cost of social care—plus being explicit about private payment on top of that.”¹⁹⁴

191 [Q 292](#) (Dr Sarah Wollaston MP)

192 [Q 104](#) (Dame Kate Barker)

193 [Q 104](#) (Professor Julien Forder)

194 [Q 118](#) (Lord Willetts)

236. We received a great deal of evidence asking us to examine the possibility of introducing German or Japanese style systems, both of which involve compulsory long-term care insurance which is shared between an employer and employee, much like the workplace pension scheme in the UK. There have also been calls in the media to examine these type of options¹⁹⁵ and we support these calls. The key features of the systems are shown alongside the English system in Table 1.

Table 1: Social care systems in Japan, Germany and England

	Japan	Germany	England
How is the care funded?	National compulsory long-term care insurance (LTCI). Roughly half of long-term care financing comes through taxation and half through premiums. Citizens aged 40 and over pay income-related premiums along with public health insurance premiums. Employers pay the same premium as that of their employees.	Mandatory long-term care insurance (LTCI). There is a contribution rate of 2.35% of gross salary which is shared between employers and employees; people without children pay an additional 0.25%. The contribution rate is set to increase by 0.2% in 2017.	The NHS pays for some long-term care, such as for people with continuing medical needs, but most long-term care is provided by local authorities and the private sector.
Who is covered?	Those aged 65 and over and some disabled people aged 40–64.	Everybody with a physical or mental illness or disability (who has contributed for at least two years) can apply for benefits, (dependent on an evaluation of need and limited to a maximum amount, depending on the level of care).	Local authorities are legally obliged to assess the needs of all people who request it, but, unlike NHS services, state-funded social care is not universal.

¹⁹⁵ Rachel Sylvester, 'Social care crisis needs a Japanese solution', *The Times* (6 February 2017) <http://www.thetimes.co.uk/article/social-care-crisis-needs-a-japanese-solution-8pqr2lgnx> [accessed 28 March 2017]

	Japan	Germany	England
What is covered?	The social care system covers home care, respite care, domiciliary care, disability equipment, assistive devices, and home modification. Medical services are covered by the public health insurance system, as are palliative care and hospice care in hospitals, and medical services provided in home palliative care, while nursing services are covered by LTCI.	Beneficiaries can choose between receiving benefits in cash, which they can use to pay family carers, or even to carry out house renovations to make their accommodation accessible; or they can choose to receive in-kind service benefits, where care is provided by an agency under contract to the insurance company. As benefits usually cover approximately 50% of institutional care costs only, people are advised to buy supplementary private LTCI.	With the exception of “reablement” services, some equipment and home modifications (in some areas), residential and home care are needs and means-tested.
Who provides the care?	The majority of home care providers are private; 64% were for-profit, 35% not-for-profit, and 0.4% public in 2013.	Both home care and institutional care are provided almost exclusively by private not-for-profit and for-profit providers.	In 2009, the private sector provided 78% of residential care places for older people and the physically disabled in the UK. The NHS provides end-of-life palliative care at patients’ homes, in hospices (usually run by charitable organisations), in care homes, or in hospitals.

Sources: Commonwealth Fund, (2015) *International Profiles of Health Care Systems* (January 2016): http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf?la=en [accessed 28 March 2017] and The King’s Fund, *The social care and health systems of nine countries* (2014), p 27: <https://www.kingsfund.org.uk/sites/files/kf/media/commission-background-paper-social-care-health-system-other-countries.pdf> [accessed 28 March 2017]

237. There is a clear need to encourage people to take more financial responsibility for the care they receive and to open up new revenue streams to be able to provide this care. The option of some form of compulsory insurance scheme should be given serious consideration.
238. Steve Webb, Director of Policy, Royal London Group, also argued that a more sophisticated solution would be required which did not simply opt for increasing personal taxation through national insurance.
239. **Social care should continue to be underpinned by a means-tested system. Where possible people should be encouraged to take personal responsibility for their own care. We support a funding system that enables those who can afford it to pay for the social care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission.**
240. *The Government should also implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms which will make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs.*

CHAPTER 5: INNOVATION, TECHNOLOGY AND PRODUCTIVITY

241. The world is changing and the NHS must adapt if it is to continue to deliver the vital services millions of patients have come to rely on. This chapter highlights the NHS's relative failure to secure the take-up of innovation and new technology at scale and make effective use of data. It also highlights the mixed picture on productivity and the persistent variation in the quality of care and outcomes. Ultimately, strong leadership and a radical culture shift are required.

Innovation and technology

242. The Five Year Forward View speaks of accelerating useful health innovation and exploiting the information revolution. Powerfully, it presents the information revolution alongside the agricultural revolution and the industrial revolution as one of the major economic shifts in human history; but it also acknowledges that the NHS has been slow to adopt information technology because of a tendency to either over-centralise on the one hand or let “a thousand flowers bloom” on the other.¹⁹⁶
243. New technologies are changing what type of care can be provided and how it is delivered. Andy Williams, Chief Executive of NHS Digital, outlined some of the ways in which new technologies would support NHS sustainability:

“In the future, as patients start to have access to their health records and so-called ‘artificial intelligence’ can be used to understand what is wrong with them and to compare their health record to the health records of the broader population, they can come up with smart diagnoses to help the patient understand what they should do next, and it could be to go to A&E or it might not be.

The second is that we can use technology better to create more efficiencies in the way the system works, through interchange and passing information around ... Within hospitals, technology systems can not only improve quality but can increase efficiency and effectiveness.

The third area is a much better use of data generally ... data can be used in all sorts of ways in the future: to understand how effective the system is; to develop new treatments and new drug treatments more effectively; and linking genomics data to phenomics data.”¹⁹⁷

244. Medical advances are constantly changing the way the NHS responds to patient need and the possibilities presented by digital innovations are enormous both for the workforce and patients. However, traditionally, the NHS has been slow to adopt and implement new technology. The evidence suggested that, worryingly, this is still the case. Some argued that this was because of inadequate levels of funding, others argued that this was because of persistent cultures of complacency. Alistair McLellan, Editor of the Health Service Journal, however, reminded us that this was not the case everywhere: “while the NHS faces many challenges, there is also an enormous amount of

196 NHS England, *Five Year Forward View* (October 2014): <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> P31 [accessed 28 March 2017]

197 Q 237 (Andy Williams)

innovation, endeavour and improvement going on within the service.”¹⁹⁸ Dr Helen Stokes-Lampard, Chair of the Royal College of General Practitioners, also told us that there was a willingness to engage with new technology systems:

“We desperately need to embrace technology. Healthcare professionals love technology generally; it is just getting standardised, joined-up systems that we can use across the board. We want to be able to communicate with each other efficiently and effectively. It needs resource to do that, because IT will help us enormously with our jobs. When I hear that midwives are spending 50% of their time on admin tasks, we know that if we had better IT systems that could be reduced massively.”¹⁹⁹

245. There was disagreement on the possibility for cost savings which could be brought about by the use of new technologies; they might increase levels of productivity but cost more to procure. Some argued that new technologies, such as healthcare and assistive technologies,²⁰⁰ as well as the use of digital health, tele-health²⁰¹ and wearable technologies, had the potential to transform care and could reduce costs and demand on NHS services.²⁰² Professor Keith McNeil, Chief Clinical Information Officer for Health and Social Care and Head of IT for the NHS, provided an illustration:

“... give you a practical example of innovation and costs, when coronary angioplasty came in, which is putting a balloon in a coronary artery to treat a heart attack or a blockage, the previous treatment would be to open someone’s sternum and do an operation. The cost of doing an angiogram is much less than doing an operation, but the angiogram enables that technology to be available to a much wider population, so you get the balance between an individual procedure which is less costly and innovative but is available across a wider population and, in fact, the aggregate cost is greater.”²⁰³

246. Andy Williams, Chief Executive of NHS Digital, argued that there were difficulties in encouraging the uptake of new technology at scale. He pointed to both a silo mentality and a “technology inhibitor”:

“... new technologies quite often get plugged into the existing technology of one of those organisations and it is unique to that, and trying to replicate it somewhere else requires an awful lot of planning, so it is hard and difficult; it is not simple just to take something from here and put it over there. From a technology point of view, over the next few years we have to make that much simpler.”²⁰⁴

198 [Q 333](#) (Alastair McLellan)

199 [Q 213](#) (Dr Helen Stokes-Lampard)

200 Healthcare and assistive technologies include any product or service designed to enable independence for disabled and older people, such as wheelchairs, stairlifts, aids for daily living and artificial limbs.

201 Tele-health is the provision of healthcare remotely by means of telecommunications technology.

202 Written evidence from British Healthcare Trades Association ([NHS0056](#)), Association of Medical Research Charities ([NHS0059](#)), Wellcome Trust ([NHS0051](#)), Association for Clinical Biochemistry and Laboratory ([NHS0043](#)), Doctors for the NHS ([NHS0027](#)), Royal College of Emergency Medicine ([NHS0029](#)), The ASHN Network ([NHS0031](#)), The Royal College of Ophthalmologists ([NHS0032](#)), Institute and Faculty of Actuaries ([NHS0038](#)), The Royal College of Radiologists ([NHS0049](#)) and Mrs Susan Margaret Oliver ([NHS00006](#))

203 [Q 237](#) (Professor Keith McNeil)

204 [Q 239](#) (Andy Williams)

247. Professor Sir John Bell, Regius Professor of Medicine at the University of Oxford, explained that the incentive to innovate was often unclear. He argued that if innovation were to be seen in the context of saving costs, the uptake would be greater:

“I think the fundamental problem with innovation in healthcare is that we do not systematically look for the ways that innovation can extract cost from healthcare systems. In fact, the definition of ‘innovation’ should be to improve outcomes and to save costs, and it saves costs by changing pathways, allowing you to re-profile the workforce, which is essentially where healthcare systems spend all their money, and you should be able to extract very large amounts of money out of the system using those tools.”²⁰⁵

He also explained the importance of applying this across the system:

“it is about being really rigorous about taking innovations and trying to evaluate how you can extract the costs of innovations in a closed system, measuring and evaluating everything and then recommending that across the system. That will make a huge difference.”²⁰⁶

248. The benefits of using new technology are well known but we were told that encouraging uptake was difficult. One possible solution might be a system which would appraise new technologies, come to a decision on cost-effectiveness and need, and then make it clear to providers that implementation should follow. Lord Willetts suggested that providers should be told what was expected of them more broadly:

“... with social care, I look at some of the extraordinary advances in technology, where they can literally track your pattern of electrical use. They can work out when you are turning on a particular device, and register that this person is turning on a kettle between 9.30am and 10am and she has not turned it on and it is 11am, just by monitoring the electricity supply. We need to use technology and embrace the capacity of innovation. We experimented, and one way of making it happen is a list of required innovations that healthcare providers are expected to introduce.”²⁰⁷

It was unclear, however, who should be charged with undertaking such a detailed technical appraisal and imposing the resulting requirements on providers, or whether there were currently any penalties for failing to do so.

249. The PHG Foundation argued for financial incentives to encourage innovation²⁰⁸ and Professor Sir John Bell suggested that the penalty for failing to make progress could be financial:

“It is worth remembering that the Americans did this in a really short timeframe. They, essentially, digitised their entire healthcare system, which, as you know, is chaotic at best, and they did it by incentivising the hospitals and making sure that reimbursement was directly related to the ability to digitise. If the NHS tomorrow said, ‘Do it at whatever pace you like, but you will not get paid if it is not digital data’, I can tell

205 [Q 237](#) (Professor Sir John Bell)

206 [Q 242](#) (Professor Sir John Bell)

207 [Q 128](#) (Lord Willetts)

208 Written evidence from the PHG Foundation ([NHS0080](#))

you that, by Christmas, you would find a lot of stuff had happened. Hospital trusts have a lot of stuff on their plate, so why would they do it when they are doing everything else? There is a bit of a problem in incentivising these places in the way we need to. The American example shows that it can happen really fast.”²⁰⁹

250. **There is a worrying absence of a credible strategy to encourage the uptake of innovation and technology at scale across the NHS. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The provision of appropriate training and development of strong leaders to support this agenda within the NHS will be critical to its success.**
251. *The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for driving this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage. This could involve relocating services to places that prove to be more technologically innovative.*

The effective use of data

252. The effective use of data is of critical importance for the long-term sustainability of the NHS. We now know more than ever about the health of patients, but the continued failure to use this data effectively is costing too much money and resulting in unacceptable levels of variations in patient outcomes.
253. The use of Big Data was raised a number of times. Big Data is a term that describes the large volume of data—both structured and unstructured—that flows into an organisation on a day-to-day basis. This may be how many people have booked appointments in certain areas of the country, cancer diagnosis rates or average prescription costs for a specific drug. However, the PHG Foundation pointed out that the existence of Big Data is not enough: “The health service is already awash with ‘big data’, but its inability to standardise it, aggregate it, share it, analyse it and then use it intelligently to drive changes in practice means that its impact on reducing cost and managing demand are limited.”²¹⁰
254. We were told that data sharing and access was also important for continued medical research.²¹¹ The Association of Medical Research Charities explained that “researchers use health information to develop understanding of disease and ill-health, discover new cures and treatments for patients; and improve the care provided by the NHS and provide efficiency and cost savings.”²¹² They continued to say that: “without access to health information, the advancement of medical research will be hampered and with it the benefits to the NHS’s future sustainability.”²¹³

209 [Q 241](#) (Professor Sir John Bell)

210 Written evidence from PHG Foundation ([NHS0080](#))

211 Written evidence from Association of Medical Research Charities ([NHS0059](#)), The ASHN Network ([NHS0031](#)) and Sense ([NHS0048](#))

212 Written evidence from Association of Medical Research Charities ([NHS0059](#))

213 *Ibid.*

255. The Secretary of State for Health acknowledged that there was still more work to be done in the patient sphere:

“What we do not do at the moment, but it is starting to happen, is allow those records to flow around the NHS, but we have complete histories of people, which is a fantastic asset ... Now we have around two-thirds of A&E departments able to access people’s GP medical records, and next year we will go a step further and introduce what we are calling the Blue Button scheme. At the moment you can access your own record if you go to your GP surgery and get a code, so you can go online and access your record, but from next year we will have a system where you can go online and identify yourself online without having to go to your GP surgery. That will be very significant, because people will be able to download their record on their phone. People with long-term conditions will be able to get engaged in their own treatment ... It will save a lot of time. In short, I think there are some very exciting things happening.”²¹⁴

256. Dr Ron Zimmern, Chair of the PHG Foundation, argued that data sharing went to the heart of the effective use of new technologies:

“No matter what technology you look at—epigenetics, microbio, liquid biopsy—in the end it is about data and data sharing. To do that properly, you have to engage the citizen, you have to break down silos and you have to actively develop leaders. Without that, you will not get the data sharing which is absolutely at the heart of everything that we want to do.”²¹⁵

257. The benefits of data sharing are obvious; it can lead to improved patient engagement and ultimately better overall outcomes. Andy Williams, Chief Executive of NHS Digital, told us: “I think we can do much more, as far as the patient is concerned, by better use of digital technologies to allow patients to understand more, to access their health records and increasingly to use intelligent systems to allow them to look at self-diagnosis.”²¹⁶ The Royal Pharmaceutical Society echoed this point and said that “there should be a shared patient record that all relevant healthcare professionals can read and write to. There needs to be systems and processes in place that enable the electronic referral of patients, and information, between one care setting and another.”²¹⁷

258. Professor Sir John Bell argued that an additional benefit was the ability to track the costs associated with a patient’s treatment pathway:

“The advantage of the digital agenda is that you will be able to capture data on the same patient in primary, secondary and social care, and you will be able to know the captured cost of that whole pathway and then manage that to try to get yourself in a better position in terms of cost reduction.”²¹⁸

259. The Government’s flagship £7.5m *care.data* project aspired to create a giant database of medical records showing how individuals had been cared for across the GP and hospital sectors, and was intended to help them develop new treatments and assess the performance of NHS services. The records

214 [Q 311](#) (Jeremy Hunt MP)

215 [Q 242](#) (Dr Ron Zimmern)

216 [Q 237](#) (Andy Williams)

217 Written evidence from the Royal Pharmaceutical Society ([NHS0077](#))

218 [Q 237](#) (Professor Sir John Bell)

would have been anonymised, removing identifiable data, and would only have revealed the patient's age range, gender and area they lived in. The project was abandoned in the summer of 2016 because of data protection concerns and accusations that the Government had mismanaged the process of public consultation.²¹⁹ The failure to successfully implement *care.data* was cited as a missed opportunity²²⁰ and, although instances of good practice were highlighted, there is clearly still more to be done.

260. Andy Williams, Chief Executive of NHS Digital, agreed that public consultation was key:

“... *care.data*, in part, failed through a lack of public trust in the use of the data that was going to be generated. When we are thinking about the benefits of data in the future, which are enormous, we have to bring the public with us and this comes down to the public having to trust that we are handling their data with care and respecting whether they agree with the use of their data. We have to convince the public that we are doing the right thing and involving them and asking them.”²²¹

261. Professor Sir John Bell said that the key was public consultation at a local level where trust already existed:

“There is an important point here, which is that engagement is unlikely to be done by Government Ministers. It is very likely to be done at a local, not a national level. If you get a letter from these guys—who are terrific, I have to say; NHS Digital are terrific—saying how they are going to use your data for X, Y and Z, you will flip. If somebody in the local GP surgery or the local hospital says, ‘We are going to try to get a system where you can look at your records. Will that be okay with you?’ you are likely to say, ‘Yes that is kind of interesting’. If they say, ‘We would also like a system whereby the hospital consultant can see the GP records and the GP can see the hospital records’, if the patient knows the GP and they know the hospital, they will say, ‘Well, I thought you did that already’, which we do not, and then they will say, ‘Well, of course you can do that because then, when I go to see the consultant, he will know what the GP said and *vice versa*’. If you can build their confidence at a local level, it becomes much easier to make those things associate with each other and you then end up with very powerful master databases, but it is all done with consent on things that will benefit the patient. If this does not benefit patients, it is going nowhere.”²²²

262. ***The failure of the *care.data* project illustrates the inevitable consequences of failing to grapple with important issues relating to personal privacy. NHS Digital and all those responsible for data sharing in the NHS should seek to engage the public effectively in advance of any future large-scale sharing of personal data. Public engagement on data sharing needs to become a priority at a local level for staff in hospitals and the community, and not be left to remote national bodies.***

219 Sarah Knapton, ‘Controversial £7.5 million NHS database scrapped quietly on same day as Chilcot Report’, *The Telegraph* (6 July 2016): <http://www.telegraph.co.uk/science/2016/07/06/controversial-50-million-nhs-database-scrapped-quietly-on-same-d/> [accessed 28 March 2017]

220 Written evidence from Association of Medical Research Charities (NHS0059) and The Royal College of Paediatrics and Child Health (NHS0133)

221 Q 240 (Andy Williams)

222 Q 240 (Professor Sir John Bell)

Productivity and variation

263. Many witnesses also referenced the Carter Review²²³ which set out how non-specialist acute trusts could reduce unwarranted variation in productivity and efficiency across every area in hospitals to save the NHS £5 billion each year by 2020/21. It was clear that, as NHS Improvement emphasised, operational productivity and efficiency were “key components to the sustainability of NHS services”.²²⁴ This view was echoed by the Health Foundation who argued that narrowing the gap between efficiency of the best and the average would make “a substantial contribution to the efficiency challenge in the Forward view”.²²⁵
264. Variable levels of productivity in the health and care systems remain an endemic problem with wide differences in levels of provider performance. Although productivity and efficiency in the NHS has improved over time and although the health system is a national service, there is an unacceptable level of unwarranted variation in what is provided and the costs of providing the same care. This presents a picture of an ineffective and inefficient NHS which is failing patients.
265. There is the potential to do much better in this area. The Office for Budget Responsibility (OBR) projections show that improving the productivity and efficiency of the health system is not simply a requirement of the current period of austerity but a fundamental, long-term imperative for a sustainable NHS. The Carter Review²²⁶ and RightCare programme²²⁷ on NHS efficiency and value reveal how much better the NHS could do. The significant underuse of technology, data and digitalisation is having a direct impact on levels of productivity. According to Dell EMC, better use of data and technology “would improve efficiency in the healthcare sector by between 15% and 60%, resulting in savings to the NHS of between £16.5 billion and £66 billion per year”.²²⁸
266. Sir Muir Gray, Honorary Professor at the Nuffield Department of Primary Care Health Sciences, explained how some of these variations could have a direct impact on patient outcomes:

“I have brought along one of our atlases of variation, which we publish to destabilise the professions, to show huge variation: a fourfold variation in amputation; a twofold variation in the percentage of people dying at home; a fiftyfold variation in knee ligament surgery; and a hundredfold variation in rheumatoid factor interventions—all by people who thought they were doing evidence-based medicine.”²²⁹

223 Lord Carter of Coles, *Operational productivity and performance in England NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health* by Lord Carter of Coles, (February 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 28 March 2017]

224 Written evidence from NHS Improvement (NHS0107)

225 Written evidence from the Health Foundation (NHS0172)

226 Lord Carter of Coles, *Operational productivity and performance in England NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health* by Lord Carter of Coles, (February 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 28 March 2017]

227 The NHS RightCare programme was set up to assist local health economies to reduce unwarranted variation, using local data and evidence on outcomes, and working in partnership with local organisations. For more information see the NHS RightCare Programme: <https://www.england.nhs.uk/rightcare/programme/> [accessed 28 March 2017]

228 Written evidence from Dell EMC (NHS0070)

229 Q 59 (Sir Muir Gray)

267. He explained to us that the variation in outcomes was often accompanied by a lack of awareness of the true overall costs of treating certain conditions. He placed this in the context of the overall budget allocation:

“There is £115 billion on the table, there is a twofold variation in allocation of money and a tenfold, twentyfold, fiftyfold variation in activity, and we cannot see that explained by need or explicit choice. It is about thinking of programme budgeting and getting clinicians and patient groups together to think about whether we are making the best use of the resources we have for this population ... There is a split between purchasers and providers, and game-playing goes on. We know to the nearest pound what we spend in every hospital. I can tell you what we spend on car parking in the Oxford University hospitals trust because it is in the annual report, but no one you meet in Oxfordshire could tell you how much we are spending on women’s health or on respiratory, because the GP prescribing is over there and the hospital over there.”²³⁰

268. This disjointed approach to tracking costs inevitably leads to different levels of service being delivered in different parts of the country. Sir Muir explained some of the work that was taking place to help the sharing of best practice to reduce unwarranted variation. He spoke of the importance of benchmarking and learning from others working on the same problems in different areas:

“The proportion of people dying at home varies from 78% to 46%, so there is something going on at the local level that is very difficult to recognise. The question is getting people to start looking at where they stand in comparison to others. Both the 78% and the 46% of people will think that they are working their socks off. We have been trying to say to them, ‘Why don’t you go and see these other people and see how they’re doing it?’”²³¹

He went on:

“[The RightCare Team] are going to every CCG and showing them where they are ... We are setting up a casebook, as you would in any well-run organisation, where people can say, ‘Okay, we have a problem with emergency calls in Scunthorpe, and this is what the Blackpool Ambulance Service did’. Learning from within the system needs to be accelerated greatly.”²³²

We believe that such initiatives should become part of the normal way in which clinicians and managers carry out their duties. Those in a position to effect change should be unafraid of questioning local practice.

269. Unwarranted levels of variations in patient outcomes are unacceptably undermining the effectiveness and efficiency of the NHS and there is no plan to bring about a greater consistency in levels of performance. However, there is an immediate opportunity in the implementation of STPs to take this forward. Moreover the professional regulators and professional bodies should consider how they can assist in reducing variation in productivity and outcomes as part of their regular inspections and reporting.

230 [Q 60](#) (Sir Muir Gray)

231 [Q 65](#) (Sir Muir Gray)

232 [Q 64](#) (Sir Muir Gray)

270. *The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance. Greater levels of investment and service responsibility should be given to those who improve the most.*

Leadership and management

271. We received a large amount of evidence on the enormous potential for cost savings, improved efficiency and higher productivity where new technologies and the effective use of data are harnessed. The evidence was almost always accompanied, however, with a call for stronger leadership and more effective management. Technologies do not implement themselves and innovative ways of working will only be adopted where there is a culture which embraces change. Dr Ron Zimmern articulated this point and noted that individuals had to take a conscious decision to implement change:

“... although innovation is necessary, it is not sufficient. There are huge barriers at the moment to diffusion—although we should not use that word because it is passive and, if you allow it to be passive, it will not happen. Change management is the thing. If we are going to have disruptive change, we need to have change champions. There are issues about both having and developing clinical champions, clinical leadership, managerial champions and managerial leadership for change management. It will not happen by itself. It is an explicit activity.”²³³

272. Andy Williams, Chief Executive of NHS Digital, also pointed to leadership as the answer:

“... this is not a technology challenge; the technology largely exists and will continue to exist. Like everything, it is a people challenge, so the one thing I would point to is to get the leadership at all levels across the system to understand the benefits generally and the benefits in particular to their organisation of these sorts of technologies.”²³⁴

Lord Willetts said: “The NHS is a slow, late adopter of innovation. It seems to be a management challenge: shifting to a new way of doing things is hard to organise.”²³⁵

273. Many witnesses questioned the quality of the current leadership and management in the NHS. Professor Alistair McGuire, Chair in Health Economics at the London School of Economics, argued that improved management was a priority.²³⁶ Dr Sarah Wollaston MP, Chair of the House of Commons Health Select Committee, also pointed to good quality leadership:

“The role of leadership is extraordinary. We have heard time and again that that is what is driving culture change, making things happen and dealing with variation and morale within the workforce. You can make differences and make efficiencies in the way health and care operate, but, without good leadership, that is much more challenging.”²³⁷

233 [Q 238](#) (Dr Ron Zimmern)

234 [Q 242](#) (Andy Williams)

235 [Q 128](#) (Lord Willetts)

236 [Q 75](#) (Professor Alistair McGuire)

237 [Q 291](#) (Dr Sarah Wollaston MP)

274. Sir Muir Gray highlighted a potential distortion in the way certain categories of leader viewed their primary role:

“Changing the culture is more important than changing the model. In Derbyshire, we asked how many people there were with type 2 diabetes, and no one could answer. We asked them what the deficit was and they said £16 million. These are clinicians. Changing the culture is the function of leadership; it is partly behaviour but it is also the language.”²³⁸

275. Professor Sir Mike Richards, Chief Inspector of Hospitals at the CQC, called for leaders from different areas of expertise to come together: “We need to build the cadre of leaders, both clinical and non-clinical. Where we see good leadership and things are happening already, we need to put people working alongside those very good leaders so that they can learn from them.”²³⁹

276. Professor Sir John Bell explained that, in some cases, the cost of maintaining a digital system could be the same as employing people to carry out the work manually and that in many cases the problem was one of the wider prevailing culture. He shared the following anecdote about the same digital system being introduced in different countries:

“... All the savings came from the efficiency of the radiologists who could flick through 10, 20 or 30 X-rays from individual patients or multiple patients much faster, so their efficiency hugely improved. In America, where they introduced the same system, they fired a lot of radiologists. In the UK, everybody just drank more tea and ate doughnuts. That is the problem and that is what you have to fix.”²⁴⁰

277. Understandably, too much management and clinical attention in the NHS is focused on the here and now and there are too few incentives to look ahead to the longer term.

278. *The testing and adoption of new health technologies should be formally integrated into medical and non-medical NHS leadership, education and training at all levels.*

279. *NHS England should develop a system to identify and financially reward organisations and leaders who are instrumental in driving the much needed change in levels of productivity, the uptake of innovation, the effective use of data and the adoption of new technologies.*

238 [Q 68](#) (Sir Muir Gray)

239 [Q 264](#) (Professor Sir Mike Richards)

240 [Q 238](#) (Professor Sir John Bell)

CHAPTER 6: PUBLIC HEALTH, PREVENTION AND PATIENT RESPONSIBILITY

280. Effective public health strategies can deliver an extensive range of benefits, not just to individuals but to communities, the health service and the economy as a whole. We heard, however, that action on public health and prevention in the past has been insufficient and frustratingly slow, and that it is now chronically underfunded. This chapter highlights the multiple concerns raised about the apparent low level of priority assigned to public health and prevention.

Preventable ill health: causes and costs

281. Non-communicable diseases (those not caused by infectious agents, also known as chronic diseases) account for around two-thirds of deaths worldwide.²⁴¹ The four main types of non-communicable disease are cardiovascular disease, cancers, chronic respiratory disease and diabetes. In the UK non-communicable diseases cause an estimated 89% of deaths,²⁴² the most significant cause being the major diseases of the health and circulatory system (coronary heart disease and stroke).²⁴³ These conditions are also, to a significant extent, preventable and the costs, in human, social and economic terms, are largely avoidable. The World Health Organisation identifies the four most important modifiable risk factors for these diseases as tobacco use, physical inactivity, the harmful use of alcohol and unhealthy eating.
282. Social determinants of health (for example economic and social conditions) also contribute significantly to levels of preventable ill health. When it published its report in 2010, the Marmot Review, *Fair Society Healthy Lives* identified striking levels of health inequalities across the country, including that people in the poorest neighbourhoods in England would on average die seven years earlier and spend more of their life living with a disability.²⁴⁴
283. From the evidence we received, it appears that preventative ill health continues to place a significant burden on patients and on the health service, and is undoubtedly a major threat to the long-term sustainability of the NHS. The UK Health Forum warned that: “The current and escalating future burden of non-communicable disease on the NHS is unsustainable.”²⁴⁵ We received a wealth of evidence on the scale of this burden, including that:
- About a third of all deaths are classed as premature. That equates to 44 years of lost life per 1,000 people or 2.6 million years each year across England and Wales.²⁴⁶
 - Around 40% of premature mortality in the UK is caused by preventable cardiovascular disease, diabetes, cancer and chronic obstructive pulmonary disease.²⁴⁷

241 World Health Organization, *Global status report on noncommunicable diseases* (2010): http://www.who.int/nmh/publications/ncd_report_full_en.pdf [accessed 28 March 2017]

242 World Health Organization, *Non-communicable Diseases (NCD) Country Profiles* (2014): http://www.who.int/nmh/countries/gbr_en.pdf [accessed 28 March 2017]

243 The King's Fund, 'Non-communicable diseases': <https://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/non-communicable-diseases> [accessed 28 March 2017]

244 Q 322 (Professor Sir Michael Marmot) and The Marmot Review, *Fair Society Healthy Lives* (2010): <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf> [accessed 28 March 2017]

245 Written evidence from UK Health Forum (NHS0142)

246 Written evidence from the Local Government Association (NHS0125)

247 Written evidence from UK Health Forum (NHS0142)

- It is estimated that 40% of the burden on health services in England may be preventable through action on the determinants of avoidable chronic conditions.²⁴⁸

Inaction on public health and prevention

284. The Five Year Forward View included a clear commitment on prevention, calling for a “radical upgrade” in prevention and public health.²⁴⁹ It acknowledged that robust action on prevention is long-overdue: “Twelve years ago, Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded and the NHS is on the hook for the consequences.”²⁵⁰
285. Despite this renewed emphasis, we heard repeated concerns that the NHS was still failing on public health and prevention. The Academy of Medical Royal Colleges expressed disappointment at the progress made on the Forward View’s ambition on prevention: “Almost two years after the publication of the Five Year Forward View, there appears to have been little meaningful development; the ‘radical upgrade in prevention’ has failed to materialise.”²⁵¹
286. The lack of progress on prevention was evident in the scale of the burden of some of the key public health issues that witnesses reported. Ian Forde, from the OECD, confirmed that in comparison to other countries, the UK was “poor on public health prevention” stating that harmful drinking and smoking, although improving, were still above the OECD average.²⁵²
287. Mark Davies, Director of Health and Wellbeing at the Department of Health, told us: “We have made lots of improvements in the way we address alcohol, through the Chief Medical Officer and the messages that the industry puts out, and people’s alcohol use, through things like the health checks.”²⁵³ However, witnesses were clear that harmful drinking continues to place a significant burden on the health and care services. Public Health England estimates that around 10.8 million adults in England are drinking at levels that pose some risk to their health²⁵⁴ and that the NHS incurs around £3.5 billion a year in costs related to alcohol.²⁵⁵ While there has been some progress, much more should be done to reduce consumption.
288. There has been some progress with smoking, with smoking prevalence falling to 16.9% in England, a significant fall from previous years.²⁵⁶ However, Action on Smoking Health told us that smoking still costs the NHS an estimated £2 billion a year and remains the major cause of preventable premature death in England, causing around 80,000 premature deaths a year.²⁵⁷

248 Written evidence from the Health Foundation (NHS0172)

249 NHS England, *Five Year Forward View* (October 2014): <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 28 March 2017]

250 *Ibid.*

251 Written evidence from the Academy of Medical Royal Colleges (NHS0139)

252 Q 70 (Ian Forde)

253 Q 19 (Mark Davies)

254 Public Health England, ‘Health matters: harmful drinking and alcohol dependence’: <https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence> [accessed 28 March 2017]

255 Public Health England, *Alcohol treatment in England 2013–14* (October 2014), p 3: <http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-2013-14-commentary.pdf> [accessed 28 March 2017]

256 Q 244 (Mark Davies)

257 Written evidence from Action on Smoking and Health (NHS0146)

289. It was also suggested that not enough was being done to address health inequalities. We expected that we would receive evidence to suggest that health inequalities still existed but were disappointed to learn that progress at tackling inequalities and the social determinants of poor health was stalling. Professor Sir Michael Marmot told us:

“If we look at early child development, the decline in child poverty stopped, became flat and is now increasing, and the projections are that child poverty will increase over the next four years ...

On employment and working conditions, the quality of work matters. There has been a rise in the proportion of work-related illness related to stress, depression and anxiety, which is complicated.

There will be increased poverty and increased inequality over the next five years, which will potentially damage health, particularly for families with children; they will be selectively hurt the worst. If you look at the gap between the minimum income standard for healthy living and the national living wage, projected over the next five years, it will be particularly large for families with children and single parents with children; they will be in real poverty, which will, of course, have an adverse effect on early child development.”²⁵⁸

290. We acknowledge that there are multiple serious public health issues, which require more robust action to tackle their impact on both patients and the health service. We felt, however, that two public health issues—mental health and obesity—warranted particular focus. Both conditions affect millions of people in England and both cost the NHS and the wider economy billions of pounds a year, but the progress made in tackling both conditions has been wholly inadequate, with potentially devastating implications for the long-term sustainability of the health and care systems.

Mental health

291. We recognise that mental health has emerged as a more prominent policy priority in recent years and, as a consequence, there have been a number of high profile initiatives aimed at addressing long-standing issues in the provision of mental health services. Since parity of esteem between physical and mental health services was enshrined in the Health and Social Care Act 2012 there has been a renewed emphasis on the need to develop integrated care spanning physical, mental and social needs to improve mental health care and outcomes. Most recently, the Government has responded to the Five Year Forward View for Mental Health (published in February 2016), committing to meeting its recommendations in full, including additional investment of £1 billion a year to improve mental health services.²⁵⁹ At the beginning of this year, the Prime Minister also announced a package of measures aimed at improving mental health support in schools, workplaces and communities.²⁶⁰

258 *Q 319* (Professor Sir Michael Marmot)

259 HM Government, *The Government's response to the Five Year Forward View for Mental Health* (January 2017), p 1: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582120/FYFV_mental_health_government_response.pdf [accessed 28 March 2017]

260 Prime Minister's Office, Press Release: 'Prime Minister unveils plans to transform mental health support', 9 January 2017: <https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support> [accessed 28 March 2017]

292. Despite a renewed focus on mental health, witnesses were clear that there is still a persistent and considerable divide between physical and mental health. People with mental health problems continue to receive lower levels of appropriate treatment and achieve poorer outcomes. The charity Mind outlined some of the key issues in the provision and delivery of mental care services, including that:

- Mental health problems cause 23% of all illness in the UK but mental health care receives only 11% of health spending.
- Two-thirds of people with common mental health problems such as anxiety and depression receive no appropriate treatment (compared to a quarter of people with physical health problems).
- There is a lack of access to physical healthcare for people with mental health problems—less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.²⁶¹

293. Sophie Corlett, Director of External Relations at Mind, told us:

We know that we may have some great healthcare here compared to the rest of the world, but compared to our own healthcare in physical health we do extremely poorly. We have got to the heady heights of a third of people with mental health problems getting mental health care at the moment, which means two-thirds of people do not.”²⁶²

294. We also heard that, as well as the disparity in care and outcomes for people with mental health issues, preventative action on mental health has also been limited. Claire Murdoch Director of NHS National Mental Health at NHS England, told us:

“... the incidence of undetected, untreated diabetes in this country is something like 8%, so we have more work still to do to reach people around detecting and treating their diabetes, and of course now prevention. The incidence of undetected, untreated mental illness or mental ill-health is thought to be closer to 70% in this country.”²⁶³

295. **We welcome the greater prominence that mental health has received in recent years and we are encouraged by the Government’s commitment to a five-year strategy for mental health. Notwithstanding the progress made, there is still a need for sustained and determined action to close the gap between the care received and outcomes achieved by people with mental and physical health issues. Achieving parity of esteem between the two must remain a top priority for service commissioners and regulators.**

261 Written evidence from Mind ([NHS0179](#))

262 [Q 143](#) (Sophie Corlett)

263 [Q 143](#) (Claire Murdoch)

Obesity

296. The evidence suggested that in comparison to other areas of public health policy, there had been a particular failure, by successive governments, to tackle obesity effectively and a reluctance to take robust action on the issue. As opposed to other public health issues such as smoking, the Government was accused of taking a watered-down approach to obesity and failing to provide consistent nutritional advice to the public. Some argued that governments often cite an unwillingness to behave as a ‘nanny state’ as an excuse for inaction.²⁶⁴

297. Obesity costs the NHS around £5.1 billion a year,²⁶⁵ with an estimated cost to the economy of £27 billion due to its effect on productivity, earnings and welfare payments.²⁶⁶ It is also thought that more than 1 in 20 cancers are linked to being overweight or obese.²⁶⁷ There is widespread recognition that obesity, and the increasing prevalence of obesity, is a significant threat to the sustainability of the health service. In July 2016 Simon Stevens, the Chief Executive of NHS England, warned that:

“... obesity is the new smoking: poor diet is now our biggest avoidable cause of ill health. Piling on the pounds around our children’s waistlines is piling on billions in future NHS costs. We now spend more on obesity than on the police and fire service combined.”²⁶⁸

298. The failure to instigate firm action on obesity and prioritise this as a public health issue was particularly evident in the Government’s recent action on the childhood obesity strategy, which was ongoing at the beginning of our inquiry. In July 2016, Mark Davies, Director of Health and Wellbeing at the Department of Health, assured us that:

“We have been working for many months on a childhood obesity strategy. There is a lot of anticipation about that piece of work. We have one prepared. It has been announced that it will be launched in the summer, but we are still waiting to press the button on it. If and when it is published, we hope that it will be a really cross-sectoral look at all aspects of childhood obesity and all the things that drive it, including behaviour, family attitude, promotion, reformulation of food and what happens in school. We are working on a comprehensive strategy. It is a long-term strategy. If we get it right, it will have intergenerational impact and will stretch way beyond the next five or 10 years.”²⁶⁹

264 Written evidence from Doctors in Unite (the Medical Practitioners’ Union) ([NHS0102](#))

265 Peter Scarborough et al, ‘The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs’, *Journal of Public Health* (May 2011), pp 1–9: <http://iasnew.onepiecejigsaw.com/uploads/pdf/Economic%20impacts%20docs/pubmed.fdr.033full.pdf> [accessed 28 March 2017]

266 Public Health England, ‘Economic impact’: <https://www.noo.org.uk/LA/impact/economic> [accessed 28 March 2017] cited in written evidence from The King’s Fund ([NHS0717](#))

267 Cancer Research UK, ‘How being overweight causes cancer’: <http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/bodyweight-and-cancer/how-being-overweight-causes-cancer> [accessed 28 March 2017]

268 Simon Stevens, ‘The radical blueprint the NHS needs to survive life after Brexit’ *The Telegraph* (18 July 2016): <http://www.telegraph.co.uk/news/2016/07/18/the-radical-blueprint-the-nhs-needs-to-survive-life-after-brexite> [accessed 28 March 2017]

269 [Q 17](#) (Mark Davies)

299. However, when the strategy was published in August 2016, it received widespread criticism suggesting that its proposals were “weak and watered down”.²⁷⁰ It was also criticised for falling far short of what was required to properly address the issue and failing to reflect the seriousness of the impact that obesity was having on the health service. In its evidence, the Royal College of Physicians expressed its disappointment at the childhood obesity strategy, and warned that a failure to address obesity would have serious implications for the sustainability of the health service:

“Despite a commitment to introduce a levy on sugar sweetened beverages, the RCP is extremely disappointed that after such a long wait for the childhood obesity strategy, the government has published a downgraded plan that fails to address key issues such as marketing and promotion of sugar-filled and unhealthy foods to children.²⁷¹ The estimated cost of obesity to the UK economy is approximately £27bn.²⁷² The consequence of failing to act now is to commit the NHS to greater expense in the future as it struggles to fund care and treatment for obesity-related medical conditions. A strong package of measures and concerted action across all government departments is required to turn the tide on obesity.”²⁷³

300. Similarly, the Academy of Royal Colleges warned that:

“If we do not tackle childhood obesity with the seriousness it deserves, the NHS will face an existential crisis. The decision to water down the childhood obesity strategy suggests that the Government does not take prevention and the sustainability of the NHS seriously.”²⁷⁴

301. A number of witnesses suggested that a renewed, cross-government emphasis was needed to tackle the devastating effects of obesity—the “public health time bomb that needs to be tackled urgently.”²⁷⁵ When asked about the possibility of a nationwide campaign to educate people on the effects of obesity and poor diet the Secretary of State for Health, signalled his support for such a move:

“I think it would be an excellent idea. We have looked very hard at the scientific evidence, and there has been research done by people such as McKinsey as to what policy interventions make the biggest difference. I agree with you that obesity is rapidly overtaking smoking as the biggest public health threat.”²⁷⁶

302. We consider that there is insufficient political recognition, across the parties, of the major threat to the long-term sustainability of the NHS posed by the absence of any credible, well-led and sustained action on obesity, as is already the case for smoking and harmful drinking which makes use of regulatory, tax and nudge techniques.

270 BBC, ‘Childhood obesity: Plan attacked as ‘weak’ and ‘watered down’’: <http://www.bbc.co.uk/news/health-37108767> [accessed 28 March 2017]

271 Royal College of Physicians, ‘RCP president Jane Dacre ‘disappointed’ with government childhood obesity plan’: <https://www.rcplondon.ac.uk/news/rcp-president-jane-dacre-disappointed-government-childhood-obesity-plan> [accessed 28 March 2017]

272 National Obesity Observatory, *The Economic burden of Obesity* (October 2010): http://www.noo.org.uk/uploads/doc/vid_8575_Burdenofobesity151110MG.pdf [accessed 28 March 2017]

273 Written evidence from the Royal College of Physicians (NHS0065)

274 Written evidence from the Academy of Royal Colleges (NHS0139)

275 Written evidence from the Royal College of Obstetricians and Gynaecologists (NHS0093)

276 Q 130 (Jeremy Hunt MP)

303. **There is still widespread dissatisfaction with the prevention agenda. We share the views expressed by many of our witnesses of the need to realise the long-awaited ambition to move from an ‘illness’ to a ‘wellness’ service. The NHS must shift the rhetoric to reality and make genuine progress on refocusing the system towards preventative care.**
304. *We recommend that the Government urgently embarks on a nationwide campaign to highlight the many complications arising from the obesity epidemic, including its links with many chronic diseases. Such a campaign must be a cross-departmental effort, target the entire population and involve those who sell food and drink to the public, especially those whose products are consumed by children.*

Cuts to public health

305. Some public health measures can have an immediate impact. Such is the case with immunisation programmes in the prevention of a range of childhood and adult diseases. Water fluoridation, folic acid supplementation and of increasing dietary vitamin D consumption all have considerable benefits.
306. Adding to our concern that the prevention agenda continues to receive inadequate focus was the fact that many witnesses drew our attention to the cuts that had been made to public health budgets, and the resulting cuts to public health programmes, both locally and nationally.
307. In 2013, much of the responsibility for public health was transferred from the NHS to local authorities through the Health and Social Care Act 2012, supported by ring-fenced public health funding. The House of Commons Health Committee’s report on public health highlighted that the public health landscape had also become more complex.²⁷⁷ This is partly because of the addition of a national and regional public health agency—Public Health England—but also because some public health responsibilities still sit with the NHS through NHS England. The Secretary of State retains ultimate responsibility for both public health and health protection.
308. In June 2015, the Chancellor of the Exchequer announced a range of measures to bring down public debt, which included Department of Health non-NHS savings of £200 million.²⁷⁸ This amounted to a 7% cut to the public health budget. This was followed in the 2015 Spending Review with the announcement of a 3.9% cut per year over the next five years to local authority public health budgets.²⁷⁹ The Health Foundation and Nuffield Trust estimated that only 5.29% of the NHS budget in England was spent on prevention in 2014–15.²⁸⁰

277 Health Select Committee, *Public health post-2013* (Second Report, Session 2016–17, HC 140)

278 HM Treasury, ‘Chancellor announces £4.5 billion of measures to bring down debt’: <https://www.gov.uk/government/news/chancellor-announces-4-billion-of-measures-to-bring-down-debt> [accessed 28 March 2017]

279 QualityWatch, *Focus on: Public health and prevention Has the quality of services changed over recent years?* (April 2016): http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/FULL%20REPORT_QualityWatch_Public%20health_and_prevention_WEB.pdf [accessed 28 March 2017]

280 *Ibid.*

309. This means that vital public health services that provide front-line preventative care now risk being scaled back or even decommissioned, as local authorities respond to the cuts. Dr Sarah Wollaston said:

“... a lot of what they [local authorities] do is also what we would traditionally think of as front-line health services, such as sexual health and various other prevention services—for example, smoking cessation services. All these kinds of things and health visiting are now sitting within local authorities. If their budgets are being restricted and squeezed, the things that they have to provide as statutory services can continue, but it is the rest of it that is being very severely cut back in prevention services, such as weight management services and stop-smoking services. This, I think, is a real threat to making the changes we want to see going forward of having people leading healthier lives, and it is things around physical activity which, we know and I agree, independently of diet, are very important. All those kinds of services are being cut back, which is a great shame; it is very short-sighted.”²⁸¹

310. The Local Government Association put the cuts into context highlighting that: “public health funding will be cut by 9.7% by 2020/21 in cash terms of £331 million, on top of the £200 million cut in-year for 2015/16 announced in November 2015.”²⁸² UNISON were one of the many voices who pointed to how undermining and potentially damaging reductions in public health spending could be, saying:

“This is likely to prove highly counter-productive, as a failure to tackle issues such as obesity and sexual ill health stores up future costs for the wider NHS.”²⁸³

311. There was some disagreement, however, on the connection between cuts to public health funding and the success of public health initiatives. The Secretary of State for Health, in response to a question on funding for public health said: “I’m afraid I don’t accept that a public health budget being cut automatically means that we are unable to make progress on the big public health issues of the day.”²⁸⁴
312. We were totally unconvinced by this assertion, given the weight of evidence to the contrary. Significant cuts to public health budgets struck us as a false economy and clearly at odds with the core aims on prevention contained in the Five Year Forward View.
313. Given the multiple pressures facing the health and care system we can no longer defer action on prevention. We heard multiple calls for a different approach to prevention, one that takes a longer-term, more strategic view to planning. The UK Health Forum suggested that: “Like the OBR, a joint analytical relationship with the Treasury and PHE” could help with investment in public health measures and “better inform fiscal and economic planning.”²⁸⁵

281 [Q 290](#) (Dr Sarah Wollaston MP)

282 Written evidence from the Local Government Association ([NHS0125](#))

283 Written evidence from UNISON ([NHS0081](#))

284 [Q 310](#) (Jeremy Hunt MP)

285 Written evidence from the UK Health Forum ([NHS0142](#))

314. The Government's failure to invest in public health and the lack of progress on prevention, as evidenced by the significant burden preventative ill health continues to place on patients and the health service, was further evidence of the type of short-sighted, compartmentalised thinking that seems to prevail across health policy. Prevention, as with other areas of NHS policy, seems to be driven by short-term payback rather than longer term sustainability, and subject to shifting prioritisations with each political cycle.
315. *We are of the opinion that a continued failure to both protect and enhance the public health budget is not only short-sighted but counter-productive. Cuts already made could lead to a greater burden of disease and are bound to result in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets, for at least the next ten years, to allow local authorities to implement sustainable and effective public health measures.*

Patient responsibility

316. The NHS Constitution not only sets out what patients should expect from their health services, but also the responsibilities of patients and the public. It asks the public to: "Please recognise that you can make a significant contribution to your own, and your family's good health and wellbeing, and take personal responsibility for it."²⁸⁶
317. Some witnesses were keen to stress that promoting personal responsibility for health was an important, but largely unfulfilled, aspect to current public health and prevention policy. There were numerous calls for greater investment to be made to empower individuals to take responsibility for their own health. The British Medical Association stressed that:
- "Increasing health literacy, particularly from an early age, is key to achieving public health prevention measures and promoting better awareness of self-care. This will also help to reduce pressure on overstretched health services and support the sustainability of the NHS by preventing ill-health in the long-term."²⁸⁷
318. There was general agreement that a better balance needed to be achieved between the Government's responsibility for implementing effective prevention strategies and public health programmes, and patients taking responsibility for maintaining their own health. The British Dietetic Association alluded to the need for this balance to be readdressed, stating that:
- "Our healthcare system needs to realign itself fundamentally to prevention, even if that involves shifting funding from acute care and regulating to improve the public's diet. At the same time the UK population needs to take greater responsibility for its own health and wellbeing, or face losing the NHS it values so much."²⁸⁸

286 Department of Health, 'The NHS Constitution for England': <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-responsibilities> [accessed 28 March 2017]

287 Written evidence from the British Medical Association (NHS0116)

288 Written evidence from the British Dietetic Association (NHS0135)

319. We also heard of the role that employers have in supporting people to stay healthy and in helping to reduce demand on the system. Norman Lamb MP raised the role of employers and how they are engaged more in the well-being of their workforces, acknowledging that “we could be achieving much more in terms of good, preventative care in that way.”²⁸⁹ Sophie Corlett from Mind explained the significant role employers have in relation to work-related mental health issues:

“We do quite a lot of work at Mind with employers. Those whom we work with are able to make quite a difference to their workforce well-being generally to make it a healthier workplace but also to support people who do develop mental health problems to stay in work. That does not necessarily always work because sometimes their employee cannot get access to the health services that they need in time, but it may be to hold a job open if somebody does have to fall out of work, to support somebody to work more flexibly while they are unwell or come back at a slower pace—all of those are things that an employer can do.”²⁹⁰

320. *The Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted with a greater emphasis on these often overlooked individual responsibilities. The Government should relaunch the Constitution as part of a renewed and sustained drive to improve health literacy and educate the public about their common duty to support the sustainability of the health service, with children, young people, schools, colleges, further education institutions and employers forming a major part of this initiative.*

289 [Q 295](#) (Norman Lamb MP)

290 [Q 145](#) (Sophie Corlett)

CHAPTER 7: TOWARDS A LASTING POLITICAL CONSENSUS

321. The time has come to change the way we approach the provision of health and adult social care. This chapter will highlight the clear lack of long-term planning across the board, including by politicians, and will conclude that further independent oversight and scrutiny is needed, and that a new independent body should be charged with this task.

A culture of short-termism

322. Our inquiry uncovered endemic short-termism in almost every area of policy making. Those charged with planning and making decisions which affect the whole NHS seemed to be plagued by short-term pressures and, as a consequence, lacked the ability to look beyond the ‘here and now’ to the longer term. Long-term planning for NHS and adult social care services is clearly insufficient. This short-termism represents a major threat, and seems to have been a longstanding problem; even when resources were more plentiful, little thought was given to the longer-term problems the NHS faced.
323. As we mentioned in earlier chapters, the most notable exception to this was the Five Year Forward View pioneered by Simon Stevens, Chief Executive of NHS England, but the timescale covered by this document (2015–20) is nearly over. He told us in December 2016 about a forthcoming extension to the document which will look beyond this Parliament:

“In three months’ time, I intend to publish the delivery plan for what the National Health Service will look like for the rest of the Parliament. Probably going into 2018, given that it is important that the strategic questions that this Committee is addressing are out there for public debate, I intend that NHS England will publish a set of proposals, a manifesto if you like, for what going into the next Parliament should look like over the medium term: the kind of timeframe that this Committee is debating.”²⁹¹

This development is encouraging, and although the delivery plan had not been published at the time of writing this report, we await its publication in the near future.

324. Despite this, we were not presented with any of the details of the planning for the NHS (including for funding, social care and the workforce) that goes beyond 2020–21, despite a wealth of evidence on the likely changes in demography, burden of disease and emerging technologies. There appeared to be a prevailing culture of complacency within the Department of Health, including amongst its ministers and officials who did not see the benefit of planning for the long term. This was clearly demonstrated when we took evidence from Chris Wormald, the Permanent Secretary at the Department of Health. Although we questioned him at length on the work taking place in his department on the long-term future of the NHS, revealingly, we were not provided with any concrete examples. Moreover, he questioned whether this was work that should even be taking place in his department explaining that: “Personally, I am not a fan of trying to answer every question from a desk in Whitehall.”²⁹² When we questioned him on what work the department was

291 [Q 278](#) (Simon Stevens)

292 [Q 252](#) (Chris Wormald)

undertaking to plan a system that was more likely to distribute the resources available in line with the service delivery needs of health and social care in the future, he went on to explain that this planning for the future was taking place within the Sustainability and Transformation Plan process. We were unconvinced by the answers he provided and we are left with no choice but to conclude that the Department of Health is failing to plan for the future.

325. **We look forward to the publication in the near future of NHS England's delivery plan for what the NHS will look like for the rest of the Parliament. This will be a positive development in the short term. We are extremely concerned, however, that the Department of Health is failing to plan for the long-term.**

Building political consensus and engaging the public

326. A lasting political settlement for the NHS and social care was highlighted by a number of witnesses as the main solution to many of the current problems. When we put the prospect of such a settlement to Chris Wormald, however, he expressed scepticism:

“Turning to your question of whether there should be a long-term settlement of that issue, obviously there is a lot of politics in that. There are few more debated topics. My personal view is that there should probably not be. I do not see that you can deal with health spending either economically or in policy terms in isolation from the rest of government. That question of whether you want to invest a greater proportion of GDP as the economy expands is a question of how you prioritise health spending against other forms of public spending and wider economic activity. I am not sure that is a question you can have a long-term answer to.”²⁹³

We are of the clear view that a political consensus on the future of the NHS and social care is not only desirable, it is achievable.

327. Toward the end of the inquiry, we invited the health spokespeople for the three main opposition political parties in Westminster to appear before us; we are grateful for the time they took to speak to us. Norman Lamb MP, the Liberal Democrat Health spokesperson, told us about the failures of the past: “The brutal truth is that none of the political parties at the last election had a solution for the long-term funding challenge of the health and care system. No party proposed any mechanism to increase funding for social care.”²⁹⁴ He went on to argue that a lack of political consensus was doing real harm and inhibiting the ability of those in positions of responsibility to plan for the longer term: “There is a sense of complete inertia. We are sleepwalking towards the edge of the precipice. There is an urgency, therefore, about this.”²⁹⁵

328. Looking to the future, he told us about a piece of work he had commissioned:

“... I have set up an expert panel to advise my party, which will report within six months. It includes the former head of NHS England, the former head of the RCN and many other eminent people, together with two health economists, looking specifically at the case for a hypothecated

293 *Ibid.*

294 [Q 295](#) (Norman Lamb MP)

295 *Ibid.*

health and care tax and the level of that tax that is needed to properly fund the system. We will come out with a policy next year, as soon as the panel has reported, to contribute to this debate.”²⁹⁶

329. Despite this specific example, from the evidence we received we were far from convinced that the political parties have truly bought into a longer-term approach that would inevitably curtail their room for manoeuvre at election times. Dr Philippa Whitford MP, the SNP Shadow Westminster Group Leader (Health) told us:

“When we move towards an election time, people are doing soundbites around the NHS because it is so important to the public and we are not moving forward ...”²⁹⁷

330. We received a number of calls for a commission to be established to help bring about a new political consensus. Mindful of the fact that there have been numerous commissions and reports on different aspects of health and social care provision in the past, we feel that this is not the most effective way to proceed at this time. The public expect political consensus to be delivered as a result of cross-party talks and it is the responsibility of the main political parties finally to come together to make progress on all of the issues examined in this report.

331. Meaningful public consultation will be critical for any political consensus to be accepted by those who work in and use the health and care systems. The Patients Association told us that such an exercise would need to be tailored and multifaceted:

“By its very nature, public engagement cannot be a ‘one size fits all’ model and engagement should be embedded in everyday practice. The public must see the value in engaging in what they want from a health service, which will require real change developed from their contributions.”²⁹⁸

332. There is, of course, a difference between consultation which doesn’t have any tangible influence on the future direction of health and care, and consultation which is actively listened to and has a discernible effect on the formation of policy. Applied Psychology Ltd explained that this would require: “closing what might be described as the ‘credibility gap’ between the public and the planners, by listening to views that are already expressed publicly, and by demonstrating an authentic desire to learn from formal consultations.”²⁹⁹

333. Many called for a ‘national conversation’ on the future of health and care, an aspiration we share. The Academy of Medical Royal Colleges presented the need for a national conversation in the light of the exceptional pressures being faced by the health and care system at present:

“In light of the extreme financial pressures the health and care system in the UK are under and the fundamental changes required to create a sustainable system, there should be a ‘national conversation’ to determine how the shortfall should be funded and what reconfigured services should look like.”³⁰⁰

296 *Ibid.*

297 [Q 297](#) (Dr Philippa Whitford MP)

298 Written evidence from the Patients Association ([NHS0170](#))

299 Written evidence from Applied Psychology Ltd ([NHS0063](#))

300 Written evidence from the Academy of Medical Royal Colleges ([NHS0139](#))

Such a conversation should be truly national and involve people throughout the country, including those involved at all levels of decision-making, as well as those who make up the NHS workforce and, importantly, those who use the health and care system.

334. *The historic political failure to take a long-term approach to the provision of health and adult social care has been a major stumbling block to longer-term sustainability. Efforts should be made to encourage cross-party consensus. If this consensus is to be accepted by the public it should emerge as a result of committed cross-party talks and a robust national conversation. The Government should seek to initiate these immediately.*

The case for a new body

335. Securing a much awaited political consensus on the way forward for health and social care is important but this is only part of the solution to long-term sustainability. Given the amount of public money spent on health and adult social care, accountability is important. Such accountability, however, should not simply refer to what the money is used to pay for. It should also cover the standard of planning, the way in which money is allocated and the over-arching long-term strategy for the future of health and adult social care provision. Apart from periodic reviews, commissions and parliamentary inquiries, there is currently no individual or body charged with performing this task.
336. When questioned on the merits of creating a new body similar to the Office for Budget Responsibility (OBR) to oversee longer-term health and social care funding and planning, Labour's Shadow Secretary of State for Health, Jon Ashworth MP, was enthusiastic:

"I am very much attracted to the idea of an OBR-type body which gives periodic reports on the financial pressures on the NHS, what is needed and what are the workforce pressures, and offers a degree of objectivity in the planning which is slightly separate from the political knockabout that inevitably happens in the House of Commons. It is a very sensible idea and is something I would support."³⁰¹

Following the evidence session, he echoed his call in the press for an OBR-style body for the NHS which would help ensure that the NHS received adequate funding and was not the subject of political rows.³⁰²

337. Simon Stevens, Chief Executive of NHS England, was similarly enthusiastic and pointed out that such an approach might reduce adverse annual variations in funding:

"It is an idea that in some respects has its attractions. With other countries' systems, which are financed with universal coverage, you get less lumpiness as a by-product of the funding mechanism in its own right. Beveridge³⁰³ systems are more prone to lumpiness, so the question arises: can you overlay the sort of mechanism that you describe?"³⁰⁴

301 Q 296 (Jon Ashworth MP)

302 Jon Ashworth MP, 'Labour calls for OBR-style watchdog to assess NHS finances', *The Guardian* (27 December 2016): <https://www.theguardian.com/politics/2016/dec/27/labour-calls-for-obr-style-watchdog-to-assess-nhs-finances> [accessed 28 March 2017]

303 The Beveridge model is named after William Beveridge, whose 1942 report contained the proposals that provided the basis of the modern welfare state, and describes a system where health is provided and financed by the government through taxation.

304 Q 279 (Simon Stevens)

338. We were encouraged to hear the Secretary of State for Health also express interest in the idea. When we questioned him on whether the Government needed more help to plan over the longer term and overcome the ‘five-year groove’, he said “I think there is merit in the direction of travel.”³⁰⁵

339. Dr Philippa Whitford MP told us that such a body should not only be advisory but should be part of the decision-making processes:

“I totally support the idea of an arm’s-length body but you have to remember that the OBR only reports in, it just says, ‘This is what it will cost, you are on track, et cetera’. We get reports on performance from the National Audit Office whereas really what you require is an arm’s-length body that is part of the decision-making so that it does not become nailed down into the five-year cycles. You can never let go of it completely politically, but you can look at setting down what are the aims of an NHS ... on an occasional cycle.”³⁰⁶

340. Robert Chote, Chair of the OBR, explained that there were a number of existing bodies which could provide inspiration:

“If you were setting up a body in health in this area, again, you have that choice between saying, ‘Do you want them to go away and work out what we need?’ or do you want to say, ‘Health can have 9% of GDP to spend in 20 years’ time. What can you deliver for that?’ It could be approached in either or, indeed, both of those ways, if you wanted to. I would have thought models such as the Low Pay Commission or the National Infrastructure Commission would be possible ways of going at this.”³⁰⁷

We were grateful for Mr Chote’s willingness to speak to us about his experiences as Chair of the OBR and were encouraged by his ability to entertain the prospect of a body which may fulfil a similar function for health and care.

An Office for Health and Care Sustainability

341. The NHS is such an iconic part of Britain’s social fabric. If its sustainability is to be assured, a new independent mechanism needs to be created to counter the endemic NHS disease of ‘short-termism’. It is possible to retain overall political control and accountability for the NHS and yet introduce some level of independent scrutiny of the key longer-term issues facing the health and care system. This happened with the advent of the OBR and the National Infrastructure Commission (NIC). The provision of advice on low pay has also been handed to an independent commission. Such a body for health and care may be charged with advising future governments in the light of robust demographic data and changing levels of demand. The time has now come to move in this direction to secure the long-term sustainable health and care system that the public clearly want.

305 [Q 303](#) (Jeremy Hunt MP)

306 [Q 296](#) (Dr Philippa Whitford MP)

307 [Q 275](#) (Robert Chote)

342. We were grateful for the work completed by Emma Norris, one of our Specialist Advisers and Programme Director at the Institute for Government who, on our behalf, carried out an audit of 16 independent and semi-independent public bodies, details of which can be found in Appendix 5. Based on her work we are convinced that there is a strong case for a new, independent standing body enshrined in statute to safeguard the long-term sustainability of the NHS and social care. This body should be named the Office for Health and Care Sustainability.
343. As explained above, the body will need to have a clearly defined and well-understood remit and its work should always be grounded in what are often termed ‘the knowns’, such as the available demographic and disease profile data, for example. It is not our intention to articulate all the specific details of the new body, which need not be very large. Instead, the Government should examine the audit set out in Appendix 5 of the report to determine the remit, governance and composition of the new body before introducing a Bill.
344. *We recommend the establishment, before the end of this Parliament, of an independent standing body named the Office for Health and Care Sustainability to assist the Government in safeguarding the long-term sustainability of an integrated health and adult social care system for England. It should play no part in the operation of the system, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should report directly to Parliament.*
345. *The new body should be given a clear remit to advise on all matters relating to the long-term sustainability of health and social care. Initially it should focus on three key issues: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. It should continually look 15–20 years ahead.*

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Service Transformation

Most people agree that key aspects of the service delivery model for the NHS need to change. There is also broad agreement on how this should happen. The general direction of NHS England's Five Year Forward View commands widespread support and, if fully realised, will place the NHS on a far more sustainable footing, especially if greater public support can be achieved. (Paragraph 43)

The Five Year Forward View appeared to be the only example of strategic planning for the future of the health service. This is clearly short-sighted. Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the Five Year Forward View will be put at risk. (Paragraph 44)

Recommendation 1

The Department of Health and NHS England, in partnership with the Department of Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services, should agree a medium-term plan that sets out the action required to deliver sustained service transformation at a local level. This plan should cover the period up to at least 2025, be supported by dedicated funds and be implemented following a full public consultation. (Paragraph 45)

We applaud the move towards more place-based commissioning which delivers integrated health and social care services. At this early stage it would be premature to make a judgement about the current effectiveness of Sustainability and Transformation Plans but we doubt the ability of a non-statutory governance structure to secure sustainable change for the medium and longer term. NHS England, with the support of the Department of Health, should ensure that all 44 Sustainability and Transformation Plan areas have robust governance arrangements in place which include all stakeholders, including NHS organisations, local government, the voluntary sector and the public. (Paragraph 58)

We are concerned by the reported lack of engagement with either local authorities or the wider public in the preparation of Sustainability and Transformation Plans. This will deter buy-in at a local level and jeopardise ongoing political support. (Paragraph 59)

The evidence was mixed on the contribution of devolution to the long-term sustainability of health and social care. There are undoubtedly lessons to be learnt from devolution, but the evidence was not clear on how well the model in Greater Manchester could be replicated nationally especially as many, if not most, of the Sustainability and Transformation Plans (STPs) are for much smaller populations than that of Greater Manchester. (Paragraph 63)

Recommendation 2

The traditional small business model of general practice is no longer fit for purpose and is inhibiting change. NHS England, with the help of the Department of Health and the profession, should conduct a review to examine alternative models and their contractual implications. The review should assess the merits of engaging more GPs through direct employment which would reflect arrangements elsewhere in the NHS. (Paragraph 76)

Recommendation 3

We acknowledge that over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped in terms of service provision but changes to the number, size and distribution of secondary care services should always reflect the needs of the local population. Any changes should take place following a broad consultation. (Paragraph 80)

The drive to consolidate specialised services is a necessary part of overall service transformation. However, as with primary care, we were left with no clear picture of how specialised service consolidation will be delivered in the medium and the longer term. (Paragraph 85)

Although recent efforts to promote joined-up health and social care services have delivered mixed results, integrated health and social care with greater emphasis on primary and community services still presents the best model for delivering patient-centred, seamless care. Although there is disagreement on the financial gains to be derived from this integration, the benefits to patients are a clear justification for continuing to pursue this agenda. (Paragraph 94)

The Health and Social Care Act 2012 has created a fragmented system which is frustrating efforts to achieve further integration and the service transformation aims of the Five Year Forward View. (Paragraph 99)

Recommendation 4

NHS England and the Department of Health should launch a public consultation on what legislative modifications could be made to the Health and Social Care Act 2012 which would remove the obstacles to new ways of working, accelerate the desired service transformation and secure better governance and accountability for achieving system-wide integrated services. (Paragraph 100)

Service transformation is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is desperately needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made the national system is in need of reform to reduce fragmentation and the regulatory burden. (Paragraph 101)

Recommendation 5

With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement should be merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government. (Paragraph 102)

Workforce

We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10-15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Much of the work being carried out to reshape the workforce is fragmented across different bodies with little strategic direction from the Department of Health. Although we recognise that Health Education England has undertaken some work looking at long-term planning for the workforce, this is clearly not enough. Health Education England has been unable to deliver. (Paragraph 119)

Recommendation 6

We recommend that, as a matter of urgency, the Government acknowledges the shortcomings of current workforce planning. Health Education England, both nationally and through the network of local education and training boards, should be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, and it should always look 10 years ahead, on a rolling basis. Consideration should be given to its name to better reflect its revised function. (Paragraph 120)

Recommendation 7

Health Education England's independence should be guaranteed and supported by a protected budget with greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system. (Paragraph 121)

Recommendation 8

Workforce strategy has been poor with too much reliance on overseas recruitment. The Government should outline its strategy for ensuring that a greater proportion of the health and care workforce comes from the domestic labour market and should report on progress against this target. (Paragraph 122)

Recommendation 9

In the light of the result of the EU referendum, we recommend that the Government takes steps to reassure and retain overseas-trained staff working in the NHS and adult social care who are now understandably concerned about their future. (Paragraph 123)

Recommendation 10

A transformed Health Education England should use its greater budgetary freedom to review current commissioning and funding mechanisms to explore how initial and ongoing education and training might achieve a more multi-professional skill mix among the workforce and be underpinned by a place-based approach. (Paragraph 134)

There has been too great a reluctance by successive governments to address the changing skill mix required to respond to a changing patient population and too little attention paid to workforce planning, education and training, all of which are necessary for delivering efficiency, productivity and overall value for money. (Paragraph 135)

Recommendation 11

Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical and social care education and ongoing training courses can be reformed. Many are too lengthy, involve unnecessary repetition and do not meet the needs of a workforce which will have to be more flexible, agile and responsive to changing need. (Paragraph 136)

Recommendation 12

Given the move to a more localised and place-based approach to the provision of health and social care, a more flexible approach to the make-up of the workforce is required. Professional bodies, education providers and regulators should embrace the opportunities for different ways of working made possible by emerging, often non-medical, workforce roles and should not be afraid of challenging the traditional allocation of responsibilities within professions. (Paragraph 137)

There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade. (Paragraph 153)

Recommendation 13

We recommend that the Government commissions a formal independent review with the involvement of the Department of Health, the pay review bodies and health and care employers to review pay policy with a particular regard to its impact on the morale and retention of health and care staff. (Paragraph 154)

Recommendation 14

The current regulatory landscape is not fit for purpose. In the short term, we urge the Government to bring forward legislation in this Parliament to modernise the system of regulation of health and social care professionals and place them under a single legal framework as envisaged by the 2014 draft Law Commission Bill. The Government should also introduce legislation to modernise the system regulators to take account of our recommendation that NHS England and NHS Improvement be merged and to reflect the clear move towards place-based care. (Paragraph 155)

Funding the NHS and adult social care

International evidence shows that a tax-funded, single payer model of paying for healthcare has substantial advantages in terms of universal coverage and overall efficiency. There was no evidence to suggest that alternative systems such as social insurance would deliver a more sustainable health service. Sustainability depends on the level of funding and, crucially, how those funds are used. (Paragraph 169)

Recommendation 15

We strongly recommend that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for delivery of sustainable health services both now and in the future. (Paragraph 170)

Recommendation 16

We received some detailed analysis of how hypothecation might work for the NHS. Given the far-reaching implications of hypothecation for systems and services beyond the remit of our inquiry, we were not well-placed to make a firm conclusion on the issue. We recommend that hypothecation be given further consideration by ministers and policymakers. (Paragraph 182)

The reduction in health spending as a share of GDP seen over this decade cannot continue beyond 2020 without seriously affecting the quality of and access to care, something which has not been made clear to the public or widely debated. (Paragraph 192)

Recommendation 17

To truly protect the sustainability of the NHS the Government needs to set out plans to increase health funding to match growing and foreseeable financial pressures more realistically. We recommend health spending beyond 2020 should increase at least in line with the growth of GDP and do so in a predictable way in that decade. (Paragraph 193)

The additional funding for social care announced in the 2017 Budget is welcome and means funding for social care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system. (Paragraph 206)

Recommendation 18

In order to stem the flow of providers leaving adult social care, meet rising need and help alleviate the crisis in NHS hospitals, the Government needs to provide further funding between now and 2020. This funding should be provided nationally as further increases in council tax to fund social care do not allow funding to be aligned with need. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding. (Paragraph 207)

Funding over the past 25 years has been too volatile and poorly co-ordinated between health and social care. This has resulted in poor value for money and resources being allocated in ways which are inconsistent with patient priorities and needs. (Paragraph 216)

Recommendation 19

The budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the ‘Department of Health and Care’. This should allow money and resources to be marshalled and used more effectively as part of an integrated approach to health and care. (Paragraph 217)

Recommendation 20

We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen. (Paragraph 218)

Recommendation 21

Regardless of this further work on integrating budgets, the Government should commit to (1) securing greater consistency in the allocation of funding to health and social care at least in line with growth in GDP and (2) reducing the volatility in the overall levels of funding allocated to health and care in order to better align the funding of both services. (Paragraph 219)

Recommendation 22

We recommend that the current Government and any successive governments should agree financial settlements for an entire Parliament to improve planning and ensure the effective use of resources. ‘Shadow’ ten year allocations should also be agreed for certain expenditures, such as medical training or significant capital investment programmes that require longer-term planning horizons. (Paragraph 220)

Social care should continue to be underpinned by a means-tested system. Where possible people should be encouraged to take personal responsibility for their own care. We support a funding system that enables those who can afford it to pay for the social care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission. (Paragraph 239)

Recommendation 23

The Government should also implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms which will make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs. (Paragraph 240)

Innovation, technology and productivity

There is a worrying absence of a credible strategy to encourage the uptake of innovation and technology at scale across the NHS. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The provision of appropriate training and development of strong leaders to support this agenda within the NHS will be critical to its success. (Paragraph 250)

Recommendation 24

The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for driving this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage. This could involve relocating services to places that prove to be more technologically innovative. (Paragraph 251)

Recommendation 25

The failure of the care.data project illustrates the inevitable consequences of failing to grapple with important issues relating to personal privacy. NHS Digital and all those responsible for data sharing in the NHS should seek to engage the public effectively in advance of any future large-scale sharing of personal data. Public engagement on data sharing needs to become a priority at a local level for staff in hospitals and the community, and not be left to remote national bodies. (Paragraph 262)

Recommendation 26

The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance. Greater levels of investment and service responsibility should be given to those who improve the most. (Paragraph 270)

Recommendation 27

The testing and adoption of new health technologies should be formally integrated into medical and non-medical NHS leadership, education and training at all levels. (Paragraph 278)

Recommendation 28

NHS England should develop a system to identify and financially reward organisations and leaders who are instrumental in driving the much needed change in levels of productivity, the uptake of innovation, the effective use of data and the adoption of new technologies. (Paragraph 279)

Public health, prevention and patient responsibility

We welcome the greater prominence that mental health has received in recent years and we are encouraged by the Government's commitment to a five-year strategy for mental health. Notwithstanding the progress made, there is still a need for sustained and determined action to close the gap between the care received and outcomes achieved by people with mental and physical health issues. Achieving parity of esteem between the two must remain a top priority for service commissioners and regulators. (Paragraph 295)

There is still widespread dissatisfaction with the prevention agenda. We share the views expressed by many of our witnesses of the need to realise the long-awaited ambition to move from an 'illness' to a 'wellness' service. The NHS must shift the rhetoric to reality and make genuine progress on refocusing the system towards preventative care. (Paragraph 303)

Recommendation 29

We recommend that the Government urgently embarks on a nationwide campaign to highlight the many complications arising from the obesity epidemic, including its links with many chronic diseases. Such a campaign must be a cross-departmental effort, target the entire population and involve those who sell food and drink to the public, especially those whose products are consumed by children. (Paragraph 304)

Recommendation 30

We are of the opinion that a continued failure to both protect and enhance the public health budget is not only short-sighted but counter-productive. Cuts already made could lead to a greater burden of disease and are bound to result in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets, for at least the next ten years, to allow local authorities to implement sustainable and effective public health measures. (Paragraph 315)

Recommendation 31

The Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted with a greater emphasis on these often overlooked individual responsibilities. The Government should relaunch the Constitution as part of a renewed and sustained drive to improve health literacy and educate the public about their common duty to support the sustainability of the health service, with children, young people, schools, colleges, further education institutions and employers forming a major part of this initiative. (Paragraph 320)

Towards a lasting political consensus

We look forward to the publication in the near future of NHS England's delivery plan for what the NHS will look like for the rest of the Parliament. This will be a positive development in the short term. We are extremely concerned, however, that the Department of Health is failing to plan for the long-term. (Paragraph 325)

Recommendation 32

The historic political failure to take a long-term approach to the provision of health and adult social care has been a major stumbling block to longer-term sustainability. Efforts should be made to encourage cross-party consensus. If this consensus is to be accepted by the public it should emerge as a result of committed cross-party talks and a robust national conversation. The Government should seek to initiate these immediately. (Paragraph 334)

Recommendation 33

We recommend the establishment, before the end of this Parliament, of an independent standing body named the Office for Health and Care Sustainability to assist the Government in safeguarding the long-term sustainability of an integrated health and adult social care system for England. It should play no part in the operation of the system, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should report directly to Parliament. (Paragraph 344)

Recommendation 34

The new body should be given a clear remit to advise on all matters relating to the long-term sustainability of health and social care. Initially it should focus on three key issues: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. It should continually look 15–20 years ahead. (Paragraph 345)

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

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

Declarations of interest

Baroness Blackstone
Chair, Great Ormond Street Hospital Foundation Trust
Member, Board of UCL Partners (Academic Health Science Centre)

Lord Bradley
Non-Executive Director, Pennine Care NHS Foundation Trust
Non-Executive Chair, Bury, Tameside and Glossop NHS LIFT Company
Non-Executive Chair, Manchester, Salford and Trafford NHS LIFT Company
Trustee, Centre for Mental Health
Honorary Special Advisor, University of Manchester
Member, Unite

Bishop of Carlisle
Lead bishop for Health and Social Care (with overall oversight of Hospital Chaplaincy)
Associate, Faculty of Public Health
International Advisory Board Member, The Dementia Centre, University of Stirling
Member, All-Party Parliamentary Group on Health in all Policies
Member, All-Party Parliamentary Group on Cancer
Patron, Acorn Christian Healing Foundation
Patron, Association for the Independence of Disabled People
Patron, Burrswood
Patron, Eden Valley Hospice
Patron, Hospice at Home Carlisle and North Lakeland
Patron, The ME Trust
Patron, North West Cancer Research
President, Silloth Nursing and Care Home

Lord Kakkar

Chair, University College London Partners Limited
Practising Surgeon
Professor of Surgery, University College London
Honorary Consultant Surgeon, University College London Hospitals NHS Foundations Trust
Director, Thrombosis Research Institute, London
Commissioner, Royal Hospital Chelsea
Trustee and Governor, King Edward VII's Hospital
Business Ambassador for Healthcare and Life sciences
Fellow, Association of Surgeons Of Great Britain & Ireland
Fellow, King's College, London
Fellow, Royal College of Physicians of Edinburgh
Fellow, Royal College of Surgeons
Fellow, Royal College of Physicians
Honorary Fellow, Harris Manchester College, Oxford
Member, Shape of Training Review (2012–2013)
Member, General Medical Council (Interest ceased on 30 September 2016)
Member, Governing Board of Harris Manchester College, Oxford (Interest ceased on 30 September 2016)
Treasurer, All-Party Parliamentary Group on Global Health

Lord Lipsey

President, Society of Later Life Advisers (SOLLA) (Non-remunerated)

Lord Mawhinney

None relevant to the inquiry

Lord McColl of Dulwich

Fellow, Royal College of Surgeons,
Patron, Royal College of Surgeons
Honorary Fellow, Kings College, London
Honorary Fellow, Royal College of Surgeons, Faculty of Dental Surgery
Retired Professor and Chair Department of Surgery, Guy's and St Thomas' Medical School
Trustee, Wolfson Foundation

Lord Patel

Chancellor, University of Dundee
Retired Professor of Obstetrics & Consultant Obstetrician, Ninewells Hospital, University of Dundee
Fellow, Academy of Medical Sciences
Fellow, Royal Society of Edinburgh
Fellow, Royal College of Obstetricians & Gynaecologists
Honorary Fellow, Royal College of General Practitioners
Honorary Fellow, Royal College of Surgeons
Honorary Fellow, Royal College of Anaesthetists
Honorary Fellow, Royal College of Psychiatrists
Honorary Fellow, Royal College of Physicians of Edinburgh
Honorary Fellow, Royal College of Surgeons of Edinburgh
Honorary Fellow, Royal College of Physicians and Surgeons of Glasgow
Honorary Fellow, Royal College of Physicians of Ireland
Honorary Fellow, Faculty of Public Health

Baroness Redfern

Vice-Chair, The Health Alliance
Councillor, North Lincolnshire Council
Chairman, Health and Wellbeing Board, North Lincolnshire Council
Leader, North Lincolnshire Council (Interest ceased in January 2017)

Lord Ribeiro

Retired General Surgeon (non-practising)
Fellow, the Royal College of Surgeons of Edinburgh (ad hominem)
Fellow, Royal College of Physicians
Fellow, Royal College of Anaesthetists
Fellow, Royal College of Physicians and Surgeons of Glasgow (qua surgeon ad eundem)
Patron, Royal College of Surgeons
Past President, Royal College of Surgeons
Honorary Fellow, Faculty of Dental Surgery
Honorary Fellow, Royal College of Surgeons of Ireland
Honorary Fellow, Faculty of General Dental Practice
Chair, Independent Reconfiguration Panel (NDPB)
Chair, CORESS (confidential reporting system for surgery) (charity)

Lord Scriven

Member, Sheffield City Council
Managing Partner, Scriven Consulting
Clients of Scriven Consulting: Carillion Plc; Maximus UK (past interest); and Cumberledge, Eden & Partners

Lord Turnberg

Fellow, Royal College of Physicians
Fellow, Academy of Medical Sciences
Honorary Fellow, Royal College of Obstetricians & Gynaecologists
Honorary Doctor of Science of the University of Manchester
Honorary Doctor of Science of the University of Salford
Honorary Doctor of Science of the University of Keele
Honorary Doctor of Science of Imperial College, London
Honorary Fellow, Faculty of Sport and Exercise Medicine
Honorary Fellow, Faculty of Public Health
Honorary Fellow, Faculty of Occupational Medicine
Honorary Fellow, Royal College of Physicians of Edinburgh
Honorary Fellow, Royal College of Physicians of Glasgow
Honorary Fellow, Royal College of Surgeons
Honorary Fellow, Royal College of Ophthalmologists
Scientific Advisor, Academy of Medical Research Charities (Interest ceased in December 2016)
Past President Royal College of Physicians
Past Chairman Academy of Medical Royal Colleges
Past Chairman Public Health Laboratory Service
Past Vice-President Academy of Medical Sciences
Past Chairman, Specialist Training Authority
Past President, British Society of Gastroenterology
Past Dean of Medicine, University of Manchester
Past Chairman, Panel reviewing Health Services in London (1997)

Retired Clinician

Retired Professor of Medicine

Trustee of a number of medical charities mostly concerned with research

Lord Warner

Member, Advisory Council of Reform (think tank)

Lord Willis of Knaresborough

Fellow, Royal College of Nursing

Consultant, Nursing and Midwifery Council

Consultant, Health Education England

Chair, National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care for Yorkshire and Humber (CLAHRC YH)

A full list of member's interest can be found in the Register of Lords Interests:

<http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests/>

Anita Charlesworth (Specialist Adviser)

Director of Research and Economics, The Health Foundation

Trustee, Tommy's the Baby Charity

Sits on the editorial board of the Office of Health Economics

Emma Norris (Specialist Adviser)

Programme Director, the Institute for Government

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at <http://www.parliament.uk/nhs-sustainability> and available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the Committee is listed below in chronological order of oral evidence session and in alphabetical order. Those witnesses marked with a ** gave both oral and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

Oral evidence in chronological order

**	Department of Health	QQ 1–21
*	Department for Communities and Local Government	
**	Nuffield Trust	QQ 22–31
**	The King's Fund	
*	The Health Foundation	
**	NHS England	QQ 32–48
**	Public Health England	
*	NHS Improvement	
*	Nuffield Trust	QQ 49–58
**	Sir Muir Gray	QQ 59–68
**	Professor Katherine Checkland	
*	Professor Alistair McGuire	QQ 69–75
*	The Organisation for Economic Co-operation and Development (OECD)	
*	Professor Andrew Street	QQ 76–86
*	Professor Nick Black	
*	Reform	
*	NHS Improvement	
**	NHS Providers	QQ 87–97
*	Association of Directors of Adult Social Services (ADASS)	
*	NHS Confederation	
*	Dame Kate Barker	QQ 98–104
*	Professor Julian Forder	
**	Sir Andrew Dilnot	
*	Ipsos MORI	QQ 105–117
*	Institute for Government	
*	The Rt Hon Frank Field MP	
*	The Rt Hon Lord Willetts	QQ 118–128

★	The Rt Hon Steve Webb	
★	Strategic Society Centre	
	Institute for Public Policy Research	
★	Migration Advisory Committee	QQ 129–134
★★	Health Education England	
★	NHS Employers	
★	Professor Paul Corrigan	QQ 135–142
★	Royal Society of Public Health	
★	Jo Moriarty	
★★	NHS England	QQ 143–149
★★	Royal College of Psychiatrists	
★★	Mind	
★★	Nuffield Trust	QQ 150–157
★★	Department of Health	
★	Professor James Buchan	
★	UNISON	QQ 158–170
★	Dr Stephen Watkins	
★	Dr Mark Porter	
★	University Hospitals Birmingham NHS Foundation Trust	QQ 171–177
★	Central Manchester University Hospitals NHS Foundation Trust	
★	Sheffield Teaching Hospitals NHS Foundation Trust	
★★	The Patients Association	QQ 178–184
★★	Independent Age	
★	Professor Maureen Baker	QQ 185–190
★	NHS Tower Hamlets CCF	
★	Dr Clare Gerada	
★★	Academy of Royal Medical Colleges	QQ 191–206
★★	Royal College of Surgeons	
★★	Royal College of Physicians	
★★	Royal College of General Practitioners	QQ 207–215
★★	Royal College of Nursing	
★★	Royal College of Midwives	
★★	Chartered Society of Physiotherapy	QQ 216–223
★★	Royal College of Radiologists	
★	English Pharmacy Board	

★	Greater Manchester Health and Social Care Partnership	<u>QQ 224–235</u>
★	Manchester City Council	
★	Professor Kieran Walshe	
★★	PHG Foundation	<u>QQ 236–242</u>
★★	Professor Sir John Bell	
★	NHS Digital	
★	Department of Health	<u>QQ 243–249</u>
★	Public Health England	
★	Professor Dame Anne Johnson	
★★	Department of Health	<u>QQ 250–256</u>
★	NHS Improvement	<u>QQ 257–264</u>
★★	General Medical Council	
	Care Quality Commission	
★★	Nursing and Midwifery Council	
★	Baroness Cavendish of Little Venice	<u>QQ 265–271</u>
★	Lord Darzi of Denham	
★	Sir Cyril Chantler	
★	Office for Budget Responsibility	<u>QQ 272–277</u>
★	NHS England	<u>QQ 278–285</u>
★★	House of Commons Health Select Committee	<u>QQ 286–291</u>
★	Jon Ashworth MP	<u>QQ 292–300</u>
★	Rt Hon Norman Lamb MP	
★	Dr Philippa Whitford MP	
★	Secretary of State for Health	<u>QQ 301–313</u>
★	KPMG	<u>QQ 314–318</u>
★	University College London (UCL)	<u>QQ 319–327</u>
★	Government Office for Science	
★★	Department of Health	
★★	Nicholas Timmins	<u>QQ 328–333</u>
★	The Guardian	
★	The Lancet	
★	The Economist	
★	Health Service Journal	

Alphabetical list of all witnesses

	AbbVie	<u>NHS0035</u>
	Association of British Healthcare Industries (ABHI)	<u>NHS0068</u>
	Academy for Healthcare Science	<u>NHS0131</u>
**	Academy of Medical Royal Colleges (QQ 191–206)	<u>NHS0139</u>
	Action on Hearing Loss	<u>NHS0082</u>
	Action on Smoking and Health	<u>NHS0146</u>
	The Academic Health Science Network	<u>NHS0031</u>
	Mr Tom Allison	<u>NHS0024</u>
*	John Appelby (QQ 49–58)	
	Baroness Altmann	<u>NHS0184</u>
	Arthritis and Musculoskeletal Alliance	<u>NHS0087</u>
	Association of Anaesthetists of Great Britain and Ireland	<u>NHS0114</u>
	The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT)	<u>NHS0115</u>
	The Association of the British Pharmaceutical Industry	<u>NHS0167</u>
	The Association of Child Psychotherapists (ACP)	<u>NHS0066</u>
	Association for Clinical Biochemistry and Laboratory Medicine	<u>NHS0043</u>
	Association of Directors of Adult Social Services (ADASS)	<u>NHS0072</u>
	Association of Independent Healthcare Organisations	<u>NHS0083</u>
	Association of Medical Research Charities	<u>NHS0059</u>
	Association of UK University Hospitals	<u>NHS0150</u>
*	Professor Maureen Baker (QQ 185–190)	
*	Dame Kate Barker (QQ 98–104)	
	Sir David Bell	<u>NHS0020</u>
*	Professor Sir John Bell (QQ 236–242)	
	Mrs Win Betts	<u>NHS0166</u>
*	Professor Nick Black (QQ 76–86)	
	John Boyd	<u>NHS0129</u>
	Juliet Boyd	<u>NHS0126</u>
	Dr Brian Boughton	<u>NHS0012</u>
	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	<u>NHS0015</u>
	British Dental Association	<u>NHS0117</u>
	British Dietetic Association	<u>NHS0135</u>

	British Geriatrics Society	<u>NHS0141</u>
	British Healthcare Trades Association	<u>NHS0056</u>
	British Medical Association	<u>NHS0116</u>
	The British Psychological Society	<u>NHS0057</u>
	British In Vitro Diagnostics Association	<u>NHS0039</u>
	British Society for Histocompatibility and Immunogenetics	<u>NHS0026</u>
★	Professor James Buchan (QQ 150–157)	
	BUPA UK	<u>NHS0099</u>
	Ms Gemma Burford	<u>NHS0112</u>
	Cancer Research UK	<u>NHS0185</u>
	The Care and Support Alliance	<u>NHS0097</u>
	Care England	<u>NHS0089</u>
★	Care Quality Commission (QQ 257–264)	
	Mr Andrew Carmichael	<u>NHS0017</u>
	Sir Andrew Cash	<u>NHS0189</u>
★	Baroness Cavendish of Little Venice (QQ 265–277)	
★	Central Manchester University Hospitals NHS Foundation Trust (QQ 171–177)	
	Centre for Applied Psychology Ltd	<u>NHS0063</u>
	Centre for Health and the Public Interest	<u>NHS0050</u>
	Centre for Mental Health	<u>NHS0079</u>
★★	Professor Katherine Checkland (QQ 59–68)	<u>NHS0022</u>
	Mr Adam Chaffer	<u>NHS0144</u>
★★	Sir Cyril Chantler (QQ 265–271)	<u>NHS0187</u>
	The Chartered Institute of Public Finance and Accountancy	<u>NHS0041</u>
★	Chartered Society of Physiotherapy (QQ 216–223)	<u>NHS0055</u>
	Children and Young People’s Mental Health Coalition	<u>NHS0058</u>
	The Christie NHS Foundation Trust	<u>NHS0157</u>
	Coeliac UK	<u>NHS0153</u>
★	Department for Communities and Local Government (QQ 1–21)	
	Dr Stephen Clay	<u>NHS0151</u>
	Clinical Council for Eye Health Commissioning	<u>NHS0071</u>
	Professor Jonathan Cohen	<u>NHS0020</u>
	The College of Optometrists	<u>NHS0013</u>
	Mrs Gaynor Collins-Punter	<u>NHS0044</u>

	Dr Brendan Cooper	<u>NHS0132</u>
*	Professor Paul Corrigan (QQ 135–142)	
	Lord Crisp	<u>NHS0176</u>
	Anne Marie Culpan	<u>NHS0190</u>
	Sir Michael Deegan	<u>NHS0189</u>
*	Lord Darzi of Denham (QQ 265–271)	
	Dell EMC	<u>NHS0070</u>
	Mr Bill Dickinson	<u>NHS0074</u>
*	Sir Andrew Dilnot (QQ 98–104)	
	Dispensing Doctors Association	<u>NHS0062</u>
	Doctors For The NHS	<u>NHS0027</u>
	Doctors in Unite (Medical Practitioners’ Union)	<u>NHS0102</u>
	John Eayrs	<u>NHS0161</u>
*	The Economist (QQ 328–333)	
*	English Pharmacy Board (QQ 216–223)	
	Faculty of Dental Surgery	<u>NHS0121</u>
	Faculty of Public Health	<u>NHS0154</u>
	Faculty of Sexual and Reproductive Health	<u>NHS0098</u>
	Dr Laurence Ferry	<u>NHS0046</u>
**	Rt Hon Frank Field MP (QQ 105–117)	<u>NHS0182</u>
	Dr Richard FitzGerald	<u>NHS0016</u>
*	Ian Forde (QQ 69–75)	
*	Professor Julian Forder (QQ 98–104)	
	Dr Florian Gebreiter	<u>NHS0046</u>
**	General Medical Council (QQ 257–264)	<u>NHS0173</u>
	GenoMed Inc	<u>NHS0011</u>
*	Dr Clare Gerada (QQ 185–190)	
**	Professor Sir Muir Gray (QQ 59–68)	<u>NHS0019</u>
*	Greater Manchester Health (QQ 224–235)	
*	Greater Manchester City Council (QQ 224–235)	
	Mrs Alison Griffin	<u>NHS0037</u>
	Professor Frances Griffiths	<u>NHS0152</u>
*	The Guardian (QQ 328–333)	
*	Government Office for Science (QQ 319–327)	
*	Andrew Haldenby (QQ 76–86)	
	Thomas Harrison	<u>NHS0127</u>

	HCL Workforce Solutions	<u>NHS0118</u>
**	Department of Health (QQ 1–21) (QQ 150–157) (QQ 243–49) (QQ 250–26) (QQ 319–327)	<u>NHS0018</u> <u>NHS0175</u>
	The Healthcare Financial Management Association	<u>NHS0090</u>
**	Health Education England (QQ 129–134)	<u>NHS0122</u>
**	The Health Foundation (QQ 22–31)	<u>NHS0172</u>
	Health Research Authority	<u>NHS0143</u>
*	Health Service Journal (QQ 328–333)	
	Hospital Consultants and Specialists Association	<u>NHS0075</u>
*	House of Commons Health Select Committee (QQ 286–291)	
	ID Medical Group Ltd	<u>NHS0076</u>
	Candace Imison	<u>NHS0193</u>
**	Independent Age (QQ 178–184)	<u>NHS0053</u>
*	Ipsos MORI (QQ 105–117)	
	Institute and Faculty of Actuaries	<u>NHS0038</u>
*	Institute for Government (QQ 105–117)	
	Institute of Physics and Engineering in Medicine	<u>NHS0092</u>
	Integrated Care 24	<u>NHS0136</u>
	The Intergenerational Foundation	<u>NHS0148</u>
*	Professor Dame Anne Johnson (QQ 243–249)	
	Paul Johnson	<u>NHS0195</u>
	Keep Our NHS Public	<u>NHS0109</u>
	Kevin Kelleher	<u>NHS0164</u>
**	The King's Fund (QQ 22–31) (QQ 328–333)	<u>NHS0171</u>
*	KPMG (QQ 314–318)	
	The Lancet	
	Lord Layard	<u>NHS0178</u>
	Lifeways Group	<u>NHS0096</u>
	Local Government Association	<u>NHS0125</u>
	Macmillan Cancer Support	<u>NHS0030</u>
	Lord Macpherson of Earl's Court	<u>NHS0177</u>
*	Professor Alistair McGuire (QQ 69–75)	
*	Christine McAnea (QQ 158–170)	
	Dr Nick Mann	<u>NHS0028</u>
*	Jeremy Marlow (QQ 76–86)	
	Mr Peter Marsh	<u>NHS0005</u>

	Professor Alison Metcalfe	<u>NHS0147</u>
	Professor Karen Middleton	<u>NHS0191</u>
*	Migration Advisory Committee (QQ 129–134)	
	Dr Elizabeth Sinclair Miller	<u>NHS0138</u>
**	Mind (QQ 143–149)	<u>NHS0179</u>
	Dame Julie Moore	<u>NHS0189</u>
*	Jo Moriarty (QQ 135–142)	
	Professor James Morris	<u>NHS0007</u>
	Mr Malcolm Morrison	<u>NHS0010</u>
	Dr James Murphy	<u>NHS0036</u>
	National Community Hearing Association	<u>NHS0105</u>
	National Health Action Party	<u>NHS0094</u>
	Sir Robert Naylor	<u>NHS0181</u>
	NHS Clinical Commissioners	<u>NHS0159</u>
*	NHS Confederation (QQ 87–97)	
*	NHS Digital (QQ 236–242)	
*	NHS Employers (QQ 129–134)	
**	NHS England (QQ 32–48) (QQ 143–149) (QQ 278–285)	<u>NHS0111</u>
	NHS Improvement	<u>NHS0107</u>
	NHS Partners Network	<u>NHS0040</u>
**	NHS Providers (QQ 87–97)	<u>NHS0110</u>
*	NHS Tower Hamlets CCF (QQ 185–190)	
	Dr Kristian Niemietz	<u>NHS0034</u>
**	Nuffield Trust (QQ 22–31) (QQ 150–157)	<u>NHS0174</u>
**	Nursing and Midwifery Council (QQ 257–264)	<u>NHS0169</u>
	Nutricia: Advanced Medical Nutrition	<u>NHS0101</u>
*	Office for Budget Responsibility (QQ 272–277)	
	Mrs Susan Margaret Oliver RN, MSc, FRCN, OBE	<u>NHS0006</u>
*	Opposition Parties (QQ 292–300)	
	Optical confederation and Local Optical Committee Support Unit	<u>NHS0085</u>
	Dr David Owen	<u>NHS0003</u>
	Oxfordshire Keep our NHS Public	<u>NHS0023</u>
	Paediatric Continence Forum	<u>NHS0054</u>
**	The Patients Association (QQ 178–184)	<u>NHS0170</u>
	Pharmacy voice	<u>NHS0163</u>
*	PHG Foundation (QQ 236–242)	<u>NHS0080</u>

★	Dr Mark Porter (QQ 158–170)	
	Prederi Ltd	NHS0145
	Primary Health Properties	NHS0128
	Professional Standards Authority	NHS0168
★★	Public Health England (QQ 32–48) (QQ 243–249)	NHS0162
	Public Health England, Chief Knowledge Officer's Directorate	NHS0137
	Mr Graham Raven	NHS0021
	Dr Martyn Read	NHS0008
	Recruitment Employment Confederation	NHS0052
	Rethink Mental Illness	NHS0156
	Kevin Riley Supplementary written evidence	NHS0124
		NHS0165
	Professor Martin Roland CBE	NHS0009
	Helen Ross	NHS0086
	Dr Emma Rowland	NHS0091
★	Royal Society of Public Health (QQ 135–142)	
	The Royal College of Anaesthetists	NHS0073
	The Royal College of Emergency Medicine	NHS0029
★★	The Royal College of General Practitioners (QQ 207–215)	NHS0078
★★	The Royal College of Midwives(QQ 207–215)	NHS0067
★★	The Royal College of Nursing(QQ 207–215)	NHS0149
	The Royal College of Obstetricians and Gynaecologists	NHS0093
	The Royal College of Ophthalmologists	NHS0032
	The Royal College of Paediatrics and Child Health	NHS0133
	The Royal College of Pathologists	NHS0061
★★	The Royal College of Physicians (QQ 191–206)	NHS0065
	The Royal College of Physicians of Edinburgh	NHS0064
★★	The Royal College of Psychiatrists (QQ 143–149)	NHS0123
★★	The Royal College of Radiologists(QQ 216–223)	NHS0049
		NHS0192
	The Royal College of Speech and Language Therapists	NHS0113
	The Royal College of Surgeons of Edinburgh	NHS0180
★★	The Royal College of Surgeons (QQ 191–206)	NHS0121
	The Royal Crescent Surgery, Weymouth, Dorset	NHS0103
	The Royal Pharmaceutical Society	NHS0077

- ★ The Secretary of State for Health (QQ 301–313)
Sense [NHS0048](#)
- ★ Sheffield Teaching Hospitals NHS Foundation Trust (QQ 171–177)
Shelford Group [NHS0134](#)
Simple Shared Healthcare Limited [NHS0104](#)
- ★ Social Care Partnership (QQ 224–235)
The Society and College of Radiographers [NHS0186](#)
Specialised Healthcare Alliance [NHS0042](#)
Stephen Smith [NHS0001](#)
Petula Storey [NHS0025](#)
- ★ Strategic Society Centre and Institute for Public Policy (QQ 118–128)
- ★ Professor Andrew Street (QQ 76–86)
Stroke Association [NHS0130](#)
Sustainable Development Unit for NHS England and Public Health England [NHS0140](#)
Telecare Services Association [NHS0106](#)
Dr Tim Taylor [NHS0108](#)
Together for Short Lives [NHS0158](#)
Trade Union Congress [NHS0084](#)
- ★ Nicholas Timmins (QQ 328–333)
UK Health Forum [NHS0142](#)
UNISON [NHS0081](#)
Unite the Union [NHS0100](#)
- ★ University College London (UCL) (QQ 319–327)
- ★ University Hospitals Birmingham NHS Foundation Trust (QQ 171–177)
University of Nottingham [NHS0069](#)
Urgent Health UK [NHS0045](#)
Vanguard Healthcare [NHS0095](#)
Voluntary Organisations Disability Group [NHS0119](#)
Walgreens Boots Alliance [NHS0120](#)
- ★ Dr Stephen Watkins (QQ 158–170)
- ★ The Rt Hon Steve Webb (QQ 118–128)
Wellcome Trust [NHS0051](#)
- ★ Professor Kieran Walshe (QQ 224–235)
Professor Peter Wells [NHS0033](#)

Dr Stephen West	<u>NHS0004</u>
Professor Chris Whitty	<u>NHS0194</u>
Dr Graham Willis	<u>NHS0188</u>
Wilmington Healthcare	<u>NHS0155</u>
Mrs Carole Woodman	<u>NHS0047</u>

APPENDIX 3: CALL FOR EVIDENCE

The Select Committee on the Long-term Sustainability of the NHS of the House of Lords, chaired by Lord Patel, is conducting an inquiry into the sustainability issues facing the NHS and the impact they will have over the next 15–20 years. The Committee invites interested individuals and organisations to submit evidence.

Written evidence is sought by Friday 23 September 2016. The submissions will guide the Committee's deliberations in oral evidence sessions which will be held later this year and inform the Committee's final conclusions and recommendations.

Public hearings began in early July and will continue until late December. The Committee aims to report to the House with recommendations by March 2017. The report will receive a response from the UK Government and will be debated in the House.

Background

The terms of reference for the inquiry as set by the House of Lords are “*to consider the long-term sustainability of the NHS*” and to report back to the House by Friday 31 March 2017.

The sustainability of the NHS is a topic of significant political and public interest. There remains a continuing level of support for a national health service which is free-at-the-point-of-use.

Yet the demographics of both England and the UK are changing rapidly. There are estimated to be 51% more people aged 65 and over in England in 2030 compared to 2010. Moreover, 101% more people in England will be aged 85 and over in 2030 compared to 2010. People with three or more long-term conditions in England will increase by over 50% by 2018 compared to 2008.

These demographic changes directly affect healthcare expenditure, potentially putting financial stability and sustainability at risk. In 2015/16 NHS providers ended in deficit for the second year running.

Alongside this, the pace of change in healthcare is dramatic. Developments in drugs and medical technology mean that treatment and prevention are becoming more personalised, opening the door for more targeted treatment of diseases.

The Committee will be looking at UK Government policy and practice. It will consider whether their strategies and planning are sufficiently long-term, and what might usefully be done in practical terms to guarantee the sustainability of the NHS. The Committee will focus its inquiry on five main themes:

- resource issues, including funding, productivity and demand management;
- workforce, especially supply, retention and skills;
- models of service delivery and integration
- prevention and public engagement; and
- digitisation of services, Big Data and informatics.

The Committee will attempt to identify the main problems in each of these areas and explore potential solutions.

The Committee is keen to take evidence from as diverse and as wide a range of stakeholders as possible, from a variety of sectors. This includes, but is not limited to: NHS Trusts and Foundation Trusts; patient organisations and charities; Royal Colleges; academics; local authorities; consultancies; civil society and non-governmental organisations; organisations working in the EU and other international bodies. We would like to hear from as many organisations and people working in these sectors as possible.

The Committee's inquiry will focus on the long-term sustainability of the NHS in relation to the five areas identified above. Submissions which do not address one or more of these issues, or which focus on the past, current, or short-term situation, may not be accepted as evidence.

The Committee will not look at or comment on personal cases. Individuals who wish to seek advice on healthcare-related complaints are encouraged to contact the Parliamentary and Health Service Ombudsman on 0345 015 4033 or at www.ombudsman.org.uk.

Questions

The following questions cover the full focus of the Committee's inquiry. It is not necessary to answer every question in detail in your submission and you are encouraged to share any other information with the Committee that you feel is relevant to the focus of the inquiry. Please consult the staff of the Committee if you have any questions. Submissions should be limited to six pages. You need not address all the questions in your response.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?
 - (a) Does the wider societal value of the healthcare system exceed its monetary cost?
 - (b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?
 - (c) What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?
 - (d) Should the scope of what is free-at-the-point-of-use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?
 - (a) What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?
 - (b) What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?
 - (c) What are the retention issues for key groups of healthcare workers and how should these be addressed?
4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?
 - (a) What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?
 - (b) What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?
 - (c) What investment model would most speedily enhance and stabilise the workforce?

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?
 - (a) How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?
 - (b) How can local organisations be incentivised to work together?
 - (c) How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?
 - (a) What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?
 - (b) What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?
 - (c) Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

- (d) Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?
 - (e) By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?
 - (f) What are the barriers to taking on received knowledge about healthy places to live and work?
 - (g) How could technology play a greater role in enhancing prevention and public health?
7. What are the best ways to engage the public in talking about what they want from a health service?

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?
- (a) What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?
 - (b) What is the role of 'Big Data' in reducing costs and managing demand?
 - (c) What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?
 - (d) How can healthcare providers be incentivised to take up new technologies?
 - (e) Where is investment in technology and informatics most needed?

APPENDIX 4: HYPOTHECATION

In paragraphs 179–182, we noted that some witnesses had proposed hypothecated taxes as a way of generating additional funding for the NHS. Some of the arguments for and against such hypothecation are set out below.

Definition of hypothecation

The hypothecation of a tax is the dedication of revenue raised from a specific tax for a particular programme or service.³⁰⁸ The evidence highlighted three kinds of hypothecation, which included:

- (1) ‘Soft hypothecation’. This involves a commitment to spend any additional revenues from a given tax or change in tax to a specific cause.
- (2) ‘Hard hypothecation’. This involves assigning a proportion of a given revenue stream to a specific programme.
- (3) ‘Full hypothecation’. This involves allocating all of the revenue from one tax to a specific programme.³⁰⁹

The case for and against hypothecation

The strongest advantage of hypothecation appeared to be the greater transparency it would provide of the link between taxation and government spending, which witnesses suggested could help improve the public’s understanding of the tax burden and the amount spent on a service, therefore enabling more of a debate on how much the electorate are willing to pay. Lord Macpherson of Earl’s Court outlined this argument in more detail:

“... the introduction of hypothecation could strengthen public understanding of the trade-offs between taxing and spending at least in relation to health spending. And it might make more palatable the likely tax increases which will be necessary to deal with the demographic pressures which are likely to become increasingly visible during the course of the 2020s. At a time when trust in government has declined, and many citizens feel a disconnect between the taxes they pay and the services they receive, it could help revive citizen engagement. This would be the case especially at election-time, when political parties would have a chance to set out their plans for any hypothecated tax and health spending as a whole.”³¹⁰

The key disadvantage to hypothecation appeared to be concerns that it would potentially undermine the ability of governments to deal with economic cycles. Lord Macpherson of Earl’s Court stated that:

“The case against hypothecation is that it is inherently inefficient. Governments need the flexibility to allocate resources as they see fit, unconstrained by trends in individual taxes, some of which are more buoyant than others while others are more cyclical. It would also constrain changes to the hypothecated tax for wider economic and distributional reasons.”³¹¹

308 Centre Forum, India Keable-Elliott, *Hypothecated taxation and the NHS*, (December 2014): <http://www.centreforum.org/assets/pubs/hypothecated-taxation.pdf> [accessed 28 March 2017]

309 Written evidence from Lord Macpherson of Earl’s Court (NHS0177)

310 *Ibid.*

311 *Ibid.*

Giving effect to hypothecation

The evidence suggested that income tax, National Insurance contributions (NICs) and VAT raise sufficient revenue to be plausible candidates for a hypothecated tax for health spending, with a number of witnesses suggesting the most viable options to be NICs. Lord Macpherson of Earl's Court outlined the various implications of using NICs to fund the health service:

- Many taxpayers already think NICs fund the NHS, which is partially right as some 20% of NIC revenues (£21 billion in 2014–15) are allocated to the NHS, the rest going into the National Insurance Fund to pay for contributory benefits, such as the state retirement pension. This might provide a “good starting point” for any debate about the levels of taxation and health spending.
- For a hypothecated tax to be seen as fair, it could be argued that as many adults as possible should pay it. Lord Macpherson of Earl's Court stated: “Since old people are likely to be the main beneficiaries of increased spending on the NHS ... there is a strong case in fairness for bringing the NICs base more into line with income tax. However, this would have major distributional implications, and the revealed preference of successive governments has been to tread carefully when it comes to the integration of income tax and NICs.”³¹²

How a hypothecated tax for the NHS might work

We received evidence on how “full” hypothecation might work for the NHS. Lord Layard suggested that National Insurance could be turned into “National Health Insurance (NHI).” He explained the process for how this might be implemented:

- (1) “Decide the share of Gross National Product to be spent on health on average over the parliament and thus compute its forecast value in [monetary terms].
- (2) Phase the expenditure over the Parliament.
- (3) Fix the NHI tax rate for the Parliament to raise the (expected) total over the Parliament.
- (4) If in a year Tax exceeds Expenditure, put it in a stabilisation fund; if Expenditure exceeds Tax, finance it from this fund (if possible), otherwise by borrowing. At the end of the parliament, close the fund and transfer the debt to the consolidated National Debt.”³¹³

³¹² *Ibid.*

³¹³ Written evidence from Lord Layard ([NHS0178](#))

APPENDIX 5: NOTE BY THE SPECIALIST ADVISER, EMMA NORRIS: AN AUDIT OF INDEPENDENT AND SEMI-INDEPENDENT PUBLIC BODIES AND IMPLICATIONS FOR A NEW HEALTH AND SOCIAL CARE BODY

The audit

During the course of the inquiry, the Committee heard the suggestion that a body should be established to guarantee cross-party agreement for long-term health policy and planning. Some witnesses suggested that this may be achieved through an independent body charged with (1) setting the strategic direction of health spending, workforce planning and models of delivery and/or (2) acting as a custodian of accurate data relating to health and social care.

To assist the Committee consider this suggestion in greater detail, I have produced a general audit of the different models on which an independent or semi-independent body established to guarantee the long-term sustainability of the NHS and social care might operate and the different roles such a body might play. I have done this by selecting public bodies from a range of areas—from policing, to social mobility, to infrastructure—and applying to them a series of questions about their purpose, functions, outputs, composition and impact. In doing so I have drawn extensively on work completed within the Institute for Government by Joshua Harris, Jill Rutter and Euan McCarthy. I am most grateful for their efforts.

In total, I surveyed 16 bodies and categorised them according to the following typology, which indicates their primary role:

Body	Abbreviation used in note	Primary role
Audit Commission	AC	Auditor, advisor
Committee on Climate Change	CCC	Analytical advisor, monitor
Education Funding Agency	EFA	Funding distributor, monitor
Higher Education Funding Council for England	HEFCE	Funding distributor, regulator
Independent Commission for Aid Impact	ICAI	Monitor
Low Pay Commission	LPC	Analytical advisor
Migration Advisory Committee	MAC	Analytical advisor
National Audit Office	NAO	Auditor, improvement agency
National Infrastructure Commission	NIC	Analytical advisor, improvement agency
National Police Improvement Agency	NPIA	Technical adviser, improvement agency
National Institute for Health and Care Excellence	NICE	Advisor, regulator

Office for Budget Responsibility	OBR	Analytical forecaster monitor
Ofcom	Ofcom	Regulator
Review Body on Doctors' and Dentists' Remuneration	DDRB	Analytical advisor
Social Mobility Commission	SMC	Analytical advisor, advocate
UK Statistics Authority (including Office for National Statistics)	UKSA ONS	Data producer, regulator

I looked across these sixteen bodies and drew out and analysed common features, before concluding with the implications and questions that arise for a consideration of any potential independent body looking at health and social care. The full audit of each body can be viewed on the Committee's website at www.parliament.uk/nhs-sustainability

Role, purpose and powers

Most independent bodies I considered had a clearly articulated and widely understood scope and purpose. This enabled them to focus, made it clearer what value the body offered, and prevented creeping scope—the lack of this is an existential risk. This proved true in the case of the Audit Commission which was abolished by the Coalition Government in 2015 (announced 2010), in large part at least due to it being seen to have “lost its way” as the then Secretary of State for Communities and Local Government, Eric Pickles, said.³¹⁴ Advisory bodies are typically set up to answer a single or narrow set of questions on which independent expert advice is needed to depoliticise the decision, or resolve conflict.

As the typology above indicates, most bodies I looked at perform an analytical and/or advisory function, some with additional responsibilities as an improvement agency—that is, to support improvements rather than just advise on or monitor them—a regulator or auditor. Of relevance to a potential health body is the monitoring role of bodies which exist to track the implementation of Government performance against a certain standard, such as the CCC with climate commitments and the OBR which assesses whether the Government is on track to meet its fiscal rules.

Irrespective of statutory status (discussed below), all bodies have a written purpose and remit, such as a Framework Agreement, Memorandum of Understanding, or annual remit letter from a minister. Several, like the ICAI, often still have some form of written framework agreement with their sponsoring department.³¹⁵ Those which undertake regular reports will often be guided by a remit letter from their sponsor setting out the terms under which they should work. For example, the

314 N. Timmins and T. Gash, Institute for Government, *Dying to Improve: The Demise of the Audit Commission and Other Improvement Agencies* (March 2014): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Dying%20to%20Improve%20-%20web.pdf> [accessed 28 March 2017] and BBC News Online, ‘Eric Pickles announces plans to scrap Audit Commission’: <http://www.bbc.co.uk/news/uk-politics-10970008> [accessed 28 March 2017]

315 ICAI, *Framework Agreement*: <http://icai.independent.gov.uk/wp-content/uploads/ICAI-DFID-Framework-Agreement.pdf> [accessed 28 March 2017]

NIC receives one from the Chancellor of the Exchequer³¹⁶ and the DDRB receives one from the Department of Health³¹⁷ as well as from the Chief Secretary to the Treasury setting out Government policy on public sector pay.³¹⁸

The political context is important, and related to the organisation's role and purpose as far as there is consensus agreement on the purpose of the body. This reduces the frictional cost of bodies operating—for example, avoiding diverting attention to combating hostile press attacks or having its independence and impartiality undermined or questioned. But it also provides greater surety of longevity in case there is a change of minister or Government. The NIC, for example, was set up by a Conservative Government but had also been a Labour party manifesto promise following their own independent review of UK infrastructure by Sir John Armitt, who is now Deputy Chair of the NIC, which they commissioned while in opposition.³¹⁹ The difficulty of taking decisions about major infrastructure projects in Government—notably airport capacity and HS2—convinced many of the need of an independent, objective assessment of what infrastructure the UK requires, and what could be done within a set fiscal envelope. The previous Labour Government's Infrastructure Planning Commission was established in October 2009³²⁰ with some of the same functions, but also a remit on planning decisions but never enjoyed cross-party support and was finally abolished by the Coalition Government in 2012³²¹ with its planning functions transferred to the Planning Inspectorate.

Though typically separated from executive functions, some independent bodies take on functions which otherwise would be performed by a department. For example, the OBR took over Treasury responsibility for published fiscal forecasts, and the EFA, while remaining part of the Department for Education and responsible to ministers, has taken over functions previously located in the core department. Few have direct executive powers: NICE's control over drugs and medical technology in the NHS is a rare example.

No independent body I considered had direct control over levels of public spending. It is quite common for Government to use arm's length bodies to distribute funding (as the EFA and HEFCE do in my sample) but none determine the quantum. Some can make recommendations which have implications for Government spending—for example the LPC and the DDRB. But in both cases final decisions rest with Government, not the body, and Government evidence to the DDRB, and other pay review bodies, focuses on affordability.

316 HM Treasury and National Infrastructure Commission, *Remit Letter to the NIC* (23 November 2016) :<https://www.gov.uk/government/publications/remit-letter-to-the-national-infrastructure-commission> [accessed 28 March 2017]

317 Department of Health, DDRB & Office of Manpower Economics, *DDRB remit letter from the Department of Health: 2017 to 2018* (31 August 2016), <https://www.gov.uk/government/publications/ddrb-remit-letter-from-the-department-of-health-2017-to-2018> [accessed 28 March 2017]

318 HM Treasury, *Letter from the Chief Secretary to the Treasury to Pay Review Body chairs* (25 August 2015): <https://www.gov.uk/government/publications/letter-from-chief-secretary-to-the-treasury-to-pay-review-body-chairs> [accessed 28 March 2017]

319 The Labour Party, *The Armitt Review: An independent review of long term infrastructure planning commissioned for Labour's policy review* (September 2013): http://www.policyforum.labour.org.uk/uploads/editor/files/The_Armitt_Review_Final_Report.pdf [accessed 28 March 2017]

320 Infrastructure Planning Commission, *National Infrastructure: A planning system fit for the 21st century; Infrastructure Planning Commission end of period report October 2009–March 2010* (26 July 2010): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/247711/0165.pdf [accessed 28 March 2017]

321 Infrastructure Planning Commission, *Infrastructure Planning Commission* (26 July 2010): <https://www.gov.uk/government/organisations/infrastructure-planning-commission> [accessed 28 March 2017]

Where they do not replace departmental functions, but add additional capability, bodies need to have a clear landing point for recommendations. For bodies with an advisory role, this can be direct to ministers (though reports are often, for transparency, also published), parliament (as set out below) or to professionals for whom the advice is intended (such as the NPIA for police). Most bodies can produce additional analysis when requested by ministers, such as the CCC and DDRB.³²²

Parliament is the landing point for several of the bodies I considered, and a parliamentary process of scrutiny offers additional protection against reports being controlled or ‘buried’ by ministers. The NAO provides the analysis and evidence to support the House of Commons Public Accounts Committee, a powerful partnership. Similar to this model, the ICAI has been designed to service a dedicated sub-committee of the House of Commons International Development Select Committee, requiring the Department for International Development to submit its response to ICAI reports to parliament and giving ICAI parliamentary backing to its follow up on how recommendations are implemented. Andrew Mitchell, who as Secretary of State for International Development established the ICAI, later said of it, “Ministers can just sweep inconvenient truths under the carpet. But we set up this Commission to report not to ministers but to the legislature”.³²³ Many of the other bodies are required to lay their reports before parliament which ensures a minimum of transparency.

A small number of bodies I considered have additional mandates to play a more active advocate role within Government or a delivery system. This can be technical, advocating best practice: the Audit Commission recommended best practice at a local level, based on its research, and the NPIA was specifically set up as an improvement agency to support police forces. Or it can be about advocating a cause: the SMC has a mandate to promote social mobility among employers, professions, universities, and schools. However, this advocacy role can lead bodies into more direct conflict with Government and, as was the case for instance with the Sustainable Development Commission (2000–2011), lead to their abolition if ministers no longer see the value in funding an arm’s length critic.³²⁴

Several bodies I considered have an explicit stakeholder engagement role. Sometimes this is simply necessary for the body to perform its role: the EFA and HEFCE must work with the institutions they fund, the NPIA with police, the AC and NAO with the bodies it audited and their service users, and Ofcom with the broadcasters it regulates.

Others exist to independently engage representative stakeholders to build consensus around a decision which otherwise could be politically difficult or controversial. For example, the LPC exists to build consensus around the minimum wage rate and therefore is comprised of employer and employee representatives as well as independents. The DDRB, like other pay review bodies, is intended to resolve conflict between Government and public sector workers by independently setting pay levels, considering the need to motivate and recruit staff as well as the

322 DDRB and Office of Manpower Economics, *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week* (16 July 2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445742/50576_DDRB_report_2015_WEB_book.pdf [accessed 28 March 2017]

323 Institute for Government, ‘Ministers reflect: Andrew Mitchell’: <https://www.instituteforgovernment.org.uk/ministers-reflect/person/andrew-mitchell/> [accessed 28 March 2017]

324 BBC News, ‘UK government axes its sustainability watchdog’: <http://www.bbc.co.uk/news/science-environment-10725394> [accessed 28 March 2017]

department's budget. It is comprised of independent members, albeit many with former health sector (though not clinical) experience, but takes evidence from bodies including the department.

Less typical is an explicit role in direct public engagement—rather than through stakeholder and representative groups—or wider consultation on behalf of Government. NICE does have a 'Citizen's Council' panel of public members to ensure it considers views of the public on a regular basis, as part of a wider programme of public engagement.³²⁵ Most others carry out *ad hoc* consultations or calls for evidence as required, for example recently by the NIC³²⁶ but these are usually targeted at specific groups or interested parties than the general public. HEFCE run the National Student Survey, which is an annual exercise in seeking user views. It is arguable that an independent body carrying out a consultation is more credible than one done by the department—and there are effective tools available to do so—but there is limited evidence of bodies successfully building up meaningful public engagement on an ongoing basis.

Form and status

Form does not determine the success or independence of an organisation but can provide insulation from interference. The Institute for Government has argued that there is a clear case for form following function and that the key determinant of this should be the degree of freedom the body needs from ministerial control to perform its functions effectively. The Institute proposed that the existing classification of arm's length bodies should be overhauled and a new category of "public interest body" should be created for watchdog and regulatory bodies whose credibility depended on their independence from ministers.³²⁷ The Government launched its own review of classifications in 2015 and produced guidance which stresses the organisation form for new bodies should be determined *inter alia* by their need for independence from ministers.³²⁸ The bodies I considered range from executive agencies, which are constituent parts of departments (EFA, NIC) through mostly advisory non-departmental public bodies (NDPBs) to, at the most independent and secure status end of the spectrum, a public corporation (Audit Commission) and parliamentary body (NAO).

Classification matters because institutional arrangement determines how ministers can change the organisation. Some, but not all of the bodies I looked at are grounded in statute. Executive agencies and many advisory NDPBs exist at ministerial discretion, with their staff remaining civil servants; other bodies are usually (but not always) established in statute. Putting bodies on a statutory basis means ministers must pass primary legislation to abolish or substantially change a body.³²⁹ In the absence of a formal institutional separation bodies depend on ministerial forbearance for their actual independence. The recent announcement that the NIC would be made an executive agency of the Treasury—i.e. remaining

325 NICE, 'Get involved': <https://www.nice.org.uk/get-involved> [accessed 28 March 2017]

326 NIC, *National Infrastructure Assessment Call for Evidence* (27 October 2016): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/563516/NIA_call_for_evidence_October_2017.pdf [accessed 28 March 2017]

327 Tom Gash *et al.*, Institute for Government, *Read Before Burning* (July 2010): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Read%20before%20burning.pdf> [accessed 28 March 2017]

328 Cabinet Office, *Public Bodies Handbook – Part 1: Classification of Public Bodies, Guidance for Departments*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/519571/Classification-of-Public-Bodies-Guidance-for-Departments.pdf [accessed 28 March 2017]

329 An attempt in the 2010 Public Bodies Reform Bill to provide for ministers to abolish bodies named in a schedule by secondary legislation proved highly contentious and ministers had to withdraw the proposed provision; for instance see HL Deb, 23 November 2010, [cols 1010–1046](#)

a constituent part of it, responsible to and controlled by ministers—raised questions about how long its actual independence will last.³³⁰ Executive Agencies can be absorbed on ministerial whim because there is no constitutional separation between them and their parent department. This has happened with operational delivery agencies, as when the UK Border Agency was reabsorbed back into the Home Office with no warning in 2013. However, even strong statutory protections do not mean bodies can avoid political risk altogether. Being based in statute did not prevent the abolition of the Audit Commission or NPIA, and the Social Mobility Commission lost its original remit for monitoring child poverty.

Statutory status can also prevent organisations from mission creep by constraining its role. For example, in the run up to the 2015 general election there was pressure for the OBR to cost election manifestos, which its Chairman, Robert Chote, explained to parliament was a potentially very complex change to make to its role, and while he supported it in principle, required serious consideration before implementing.³³¹ Since the OBR could not fulfil this role without a change to legislation, this meant the OBR could resist the pressure until and unless parliament deemed otherwise.

Independence

First, the popularity and support for certain independent bodies—especially the OBR currently—and general acceptance of others—like the NAO—suggests they continue to play a useful role for ministers. Indeed, several of the more significant bodies I considered including the OBR, NIC and ICAI were set up by a Government otherwise committed to a ‘bonfire of the quangos’. Of the ICAI, Andrew Mitchell, the then Secretary of State, said later of it, “the ICAI could be very testing and very difficult, but they did a good job, a very important job”.³³² At the most recent Autumn Statement, the Chancellor of the Exchequer, Philip Hammond, remarked that due to the OBR’s forecasts, “gone are the days when the Chancellor could mark his own homework”.³³³ Of course, this does not apply universally to independent bodies and some have fallen out of favour, as the abolition of the Audit Commission and NPIA demonstrates.³³⁴ In his recent book, Ed Balls describes the benefits to politicians of arm’s length bodies: “Following the success of Bank of England independence the idea of handing over power and control to experts and suitable bodies took hold. The Government would establish the objective, the structure and the rules for an institution, but hand over control to an arm’s length agency to make the case-by-case decisions on the basis they would be able to take a long-term, proactive approach, undeterred by short-term political pressures”.³³⁵

330 ‘Chancellor Philip Hammond slammed over misleading claims over National Infrastructure Commission ‘independence’’, *The Independent* (13 October 2016): <http://www.independent.co.uk/news/business/news/government-slammed-over-national-infrastructure-commission-independence-claims-a7359956.html> [accessed 28 March 2017]

331 OBR, *Letter to Chairman of the Treasury Select Committee* (15 January 2014): http://budgetresponsibility.org.uk/docs/dlm_uploads/TSC_pre_election_costings.pdf [accessed 28 March 2017]

332 Institute for Government, ‘Ministers reflect, Andrew Mitchell’: <http://www.instituteforgovernment.org.uk/ministers-reflect/wp-content/uploads/2015/11/Andrew-Mitchell> [accessed 28 March 2017]

333 HC Deb, 23 November 2016, [col 899](#)

334 For a full discussion of the demise of both the Audit Commission and National Police Improvement Agency, see N. Timmins and T. Gash, Institute for Government, *Dying to Improve: The Demise of the Institute for Government, Audit Commission and Other Improvement Agencies* (March 2014): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Dying%20to%20Improve%20-%20web.pdf> [accessed 28 March 2017]

335 Ed Balls, *Speaking Out: lessons in Life and politics* (London: Hutchinson, 2016), pp 150–151

Small advisory bodies are used to try and take heat out of political arguments or defer decisions: recently this has included the Secretary of State for Health asking the DDRB to review suggested contract changes for doctors³³⁶, and the MAC being commissioned to review Tier 2 visas.³³⁷

Second, bodies differed over the level of autonomy they exercised over their workplan, and whether they have their own power to act, or whether they can only do so at ministerial behest.

- (a) Where their purpose is advisory, it makes sense for this to be on demand, as with the MAC, to avoid producing advice which is not needed. Even where bodies determine their own workload, it is prudent to work on areas which are of relevance and value. However, where bodies have more of a monitoring function it is important that they have significant freedom to determine their own investigations. This is of course crucial for audit bodies like the NAO, and when others are acting in an inspection or regulatory capacity like Ofcom, HEFCE, EFA and the UKSA. But is also important for bodies like the ICAI to be able to have a workplan determined independently of ministers, in that case when it is agreed with the House of Commons International Development Committee.
- (b) Other bodies have a regular rhythm of operation which means their freedom to act is not questioned because they do not need a mandate for each piece of work. For example the OBR is required to produce forecasts and analysis for fiscal events, and annually such as on compliance with the welfare cap. The LPC and DDRB produce annual outputs. The CCC produces annual progress reports to parliament on “meeting carbon budgets”.
- (c) Where bodies act on the basis of ministerial instruction, these are best written and published to ensure transparency and accountability. Many of the bodies work within parameters set by ministers, which are then published: the Charter for Budget Responsibility sets out the Government’s approach to fiscal policy for the OBR for example. The DDRB and NIC both receive remit letters from ministers for each report.

Third, an independent body requires secure funding to avoid ministers neutering it through unscrutinised cuts to its funding—or by withholding resources required to undertake investigations. The NAO, which has its budget direct from parliament, has the most secure funding. But at least bodies with non-ministerial department status have a separately identifiable budget line so that any punitive cuts to its funding following a spat with the minister can be seen. When the Treasury opted to keep the OBR as part of the department (albeit as a body corporate established in statute), it agreed to give it a separate budget line in Treasury accounts for this reason. Those which do not have these protections risk having pressure applied to their funding—or simply having their resource cut along with the department as a savings measure, which may inhibit the ability of the body to perform its function

336 DDRB and Office of Manpower Economics, *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week* (16 July 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445742/50576_DDRB_report_2015_WEB_book.pdf [accessed 28 March 2017]

337 Migration Advisory Committee, *Review of Tier 2 report: balancing migrant selectivity, investment in skills and impacts on UK productivity and competitiveness* (19 January 2016): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493039/Tier_2_Report_Review_Version_for_Publishing_FINAL.pdf [accessed 28 March 2017]

as effectively as it would like. Bodies have also been subjected to the wider Cabinet Office controls on spending which can affect their ability to hire consultants. This has been a source of tension between public bodies, departments and the Cabinet Office.³³⁸

Fourth, leaders of independent bodies need to feel sufficiently secure in their post to resist political pressure—and they need to be credible candidates rather than ministerial ‘placemen’. Thus a number of the bodies I considered had legislative safeguards against leaders being ditched unilaterally by ministers, or to prevent inappropriate appointments.

- (a) Parliament has a role in some appointments.³³⁹ The NAO has the strongest protection against the removal of the Comptroller and Auditor General, who as an Officer of the House of Commons can only be appointed or removed by parliament, and the address to appoint can only be moved by the Prime Minister with the agreement of the chair of the House of Commons Public Accounts Committee, which is always an Opposition MP. Other than for parliamentary bodies, the greatest power lies with the House of Commons Treasury Select Committee which both has to approve the appointment of the chair of the OBR and veto their dismissal. In other cases parliament’s role is limited to holding a confirmation hearing. Parliamentary arrangements can have teeth: the Government’s original preferred candidate for Chair of the UK Statistics Authority, Dame Janet Finch, withdrew her candidacy in 2011 after a pre-appointment hearing with the House of Commons Public Administration Select Committee revealed differences in how independence from Government was understood, and it seemed possible that the Committee would not confirm her appointment though a report was not published.³⁴⁰ For the ICAI, ministers decided the final appointment (and indeed, there was controversy that they were given an unranked choice of candidates),³⁴¹ but the House of Commons International Development Committee was represented on the appointment panel.
- (b) UK-wide bodies also have a responsibility to reflect devolved arrangements, and this includes for some either reporting or leadership appointment responsibilities. So the Social Mobility Commission for example includes at least one commissioner each from Northern Ireland, Scotland and Wales. While no safeguard against political interference *per se*, this is another informal block against a body becoming dominated by the Government at Westminster. In such cases the devolved administrations will usually need to agree to chair appointments.

338 Jill Rutter *et al.*, Institute for Government in partnership with the Public Chairs Forum, *It Takes Two* (March 2012): https://www.instituteforgovernment.org.uk/sites/default/files/publications/it_takes_two_final_0.pdf [accessed 28 March 2017]

339 For a fuller discussion of the potential role for parliament in public appointments see A. Paun and D. Atkinson, Institute for Government, *Balancing Act: the right role for parliament in public appointments* (March 2011): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Balancing%20Act.pdf> [accessed 28 March 2017]

340 Public Administration Select Committee, *Appointment of the Chair of the UK Statistics Authority* (Sixteenth Report, Session 2010–12, HC 910–1)

341 ‘Dr Alison Evans to head Britain’s independent aid watchdog’, *The Independent* (11 December 2014): <https://www.theguardian.com/global-development/2014/dec/11/dr-alison-evans-icai-head-britain-independent-commission-aid-impact-watchdog> [accessed 28 March 2017]

Finally, while independence is important, effective governance is vital for ensuring the body itself acts properly, and maintains focus on its core role. Independent organisations can be the greatest danger to their own independence by acting improperly, and appearing to be unaccountable. The Audit Commission in hindsight had overreached itself while alienating those who would have supported it, reversing a previous record of good engagement with local councils and minister.³⁴² While independence is aided by leaders feeling secure enough in their positions to defy ministers when required, it is important that there are mechanisms for replacing leadership when needed—which is why the Comptroller and Auditor General is now subject to a ten year non-renewable term limit, a change introduced after the previous post-holder, who had been in post for nearly thirty years.

What bodies need to operate

My analysis suggests that as well as the form and safeguards needed to ensure independence, bodies require the following to operate effectively:

- (a) A right of access to information is vital for bodies to do their job. Some of the bodies considered do gather information from those they monitor or regulate which can be used for broader interpretive analysis, as with HEFCE and EFA for sectoral insight, or the NPIA drawing on police data. But a right of access is crucial for those who do not gather the information they require themselves. The DDRB is dependent on bodies submitting evidence to it, such as the BMA and Department for Health. Some have this right in law: for example, the OBR has a statutory right to all Government information required to fulfil its duties.
- (b) The right staff is required for the body to do its job. In most cases this consists of a secretariat plus analytical capacity—the latter needs to be of sufficient calibre and capacity to produce robust material. This can be in-house—as it is with the UKSA which has the ONS as its executive office, and the OBR—or contracted, as with the ICAI. Other models include the DDRB which, alongside the other pay review bodies, is serviced by analysts in the Office for Manpower Economics, and hybrid models which combine their own analytical capacity with contracting specific pieces of analysis, which the LPC does. Indeed, the LPC began with very cautious wage increases in the late 1990s because it discovered the evidence around labour market effects was limited: its commissioning of research since has hugely strengthened this evidence base. Some of these bodies which take on additional functions become very large, especially those with delivery, regulatory and inspection functions like the EFA, HEFCE and the Audit Commission. But those with a tightly defined remit have small dedicated resource: the LPC has nine commissioners and a secretariat of eight, and spent £244,000 on commissioned research in 2015. The point is not the size, but the appropriateness of resource to fulfil its role effectively—and for this resource to be guaranteed.
- (c) Effective leadership is essential, especially chairs for larger bodies to establish them as independent entities, especially in the media, as has happened with the OBR in recent years. This does not always entail appointing ‘big beasts’—the credibility of the LPC depends on effective consensus among the commissioners—so experience of effective chairing rather than representation is the key skill required.

342 Nicholas Timmins and Tom Gash, Institute for Government, *Dying to Improve: The Demise of the Audit Commission and Other Improvement Agencies* (March 2014): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Dying%20to%20Improve%20-%20web.pdf> [accessed 28 March 2017]

Implications for a new, independent health and social care body

Establishing a new body on health and social care has been the subject of much discussion recently, including in written and oral evidence given to the Committee by figures including Jennifer Dixon from the Health Foundation and Robert Chote from the OBR. Spokespeople from the Labour, Liberal Democrat and Scottish National parties supported some form of independent body to give periodic reports on health and social care funding.³⁴³ The Labour party recently reiterated its support for such a body to report on the level of funding required by the NHS.³⁴⁴ Think tanks including The King's Fund and Health Foundation have also suggested a case for an independent body to advise on health and social care resourcing.³⁴⁵ Think tanks have also mooted other possible roles for an independent body, such as the SMF suggestion of an OBR-style Office for Patient Outcomes to increase accountability for patient outcomes.³⁴⁶

The remit of any new body would need to be carefully considered and clearly agreed. As my analysis indicates, clarity on scope and purpose is critical to a body's potential effectiveness. For a new health body, choices would likely need to include what functions it will perform, for example analytical, advisory, monitoring—or indeed if it would exercise any executive or decision-making function, which is rare for independent bodies. The remit would need to be clearly and widely understood, and would need to fit within the wider landscape of existing health bodies—potentially therefore entailing further changes in the system.

A new body set up to provide an independent and impartial overview of Government policy relating to health and social care is unlikely to be able to adopt wholesale an existing model, such as the OBR, which is most often cited as an example of an effective, influential body some would like emulated in the health and social care sector. However, from considering comparable independent bodies which perform a range of functions, there are key implications for the composition and reporting arrangements of any new independent health body.

First, in terms of the composition of a new body, the key decisions relate to the resource it requires to fulfil its role, and its leadership.

Resource

Bodies I looked at either add new or expert insight (e.g. NICE) or are intended to bring together stakeholders and data to establish consensus positions on controversial issues like the minimum wage level or doctor's pay rates. Would a new body be intended primarily to conduct expert analysis currently missing, or solve a problem of current unresolvable politics or misaligned incentives?

If a body is to undertake its own analysis to inform health and social care decision making, it would need a sufficiently well-resourced analytical capacity—and/or a research budget to commission additional work—in order to do this. The OBR has a budget of £2.6m and staff of 27 civil servants, which is slightly less than the Committee on Climate Change which is a similarly analytically-heavy body but with a relatively narrow remit.

343 [Q 296](#) (Jon Ashworth MP, Norman Lamb MP, Dr Philippa Whitford MP)

344 'Labour calls for OBR-style watchdog to assess NHS finances', *The Guardian* (27 December 2016): <https://www.theguardian.com/politics/2016/dec/27/labour-calls-for-obr-style-watchdog-to-assess-nhs-finances> [accessed 28 March 2017]

345 *Ibid.*

346 Social Market Foundation, *E. Mian, An Office for Patient Outcomes* (April 2016): <http://www.smf.co.uk/wp-content/uploads/2016/04/Social-Market-Foundation-An-Office-for-Patient-Outcomes-Embargoed-0001-050416.pdf> [accessed 28 March 2017]

Leadership

A new body would require effective leadership, of at least a Chair and likely a number of Commissioners too (the comparators started at a minimum of two additional Commissioners) with requisite expertise and credibility to establish the body, build strong relationships with powerful stakeholders—including NHS England, and the Department for Health—and ensure its independence.

Permanence

Is the problem the body is set up to resolve a temporary or permanent one? One option would be to set up a temporary commission—similar to previous attempts to establish consensus on the way forward, such as the Wanless Review—to devise, set out and agree a course of action on health and social care, but then to establish a small, focused independent body to monitor its delivery—for example, of spending against a level of GDP—and act akin to those bodies I looked at which have advisory and monitoring functions, such as the CCC.

Second, my analysis suggested there would be four key decisions to take on reporting arrangements:

Frequency

Most bodies I looked at with a regular reporting rhythm did so annually, such as the LPC and SMC. This includes financial bodies like the EFA and HEFCE.

Initiation

Independent bodies with a similar remit to that which has been proposed for a new body on health and social care usually report on a regular basis, typically annually or alongside an existing timetable, as the OBR does with fiscal events. This should be set out clearly when the body is established. Beyond that, it should also be determined whether ministers, NHS England, or indeed anyone else should be able to request or commission additional analytical work and, if so, under what circumstances. There are good reasons for allowing this, particularly in an area where independent, evidence-based analysis is required. But the process for it should be clear.

If the body is to be given a role which includes a monitoring or inspection function, it should not only be clear that it can initiate this work itself but that the power of ministers to circumscribe it—for example, by denying necessary information—are limited.

Time horizon

If the body is to contribute analysis to, or even have a more direct role in determining future funding of health and social care, there is a choice about how long-term it should report on, for example, whether it should report on future demand.

Purpose

Advisory bodies typically report to ministers, but publish and/or lay before parliament their final reports, including the MAC and NIC. However, others have been deliberately structured to feed into parliamentary scrutiny, most recently the ICAI. This is perhaps most appropriate when, like the ICAI, a body is itself evaluating Government performance and making recommendations. If a body exists to provide independent analysis, then a reporting line more like the MAC, LPC and so on may be more appropriate.

In any case, it should be clear what is expected to happen because of a body's reports: to inform ministerial decisions, to determine a course of action, to report against a target or standard to enable parliamentary and/or public accountability, and so on.

Emma Norris, Specialist Adviser

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APPENDIX 6: LIST OF ACRONYMS

A&E	Accident and Emergency
ADASS	The Association of Directors of Adult Social Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
GDP	Gross Domestic Product
GP	General Practitioner
HEE	Health Education England
LTCI	Long-term care insurance
NAO	National Audit Office
NHS	National Health Service
NIC	National Infrastructure Commission
NICs	National Insurance Contributions
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
OBR	Office for Budget Responsibility
ONS	Office for National Statistics
PAC	House of Commons Public Accounts Committee
RCN	Royal College of Nursing
RCP	Royal College of Physicians
STP	Sustainability and Transformation Plan