

The People's Inquiry: One Year On

Evidence presented by Seán Boyle (SB) and Roger Steer (RS)

Thursday 11 December

Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT).

RL: What we are interested in doing is exploring life after our original inquiry and the conclusions that were made and the extent to which things have changed. We're required to make recommendations. This is the first session. We're in your hands for the first 10-15 minutes then perhaps you'll give us the opportunity to contribute.

SB:

Among other things, we specialise in advising local authorities on NHS plans and we have a lot of experience around London between us. In the last 12 months we have been working in South-West London advising councils and just now Roger is engaged to work with four London councils in the west of London, looking again at the changes to services there. We're going to do this as a double-hander, and hopefully we'll get through fairly quickly.

Last year we highlighted five areas where the arguments put forward by the NHS in London were inadequate or non-existent. Those were around finance, PFI, clinical arguments around quality, the process for making changes happen and access issues for the public. We made a series of recommendations to the Inquiry and we have distributed a copy of this again for ease of access (Appendix 1).

In our view little has happened to change our conclusions in that time. If anything there has been a move in our direction both in the assessment of evidence and in the policies that emanate from that evidence. We feel this has been duplicated from research that is just coming out. At a policy level there is even more doubt being cast on the evidence base justifying reconfigurations and transformations and integration as the rescue planks for the NHS.

PFI is now universally regarded as a financial disaster, but we have yet to see any alternatives or relief emerging. There have been changes for PFI, Roger may be able to talk about this. We're not going to go into our arguments all over again, but we will just mention brief points to you then throw it open for questions and discussion. So I'll hand over to Roger.

RS:

Firstly on the arguments surrounding reconfiguration. We were sceptical last year about the arguments being put forward by the NHS for reconfiguration – for out of hospital services substituting for hospital care, and for integration as a means of reducing demand for acute care.

During the course of the last year, there has been a trickle of further evidence from a number of bodies (academic think tanks, policy organisations) that reach similar conclusions.

There have been three studies published in November, very recent studies, all of them saying pretty much the same thing. I will read you extracts from those.

The first was the Commission for Hospital Care for Frail Older People, which was featured in the *Health Service Journal*. They concluded:

‘There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true.

‘The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong.’

Then, Candace Imison published her report from the King’s Fund, called *The Reconfiguration of the Clinical Services: What is the Evidence?*:

‘There have been very few studies to assess the impact of centralising A&E services. The limited evidence available suggests that if services are centralised, there are risks to the quality of care where the centralised service does not have the necessary A&E capacity and acute medical support for the additional workload. A proportion of A&E attenders can safely be seen in community settings, but there is little evidence that developing these services in addition to A&E will reduce demand’.

She concluded:

‘The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change.’

In particular she found that evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking; and evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.

Another study, this time from the Nuffield Trust, *The Effect of the British Red Cross ‘Support at Home Service’ on Hospital Utilisation*, was designed to show that better integration of social care and hospital care would reduce demand for acute care. It concluded:

‘Our research did not detect lower use of hospitals for the British Red Cross group compared with a matched control group over the longer term. In fact, the evidence suggested that emergency admissions may have been slightly higher in the British Red Cross group.

‘The results reinforce the challenges around reducing rates of emergency hospital admission. This is a common concern across health services, and one that has proved difficult to convincingly address. In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision of this type to thorough evaluation.’

Apologies for reading that out. I couldn’t put it more succinctly than that. So we’ve got a series of authoritative statements undermining the case for reconfiguration.

So why the rush for reconfiguration? The problem is always said to be unsustainable finances. But is it? The first question we always ask is, what is the problem we are talking about?

It makes a big difference to the action you take if a commissioner is spending more or less than you expect; if a provider is costing too much or less than expected; if GPs are referring too many patients or not providing the appropriate treatment; or if there is too much care provided to people in one area and not enough in others. In other words, there isn't a general problem but there will be a specific problem.

It is not good enough for NHS managers to say that overall we are overspending and so we just need to cut back. Nor is it good enough to get a blank look when we pose the question of what is the precise nature of your problem and where is your analysis, which we often face.

When we review a reconfiguration proposal we find that the problem being addressed is often poorly defined and often mis-stated, in other words they say one thing and tend to mean something else.

At the macro level, comparative information published this year makes it clear that the UK and England and Wales in particular did not reach the target that had been set of achieving the average spend on healthcare of our European neighbours. Matched against those countries the UK spends about 2% of GDP less than (that's approx £30bn a year) less than our neighbours, and the gap is even more in comparison to the US. It is not true therefore that spending extra on healthcare is unaffordable. It is a matter of electoral choice, or it should be.

But still we hear about the £20bn, the £30bn or the £50bn gap. Where do these figures come from? It's purely an extrapolation of the 4% gap between supply and demand that accumulates year on year, and if supply can't keep up, something has to give. The reality is of course that the NHS has lived within its budget and amazingly has even under-spent – and even this year will be able to contribute £750m to the Chancellor.

PT:

Did you say the NHS was returning £750m?

RS:

It's within the £2bn that was put forward.

RL:

To be clear, the £2bn is composed of a number of contributions and part of it is the £750m back from Richmond House, and one wonders really if it's within the departmental expenditure, why is it there?

RS:

We will come onto that!

The financial case is put forward for reconfiguration as the cure all – but is it? It seems plausible that if you close hospitals you save a lot of money. But it doesn't actually work out that way.

Reconfigurations are extremely complex; they usually require significant PFI investment, hundreds of millions of pounds; it takes a long time and is very costly to do well; and mostly it doesn't seem to have been done well. So it's not a simple matter, and this is where the link to PFI comes in, and in our analysis of areas we looked at, it can be difficult to control and is now becoming an obstacle to reconfiguration.

We argued last year that PFI was the cause of many problems, and called for a fairer system of allocation of capital costs to take account of some of these excess costs of PFI.

It is now pretty standard to say that PFI has been a financial disaster – perhaps a strong word, but a burden on the NHS. It is accepted that the capital costs associated with PFI are a lot higher – and will increase over the years.

Yet still we find Monitor investing a great deal of time and money in a comprehensive review of the tariff system without taking account of the ideas that have been put forward by Keith Palmer and ourselves.

RL:

Have you done any work on the tariff?

RS:

Yes, we have done a lot of work on the tariff.

PT:

Perhaps if I ask you one question about PFI? PFI is a disaster where it is, but it's still quite a small portion of the overall NHS financial problems.

RS:

Not in East London it's not. Not in other hospitals.

PT:

But it's about 2%?

RS:

In general it can seem manageable and it is.

PT:

If you look at the financial problem of the NHS, in general it's quite a small part.

JL:

The problem is that some aren't hit by it at all, but others are hit very hard.

RL:

We can come back to this. You could subsume all PFI payments back into the tariff and that would take the pressure off?

RS:

Yes.

RL:

So you take the financial pressure off, but whether you continue to be an impediment towards more reconfigurations is another question. It probably would, because even if you disaggregated our payments across the NHS you're still left with a contractual obligation to keep a hospital open that you may want to reconfigure.

RS:

The biggest problem is that for any new request PFI costs are too high to enable a positive business case to be put forward so paradoxically the continuing existence of PFI is a major obstacle to some of the changes.

RL:

Let's leave that there because I'm sure we'll want to ask you more about that in more detail.

SB:

I'm going to talk briefly about processes in terms of reconfigurations. Last year we said that there was only lip service paid to the views of the public, and nowhere have we seen real involvement of the public or even a real attempt to involve by the NHS. It doesn't go through the process in an open and transparent way. The NHS must be made to go through that process for everyone. And that's particularly important in terms of the business case. What we is that there is still now constant pressure to hurry things along so again a recent review which came out in December just now. David Dalton's review of organisational forms.

In his report he says he wants to streamline processes, to make it easier, quicker and less costly to transact organisational change.

But the problem we said last year and I think is still a problem is that if you hurry due process then mistakes are easily made, you fail to get engagement and commitment and risks and costs tend to be underestimated.

In our view, it can't be right that you are looking at services for up to 2million people involving investments of hundreds of millions of pounds – things which are going to affect the lives of populations – and yet you want to push things through, and do not have robust business cases. The attitude seems to be 'well that service can be closed in advance of business cases being written'. You will have read things that say that isn't happening or it won't happen. We have already found this happening in North-West London and we have only been looking at it for a few days and we can see that is what is happening.

Promises are frequently made that acute services won't be cut until there is sufficient investment in out of hospital services: but these are just hollow promises. What we're seeing in North-West London, and in South-East London is changes made in capacity before any of the benefits of our hospital services have been made or there is any impact. What you see then is the kind of thing you've seen in the press in the last month: the A&E departments in North-West London that are left are unable to cope with the increase in demand that is coming to their doors.

So what we are saying is that fundamentally you must do a proper business case and that the NHS over the years has been poor at that. The arguments about quality of care and access have not really moved much in the last year. In my view the NHS continues to pick and choose the evidence on quality to support whatever case it wants to make, and often applies it erroneously.

On access, which is the key concern for most members of the public, that's just paid lip service by the NHS, but it's never given any merit in planning and business cases. You can see that from the weighting that it's given. These weights are made up by the panels of NHS apparatchiks really; they just come up with a percentage of a weight for access but it's often mostly of very low weight.

Last year I talked about the five D's in care and it's worth repeating those:

- Distance does kill.
- Delay does kill.
- Discouragement kills.
- Denial of healthcare kills.
- Disadvantage – those four are particularly true for people of disadvantaged backgrounds.

So great care has to be taken in terms of where you allocate services to.

RL:

Can you give those again?

SB:

Distance, delay, discouragement, denial and disadvantage. It's the kind of issues around inequality. All government departments have a duty to look at it, the impact on inequality in terms of all their policies.

I will just finish off on this particular thing on access to say how often do you find the public being asked the real question which should be asked, which is 'what would you give up to ensure access to these services'. So the question might be something like if you have to make a saving of £1m would you choose your local A&E service? If you don't want to close it then you have to answer well what would you cut? So that's the kind of option I think people could be given but in fact they're never given those kind of options, so I am just repeating what I said last year on that. So now it's over to Roger who will just conclude very quickly.

RS:

In conclusion, last year we recommended that you understand what the local problem is, you can't just take it on. Any assessment needs to be based on the needs of the long-term population to determine the direction. It makes no sense talking about reducing capacity in areas that are going to have a massive increase in building or increase in population. You have to construct a full business case and there should be no closures to acute services until changes to out-of-hospital care have been put in place and seem to work.

Instead of policies for reconfiguration we believe there should be incremental change determined locally through local partnerships focusing in on improvements to GP services and community care rather than to over-ambitious wide-scale reconfiguration. We also said there should be a fairer system of funding for costs of capital.

The only things that we would add to that in terms of our conclusions is that the evidence is more and more against reconfiguration. I've given you some today but there are others. The NHS seems to be continuing to ignore the evidence. They're ploughing on regardless. The real problems that London faces are that there hasn't yet been a satisfactory answer to how to cover the excess costs of PFI and how to fund the need to replace ageing hospitals.

We have been doing this work at the moment. We are sympathetic to the development of Imperial as a major academic centre. It is ridiculous that St Mary's Hospital is still functioning out of an ex-workhouse. But that is not a reason for closing Ealing Hospital. Similarly, you can argue about whether or not parts of London should have been redeveloped as it is, but that is not a good reason for denying Whipps Cross Hospital the ability to be re-built when much of that was built in 1903. The NHS hasn't got an answer to this.

I would emphasise at this point how important it is for London to develop its large academic centres. Both Seán and I have been in London healthcare issues for a long time now. In the past it was always said that the London teaching hospitals had a problem, that you had to cut back, rationalise, and redistribute resources to act on that. They suddenly discovered that actually our academic centres are the last hope for British industry, that higher technology pharmaceuticals have earned more profits in the last 10 years than the rest of the Fortune 500 companies put together – that’s in the Mazzucato report¹ which I reviewed for Roy.

PT:

Can I ask about that last point? It’s very counter-intuitive. If you look at the chaotic way it’s developed – you’re going back to the beginning of the last century – the hospitals were just wherever they were: old workhouses, whatever, for charity. It always sounded a very rational argument when people like in the South-West or whatever said ‘you know, we can configure this better. It doesn’t make sense. All hospitals must be in best of all possible places serving communities in the best possible way because they happen to be there’. You seem to be arguing for a sort of ‘well that’s not it’.

SB:

No, let’s give you the example of South-East London. I get this directly from the person who was responsible for doing it, for managing it at that time. They would not have closed Queen Mary’s Sidcup. Queen Mary’s Sidcup wasn’t a problem. The problem was QEH in Greenwich. The problem was the PFI there. But because of that PFI they were forced to keep QEH open and close Queen Mary’s Sidcup. So it wasn’t a decision made on the basis of where the flow of patients goes. And that’s what I think in terms of rationalising the PFI issues around London; it should allow you to make a decision based upon what access is needed to keep services where, rather than thinking about ‘you’ve got that in place now and we’ve got to run it’. It’s beyond me to understand why if you are planning across health funding for 2-3 million people, then why do you still have to hang on to the PFI hospital? The reason is because you can’t admit that you’ve got it so badly wrong in the first place.

RL:

Just to play the devil’s lawyer on that for a moment because I’d like to test your arguments a bit more. The reason is that the NHS is contractually obliged to keep paying for their hospital. Now there are a couple of things that we could do. We could pass a law and annul all the PFI contracts which would have a huge effect on markets and the government’s standing as a contractual partner. It would spook everybody, so that’s probably not the best thing to do. We could pay the PFI costs through the tariffs so everybody in the NHS bears the 2% - I’m not sure if we could put 2% on the tariff but we find some way to do it off the tariff. So that might be a solution but we would still be left with the prospect of closing a hospital that we continue to pay for through the PFI, through the tariff. So we are locked in an extremely awkward and unwelcome arrangement which was entered into at a time when the economy was very different. Do you see a solution that is practical and viable?

RS:

Yes, we advocated that at the last Inquiry. It is as you described. We’d equalise the capital charges as a component of the tariff, so those providers whose costs are far higher than is included in the tariff at the moment would be compensated.

¹ “The Entrepreneurial State – Debunking Public vs. Private Sector Myths”, by Mariana Mazzucato

RL: Supposing just for a moment that we rolled up the whole cost of PFI and spread it in the public dividend capital of every foundation trust? So effectively it would never get paid, but the Treasury would continue to pay, or attempt to negotiate a discounted payment as a one-time payment. So the debt stays on the books spread throughout the equity loss.

RS:

At the moment the Treasury is making billions of pounds' worth of profit from the capital charges.

RL:

Well, interest-bearing debt. There are two ways. Interest-bearing debt and public-ended capital. You spread the charge.

RS:

Capital charge is charged against the profit and loss account of all trusts. At the moment the Treasury aren't spending any of that on health.

SR:

How much money are the Treasury taking?

RS:

About £5 billion pounds.

SR:

So at the moment the Treasury is taking about £5 billion from the health budget?

RS:

Yes.

RL:

When it was set up in the 1989 Act, the idea was that capital charges were effectively a spreadsheet depreciation, sold as a reserve for the NHS. All capital items in any business or public service will depreciate. So you have to set aside enough money to replace them when they wear out.

RS:

But they have not replaced them.

RL:

The purpose was to provide a depreciation fund. But I know this phrase very well, 'capital is not a free good'. So it was a very sensible thing to do. What's happening in the passage of time is that that money's never been circulated back.

RS:

Withheld. We're talking about a £5bn reserve they've accumulated.

RL:

Can I bring this back to the PFI issue? Is there a way of rolling PFI into that? Is their money available? Or writing it off?

SB:

Why do you have to keep a hospital open just because you made a mistake? That's the thing. Why would you say we're going to keep that one open?

RL:

Seán we accept the argument. What we're trying to define is some recommendations that make some sense to get out of this. Let's say with some blue-sky thinking it would be possible to roll up the PFI debt into one lump of money and offset it effectively against the depreciation fund which the Treasury said is £5 billion and say ok we will write that off in one go against the £5 billion.

LI:

I don't understand what you mean.

RL:

Ok, you're very familiar with the PFI being a debt which sits on the NHS books and is paid off by the trust that owns the building?

LI:

Yes.

RL:

What we're saying is two things. One, would it be possible to spread those costs throughout the whole of the NHS so that it doesn't exacerbate and over-heat an already over-heated London health economy. But further, would there be a way of aggregating – rolling up – all of the PFI debt? All of the London hospitals that have PFI debts, which might come to, say, a hundred pounds and then offset that hundred pounds against the money that's with the Treasury which was effectively set aside for depreciation on the interest-bearing debt.

RS:

The solution has been looked at in the past and seen to be establishing an 'NHS bank' and there are ideas about having a public-sector infrastructure bank which would pool a lot of the liabilities and assets.

RL:

Let's not cloud the argument. Let's just look at the money that is just sitting in the Treasury which has effectively come from the NHS, off the NHS balance sheets, and is now in the Treasury. Is there a mechanism where we could take that amount of money and say ok we are owe a hundred quid for PFI debts right across Britain, pay it with the money sitting in the Treasury?

LI:

Aren't the costs of PFI hospitals something like £80 billion? It's hardly 5 or 6 billion.

RL:

Well that's the question. We could do that – if that's the answer, then fair enough.

RS:

It's annual rent.

LI:

Is this £5 or £6 billion annual?

RS:

We're confusing two '5 or 6 billions'. The overall capital charge is of that order certainly. The accumulated balances remaining from the past that hasn't been spent by the Treasury on something else has been about £5 or £80 billion?

RS:

Well no, but the £80 billion is the future liability over the next so many years.

RL:

So thinking about how it might be possible to address this, it might be possible to go to all PFI companies and say we want to do a deal to buy them out?

RS:

Yes.

RL:

In which case we would get a discount because they would get their money quicker.

RS:

No.

RL:

Well, let's say it's possible – if we keep saying no to everything we'll never say yes to anything. We simply go to the companies and say is there a way in which in return for us paying this off early you will give us a discount. We still take that money. The Treasury then could pay it off over a period. The Treasury could subsume the debt and offset it against the reserve that we've been talking about. Now that of course is then going to end up still on the national budget. There's no damage to the balance sheet.

SR:

I was just going to say what do you think of the idea that I think was promoted by Jesse Norman, Conservative MP, that we could actually change the law so that PFI debt couldn't be held by companies registered abroad – and therefore payments would be subject to UK tax. That would be one example of how to shift the incentives to actually force them to the negotiating table, whereas they wouldn't come voluntarily now, because there would be such a good deal for them. Is that a possibility?

SB:

That's a very good question whether you want to do that or not, but in terms of accounts it may or may not work. I do need to point out that there has been one PFI which has been bought out, I think in the North-West of England, by the trust itself. They negotiated a buy-out.

RL:

I think the contract has been slightly different in that allowed a buy-out. The law doesn't allow a buy-out.

JL:

That was a very untypical one because the money they borrowed was from the local authority that had several hundred million pounds to buy this out. I don't know if Roger knows off the top of his head what the annual rate of his general capital charges are, when we do know what the general rate of PFI payments are because they are just topping £2 billion a year. Now if the capital charges match the PFI payments there are possibilities. Rather than raising big lumps of money, if you just

recognise that a historical error has been made in signing these deals, a very expensive mistake. But there's no reason why anyone should use capital to pay it off in one lump when you are due the money each year. So all we need to do is find a way in which we could access £2 billion a year to clear the problem. In fact, if you look at the figures, not all the PFIs are equally disastrous. A few of them are actually probably about as cheap as you could do it anyway.

PT:

Do you know what proportion are good or bad?

LI:

I just wanted to ask, surely government is in a stronger position to re-negotiate towards something more fair? Because there's something extortionate, something extreme about those PFI re-payments. To re-negotiate to a fairer level than individual trusts could ever reach, because they are pretty powerless so is there no political pressure? Obviously there has to be political will that if enough fuss was made about how awful the impact of PFI on hospitals etc could there not be political pressure on government to re-negotiate from a position of strength as a government.

RS:

It's true that Jesse Norman was the leading MP who proposed that. I wrote to Public Finance in 2008 saying that now the banks are looking for support we should take the opportunity to re-investigate PFI.

SB:

I can remember back in '95 or '96 in a meeting about PFI, and the Chair of KPMG was there and the discussion was around what would happen if the capacity was too much and that he wanted to re-negotiate? It's clear that the contracts didn't allow you get out of it. I remember pointing that out. The chair said 'Oh no, my dear boy, we wouldn't hold them to that in that way, we keep looking to our future and more business'. So that was his answer to it so I am sure it would be within the ability of government to negotiate.

PT:

But haven't all the PFI contracts been sold on to financiers who don't give a damn? They're not held by the G4S's and Sercos who might want future contracts. Isn't it all a grey market?

SB:

There are different people holding them now, but still you could imagine that there would be room for re-negotiation.

RL:

Let's just stop for a minute and clear our minds and think again about this. Because I think what you've opened is some very interesting thinking here. So let's just think for a minute. First of all, not all PFIs are having a problem. UCLH for example down the road, is trotting along quite happily making a surplus. They have a surplus on their revenue side. Their capital is a different issue, and you know you can't turn capital into revenue without exceptional help from the Treasury. So let's not look for reasons for doing things. So we're not looking at the whole of PFI debt. We're looking at a percentage of the PFI debt that is exacerbating local issues.

I think we're forming a recommendation now. There's a core issue and if we can find some new ground here we need to get this right. So let's think about it. If we analyse PFI debt, do a risk analysis on all of the ones that are there and identify the ones that are exacerbating local problems – a choke point, over-heating local economy – then there will be a percentage of the PFI debt we would need

to deal with. That makes it easier then because then we're not talking about inflating the tariff by 2%, we might think about inflating the tariff by under 1% or less. So that might be – and we'll do a more doable thing – to spread the debt.

RS:

I'm not talking about increases. I'm talking about re-distributing. It's already there.

RL:

The next point is, we're going to look at the public dividend capital issue and the Treasury's annualised reserve that seems to disappear. It would be a lesser percentage of that to set against that amount and might be more attractive to in some way deal with the debt. Because you can't write this off, you can't write off public money. But we've got to find a way of paying for it in a more subtle way.

RS:

Yes. I call it mitigating the consequences of PFI.

RL:

Yes, very good word. So if that mitigation could be achieved by setting it against the Treasury's holding of the NHS reserves for what is in effect depreciation we never see, we need to get some advice from the Treasury for the extent to which that money is accessible and be able to turn it into cash because it's public dividend capital not public dividend revenue and so there may be an impediment there. But I think you've raised a very important point.

RS:

It's not me who's invented these ideas, it was the Chair of Barts Hospital. He's now a Non-Executive on Monitor.

PT:

I like the idea of this other thing, but if you were to do the idea of increasing the tariff and spreading it around, would some hospitals who were in crappy old buildings object to the fact that they're now paying to subsidise a beautiful new PFI building? So that would not be that popular.

RS:

No, what we're enabling is a mechanism by which those hospitals can be renewed. At the moment they face no prospect of those hospitals ever being renewed because the excess costs associated with the only route that's made available which is fund them through PFI.

JL:

You're saying that from now on you could have no more PFI and no funding at all except through government borrowing; or are you saying those other not very good old-fashioned buildings could be re-done using PFI, but because the cost would be spread that's OK then?

RS:

There are general problems with PFI and the costs of directly funding it would be less probably so long as you invest in proper risk management which is the function of the PFI process.

PT:

Could I ask just one question, because I am so struck by this. You're telling us that in every year the Treasury takes £5 billion off the NHS for dilapidations. Quite rightly – capital isn't free, and so on. But they actually use it for something else. It is not funny that dilapidated hospitals could call on them

and say 'right we'd now like some of that dilapidation money please', it's gone. It's not in the fund. It's used for general purposes. It's used for anything else they want to. So what's there excuse for taking money for dilapidations that isn't there?

RS:

I think trusts get about half given back to enable them to pay for new X-ray tubes etc.

PT:

But why only half? Why not the whole lot?

RS:

Because the need is not evenly spread. Not every hospital needs all of it.

PT:

I mean the entire sum should be sent back in some form or another to the whole of the NHS.

RS:

That's one of the sources of the £750 million extra from George Osborne.

SR:

I've got one specific question and then one asking your opinion based on your experience of working with local government. So the second one is really, what can you tell us that's encouraging at all about the role of Health and Wellbeing Boards and is there any sign of development of them seizing the strategic agenda? So that's your second question. The first one which is specific is, could you give us your best estimate of what we're currently spending on the NHS as a proportion of GDP and that will probably be taking whatever is the latest measured figure and discussing it intelligently in the light of other things that have happened because that would be a really useful figure to have, particularly if it's dropped below 9% which it may have done.

SB:

I think the figure I've got in mind is 9.6% for the total. That's NHS and private. But if you take the private out of that, the private is about 15% [of the 9.6%] so I think it comes down to about 8.5% or 8.4%.

SR:

So that doesn't include NHS spending on private?

SB:

No; 9.6% is the total spend on health as a proportion of GDP and then within that you have spent from the public purse and spent from private sources.

SR:

So it's 8.5%.

SB:

So it's down to about that. I'd have to check because I've just written something about this, that was 2013 and I was doing a comparison with other countries. All countries in the world more or less have seen a fall in the proportion of GDP spent on health care. So you have to be very careful when you think about what was going on 2 or 3 years ago. In France or Germany you will find that their proportions going down a bit. So you always have to be very careful about comparing like with like on that.

On the Health and Wellbeing Boards. I honestly can't think that they are really much use whatsoever. To be fair, they haven't a lot of time either. And to be fair, I suppose the local authorities are under extreme pressure in terms of cuts they are facing. It seems to me that there hasn't been as much energy put into that as you might have wanted, and I am sure there are places where there seems to be a lot more co-operation between the social care and health care where Health and Wellbeing Boards do have an active role. Our experience is that they are a waste of space.

RL:

We're going to have to leave it there. Thank you very much.

Appendix 1

When we presented to the Peoples Inquiry last year we made the following recommendations:

1. **Understand what the local problem is** – too often it is not understood or misunderstood.
2. **A fairer system of funding for costs of capital.** Often the problem is a recent PFI (as in NE and SE London). But it can be the prospect of one as vested interests jostle to secure the funding for their pet project. Thus the refurbishment of St Helier in SW London and Whipps Cross in NE London have been obstructed.
So what is needed is a fairer system of capital funding that supports the actual costs of new hospitals. This can be achieved without costing the NHS another penny.
3. **The projected long-term needs of populations must determine the direction of change.** Pressure for short-term savings remind us of what happened in primary schools. Schools closed, land sold off and now these need to be replaced more expensively. The NHS is being driven into cutting capacity even though we all know that additional capacity will be required in the future.
4. **Full business case** – all reconfiguration proposals should be preceded by a full business case rather than a pre-consultation business cases. This PCBS often is a tissue of half-truths and specious claims not backed up by evidence of figures. Far-reaching decisions must be based on sound fact and analysis.
5. **No closures of acute services until changes to out-of-hospital care** have been put in place and are demonstrated to be both effective and affordable in reducing accrued demand.
6. **Incremental change determined locally through partnerships** between CCG and local authorities instead of over-ambitious wide-scale reconfiguration.
7. **Support of GPs crucial** – there should be a secret ballot of GPs in every local area where reconfiguration is being considered.