



House of Commons  
Committee of Public Accounts

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# Tackling inequalities in life expectancy in areas with the worst health and deprivation

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**Third Report of Session 2010–11**

*Report, together with formal minutes, oral and  
written evidence*

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## The Committee of Public Accounts

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### Committee staff

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# Contents

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<b>Report</b>	<i>Page</i>
<b>Summary</b>	<b>3</b>
<b>Conclusions and recommendations</b>	<b>5</b>
<b>1 Weakness in the approach taken</b>	<b>7</b>
<b>2 The role of GPs</b>	<b>10</b>
<b>3 Applying the lessons to the new NHS</b>	<b>12</b>
<b>Formal Minutes</b>	<b>14</b>
<b>Witnesses</b>	<b>15</b>
<b>List of written evidence</b>	<b>15</b>
<b>List of Reports from the Committee during the current Parliament</b>	<b>16</b>



## Summary

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Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proved difficult to change. In 1997, the Government put tackling health inequalities at the heart of its health agenda and subsequently published a number of policy documents and related targets. In 2004 the Government set the Department of Health (the Department) the target of reducing the gap in life expectancy between 70 ‘spearhead’ local authorities with high deprivation and the population as a whole by 10 per cent by 2010. The Department has not met this target and has been exceptionally slow to tackle health inequalities.

Whilst it is heartening to recognise the overall improvements in health over the last decade it is of great concern that inequality in health has increased. The Department should be commended for setting out to tackle a problem that has proved historically to be so intractable. However, we find it unacceptable that it took it until 2006—nine years after it announced the importance of tackling health inequalities—to establish this as an NHS priority. Although it was known in 1997 that certain key interventions such as smoking cessation had the most impact on the health of those living in deprived areas, it took the Department until 2007 to produce evidence about how such treatments could be delivered cost-effectively.

GPs are crucial to improving the health of people in the most deprived areas. However, in many of these areas the number of GPs per head of population is well below the number in more affluent areas. The Department missed an opportunity to use the revised GP contract to ensure more doctors work in deprived areas, and has not focused its attention sufficiently on implementing the key interventions that would make a difference.

“Equity and Excellence: Liberating the NHS” sets out the Government’s long-term vision for the NHS. In the transitional period while this change is managed, it is important that tackling health inequalities does not slip down the Department’s agenda. The Department will need to set a clear framework of accountability at all levels of the health service if it is to be successful in addressing health inequalities in future.

On the basis of a Report by the Comptroller and Auditor General,<sup>1</sup> we took evidence from the Department on why it had failed to meet its health inequalities target, the role of GPs, and the lessons of this for the new NHS.

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1 C&AG’s Report, Session 2010–11, *Tackling inequalities in life expectancy in areas with the worst health and deprivation*, HC 186



## Conclusions and recommendations

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- 1. The gap in life expectancy between people in deprived areas and the general population has continued to widen.** Having set an objective to tackle a complex and intractable problem, the Department did not set about its task with sufficient urgency or focus. The Department did not deploy its own resources effectively or coherently, was too slow in making health inequalities an NHS priority, and set a performance measure that proved too blunt an instrument to target those most in need effectively. Our recommendations below are designed to help the Department make progress in tackling health inequalities within the new NHS structure it is putting in place.
- 2. The Department was too slow to develop an evidence base of cost-effective interventions.** It knew at an early stage that certain key interventions cost little but could have a major impact, but did not provide relevant tools and guidance until 2007. It also failed to put in place mechanisms to hold providers and commissioners to account over whether they apply these interventions, and even now implementation of the three most cost-effective treatments is inconsistent, with considerable variation by location. The Department and NHS Commissioning Board should identify and implement the action needed to stimulate the wider adoption of these treatments so that GPs in all areas comply with accepted good practice.
- 3. The Department has failed adequately to address GP shortages in areas of highest need.** The Department should identify, as a matter of urgency, what measures it can take to drive up the numbers of GPs in deprived areas, including using direct financial incentives to encourage GPs into areas of greatest health need. The Department should implement an action plan to deliver this objective within a defined timeframe.
- 4. Many GPs fail to focus their attention sufficiently on the more deprived people registered with their practices.** More affluent people are generally more likely to seek help from their GP, and be clearer about the services they expect to receive. The Department and the Commissioning Board should use the GP contract to link payments explicitly to GPs' success in improving the health of the neediest people in their practices and to encourage up-take of good practice preventative treatments for those with the greatest health needs.
- 5. Two thirds of primary care trusts in areas with the highest deprivation still do not receive the money due to them under the Department's funding formula.** The Department is seeking to move all areas towards the right level of funding based on an assessment of need, but significant imbalances remain. In developing the funding model for GP consortia and public health, the Department and the Commissioning Board should consider how funding shortfalls in the most deprived areas could be corrected.

6. **The NHS spends around 4 per cent of its funding on prevention, although individual commissioners' spending on prevention is not readily identifiable.** In the new NHS structure the Department's intention is that the public health budget will be ring-fenced and Directors of Public Health will be responsible for how it is spent. The Department should develop a robust process so that there is transparency and accountability for this funding and should require Directors of Public Health to benchmark the costs and effectiveness of their public health activity.
7. **Addressing health inequalities is a complex challenge requiring sustained and targeted action.** The Department's experience to date shows that greater focus and persistence will be needed to drive the right interventions. We expect the Department to provide strong leadership and to continue to monitor the outcomes of those suffering health inequalities. As there is an inevitable time lag between public health interventions and observable outcomes, the Department should monitor the implementation of those activities which, in the short term, would be strong indicators of progress.
8. **The Department is not clear why some areas are performing better than others, or of the extent of the NHS' contribution in tackling health inequalities.** It is fundamental that there should be clear accountability within the new NHS structure to improve health outcomes in those populations with the highest levels of deprivation. The Department intends that each local authority will establish a Health and Wellbeing Board that will have the power to hold commissioners to account. The Department should put in place an effective mechanism to hold the NHS Commissioning Board to account for tackling inequalities in access to healthcare and should seek assurance that local accountability arrangements are operating effectively. It should report back to the Committee in 2011 on these arrangements once it has finalised its plans.



# 1 Weakness in the approach taken

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1. In 1997, the Government announced that it would put reducing health inequalities at the heart of tackling the root causes of ill health. The Government's 2000 Spending Review set the Department of Health (the Department) the target to 'narrow the health gap between socio-economic groups and between the most deprived areas and the rest of the country.' In 2002, the target was made more specific—by 2010, to reduce inequality by 10 per cent, as measured by life expectancy between the fifth of health authorities with the lowest life expectancy and the population as a whole.<sup>1</sup>

2. In 2004, it revised the target to focus on reducing by 2010, by at least 10 per cent, the gap in life expectancy between 70 'spearhead' areas (a fixed group of local authorities with high deprivation and poor health outcomes) and the population as a whole. These spearhead local authorities map onto 62 primary care trusts with lead responsibility for delivering the target.<sup>2</sup>

3. Although life expectancy for the whole population has improved, the gap between the national average and spearhead areas has widened by 7 per cent for men and 14 per cent for women since 1995–97. Life expectancy for the whole population is now 77.9 years for men and 82.0 years for women, whereas in spearhead areas it is 75.8 years for men and 80.4 years for women.<sup>3</sup>

4. The government removed this target. When they did so, only 12 of the 70 spearheads were on track to narrow the life expectancy gap for both men and women, and over half were off track for both (**Figure 1**). Only spearheads in London had reduced the life expectancy gap for both men and women since 1995–97.<sup>4</sup> The Department could not say with any certainty what the reasons behind London's better performance were, but told us that some of this was because of population changes.<sup>5</sup>

5. Not all deprived populations were covered by spearheads: over half (52%) of the local authority wards in the bottom fifth for life expectancy were outside of spearhead areas. In addition, the size of spearhead areas meant that many contained both affluent areas and deprived areas.<sup>6</sup>

6. The Department recognised that it had been slow to put in place the key mechanisms to deliver the target it had used for other national priorities. Despite data consistently showing that the life expectancy gap was widening, not narrowing, it had also been slow to mobilise the NHS to take effective action.<sup>7</sup> The Department accepted that it did not put enough resource into tackling this issue at an early stage, and that it had lacked leadership

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1 Q1; C&AG's Report, paras 1.3–1.4

2 Qq 1, 33; C&AG's Report, paras 1.4–1.5

3 Q 1; C&AG's Report, Figure 3 and para 7

4 C&AG's Report, paras 2.2–2.3

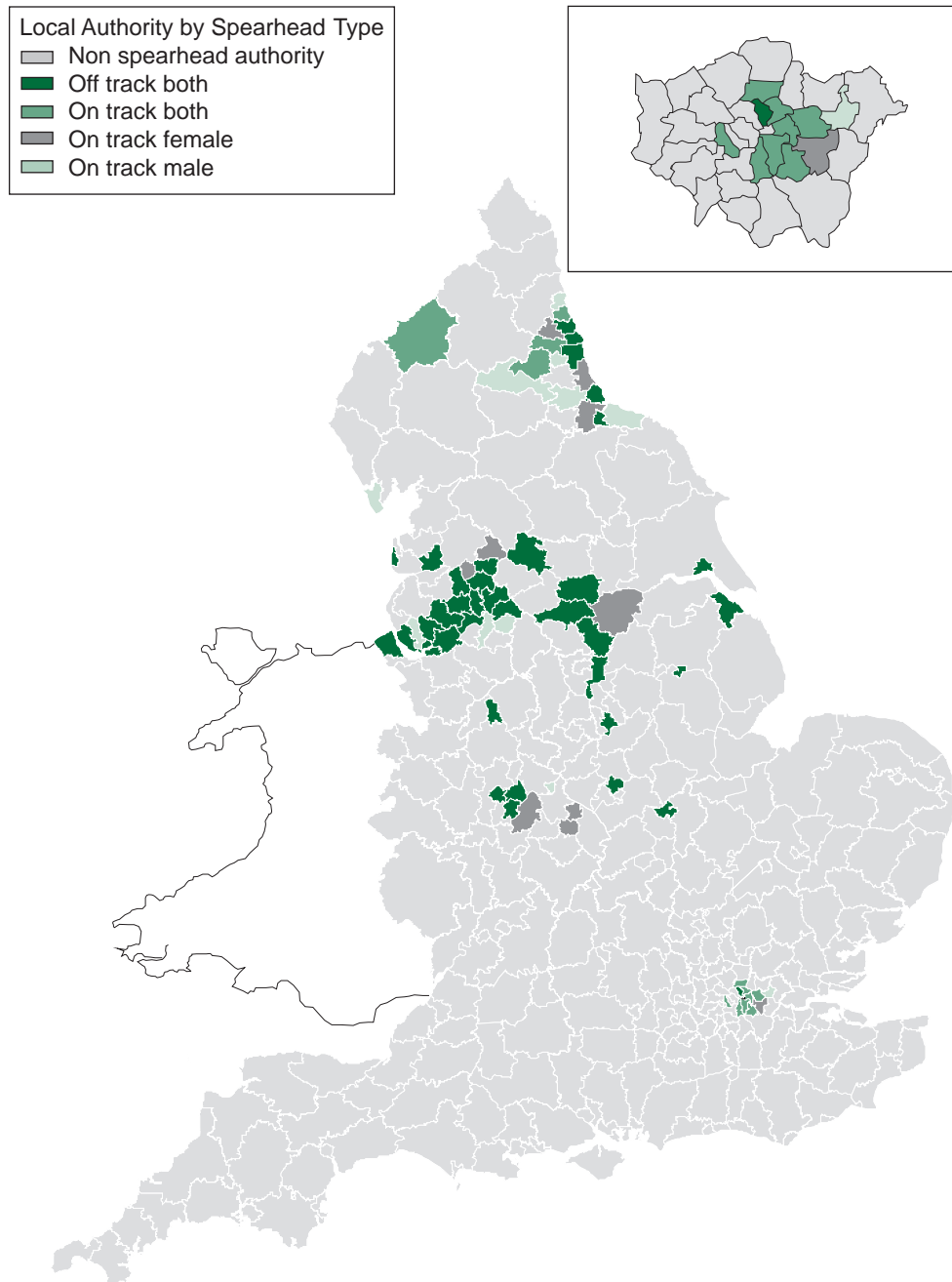
5 Qq 21–25

6 Q 34

7 Qq 1–2, 20, 29, 35

and a clear focus on tackling health inequalities.<sup>8</sup> The Department also told us that it had tended to work in silos, making the development of coherent policy more difficult.<sup>9</sup> Having made tackling health inequalities a policy priority in 1997, the Department did not make it a top six NHS priority until 2006, and primary care trusts had not been required to report on action taken until 2007.<sup>10</sup>

**Figure 1: Few spearhead areas are on track to narrow their life expectancy gap relative to England by 10 per cent by 2009–11, from the 1995–97 baseline, based on data up to 2006–08**



National Audit Office

8 Qq 45–47

9 Q 128

10 Qq 1–3

7. In 2002, three key cost-effective health interventions that were known to improve life expectancy were emphasised by a Treasury-led review of health inequalities. These were: the prescription of drugs to control blood pressure; the prescription of drugs to reduce cholesterol; and smoking cessation services. Yet it took the Department until 2007 to develop an evidence-based tool to help primary care trusts implement these treatments, and to start to monitor how they were using them.<sup>11</sup>

8. The Department also told us that these three key interventions had not yet been adopted on the scale necessary to close the inequalities gap.<sup>12</sup> There was considerable geographical variation in the approach taken by primary care trusts in spearhead areas. For example, the NHS offers a number of different types of intervention to encourage smokers to stop, but NHS commissioners had largely favoured one-to-one support, which is one of the least effective types of intervention.<sup>13</sup>

9. The NAO found that primary care trusts had not been allocated funding specifically to tackle health inequalities, but were required to address them from general funding allocations.<sup>14</sup> The Department had a long-standing commitment to allocate resources to primary care trusts through a needs-based formula which aims to ensure ‘equal access to healthcare for people at equal risk’. Ministers introduced a second objective in 1999 ‘to help reduce avoidable health inequalities’. The Department sets a target for the amount of funding a primary care trust should receive.<sup>15</sup>

10. The Department told us that it was moving trusts towards their target allocation over time to avoid financially destabilising them. This pace of change had been slow, meaning that the actual allocations to primary care trusts in spearhead areas did not always reflect their higher levels of need. In 2010–11, 68 per cent of spearheads would still not receive their full funding based on assessment of need, a net underfunding of spearhead primary care trusts of £423 million.<sup>16</sup> The Department could not say when this imbalance would be addressed.<sup>17</sup>

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11 Qq 4, 9–10, 20, 30–31, 36–37, 52–55

12 C&AG Report, para 10

13 Qq 55, 123–124; C&AG Report, Figure 18

14 C&AG Report, para 3.2

15 CA&G Report para 11

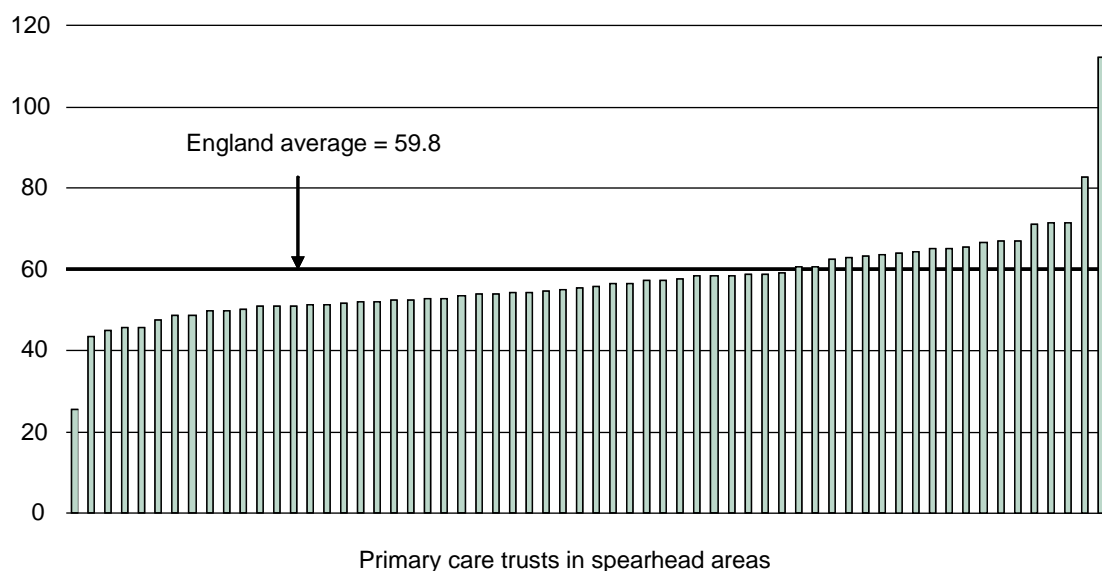
16 Qq 56–62; C&AG Report, para 3.9

17 Qq 102–104

## 2 The role of GPs

11. GPs provide care to the neediest groups and are crucial to tackling health inequalities.<sup>18</sup> One of the objectives of the NHS plan 2000 and subsequent initiatives was to increase the number of GP in deprived areas.<sup>19</sup> However, in 2008, 65 per cent of primary care trusts in spearhead areas still had lower levels of GP coverage than the national average of 60 GPs per 100,000 population, when weighted for age and need. In Redcar and Cleveland the number of GPs was only 25 per 100,000 population (**Figure 2**).<sup>20</sup> The Department told us that in 2008 it had provided £250 million for 112 new GP practices in areas with the greatest need.<sup>21</sup>

**Figure 2: GPs per 100,000 population weighted for age and need in primary care trusts in spearhead areas**



*National Audit Office*

12. Spearhead areas have high levels of unmet healthcare need, as indicated by higher than expected hospital admissions for conditions such as coronary heart disease. Spearheads also have lower than expected recorded prevalence levels for these conditions, suggesting that those most at risk do not access GP services and therefore do not receive the advice and treatment that might prevent the development of these conditions.<sup>22</sup>

13. A contributory factor to low levels of GP coverage has been the presence of single-handed GP practices. Although the proportion of these had dropped from 34 to 22 percent in the most deprived areas since 2006, there were still 371 single-handed practices.<sup>23</sup>

18 Q 63; C&AG's Report, para 4.2

19 C&AG's Report, para 13

20 Qq 63 and 65; C&AG's Report, para 4.2 and Figure 14

21 Qq 64–66; C&AG's Report, para 4.4

22 Q 120; C&AG's Report, para 4.3

23 Qq 82–84 ; Ev 18

14. The Department told us that the GP contract did not provide enough of an incentive to GPs to focus on the neediest groups. Only 10 of the 146 indicators in the GP contract's Quality and Outcomes Framework reward preventative treatment for those most at risk of developing symptoms. In addition, GPs can receive full payment of the additional income available under this framework without treating the hardest to reach and neediest groups. Until 2009, payments to GP practices did not fully reflect the level of illness in the practice population.<sup>24</sup>

15. The Department introduced practice-based commissioning in 2004 with the aim of getting GPs and other primary care professionals more involved in commissioning services for their patients. It was designed to provide GPs with an opportunity to commission initiatives to encourage the people registered with their practices to adopt healthier lifestyles. However, few preventive services have been commissioned using practice-based commissioning.<sup>25</sup>

16. The Department said that it aimed to renegotiate the GP contract to help achieve specific outcomes, which would be set out in a new Outcomes Framework. The Department said that its intention was that for every outcome indicator in this framework there would be a health inequalities element.<sup>26</sup>

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24 Qq 69 and 78

25 Q 125; C&AG Report, para 3.14

26 Qq 70–76, 80, 87–88

## 3 Applying the lessons to the new NHS

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17. In July 2010, the Secretary of State for Health published *Equity and excellence: liberating the NHS*, a White Paper setting out the Government's long-term proposals for the future of the NHS. The Department told us that the proposed new arrangements, together with a public health white paper, due for publication in autumn 2010, should provide an opportunity to narrow health inequalities.<sup>27</sup>

18. The Department told the Committee that under its proposals its new role would be to improve public health, tackle health inequalities, and reform adult social care. A new Public Health Service would be created to integrate and streamline existing health improvement and protection bodies. For all other healthcare, the Department would establish an NHS Commissioning Board, responsible for achieving health outcomes, allocating resources, improving quality improvement, and promoting patient involvement and choice. The Department told us that this Board would have an explicit duty to promote equality and access and would be held to account through an outcomes framework.<sup>28</sup>

19. The Government intends to devolve power and responsibility for commissioning healthcare services to GPs and their practice teams working in consortia.<sup>29</sup> We expressed concern as to how these arrangements would encourage GPs to work in deprived areas, especially given the Department's lack of success to date. The Department told us that responsibility for commissioning primary care would reside with the Commissioning Board, which would be responsible for the appropriate distribution of GP practices around the country.<sup>30</sup>

20. The White Paper also proposed the abolition of primary care trusts by 2013, with their responsibilities for local health improvement transferred to local authorities, who would jointly employ a Director of Public Health with the Public Health Service. The Department told us that its intention was for each local authority to establish a Health and Wellbeing Board that would scrutinise what the NHS and the Public Health Service were doing to reduce health inequalities.<sup>31</sup>

21. The Department said that the Health and Wellbeing Boards would have the power to hold local commissioners to account for what they delivered.<sup>32</sup> The Committee was not convinced about the effectiveness of the proposed accountability arrangements for GPs and GP consortia,<sup>33</sup> and was concerned that local Health and Wellbeing Boards would have no control over their funding. The Department told us that Health and Wellbeing Boards

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27 Qq 98–99, 116

28 Q 99

29 Q 99

30 Qq 100–101

31 Q 99

32 Qq 106–115

33 Qq 106–114, 125–128

would be able to make their concerns clear to consortia, and talk to them about changes they needed to make, while placing these concerns in the public arena to enable debate.<sup>34</sup>

22. The Department told us that action for improving population-wide health and reducing health inequalities would be funded from a ring-fenced public health budget. The Secretary of State, through the Public Health Service, would set local authorities objectives for improving their health outcomes.<sup>35</sup> Approximately four per cent of total health expenditure in England was estimated to be spent on prevention and public health, but spending on prevention and public health varied between local areas.<sup>36</sup> The Department was unable to say whether the current level of public health spending would at least be maintained.<sup>37</sup>

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34 Qq 113–115

35 Qq 99 and 116–120

36 Q 106; C&AG's Report, para 4.18

37 Qq 117–119

## Formal Minutes

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**26 October 2010**

Members present:

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon  
Stephen Barclay  
Jackie Doyle-Price  
Joseph Johnson

Rt Hon Mrs Anne McGuire  
Mr Austin Mitchell  
Nick Smith  
Ian Swales

Draft Report (*Tackling inequalities in life expectancy in areas with the worst health and deprivation*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 22 read and agreed to.

Conclusions and recommendations 1 to 8 read and agreed to.

*Resolved*, That the Report be the Third Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till 27 October 2010 at 2.30 pm]



## Witnesses

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**Tuesday 14 September 2010**

**Mr Richard Douglas CB**, Acting Permanent Secretary, Department of Health,  
**Dr Ruth Hussey**, Regional Director of Public Health/Senior Medical Director for  
NHS North West and DH North West and **Mr Mark Davies**, Director, Health  
Inequalities and Partnerships, Department of Health

Ev 1

## List of written evidence

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Department of Health

Ev 18

## List of Reports from the Committee during the current Parliament

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First Report	Support to incapacity benefits claimants through Pathways to Work	HC 404
Second Report	Delivering Multi-Role Tanker Aircraft Capability	HC 425
Third Report	Tackling inequalities in life expectancy in areas with the worst health and deprivation	HC 470

# Oral evidence

## Taken before the Public Accounts Committee on Tuesday 14 September 2010

Members present

Margaret Hodge (Chair)

Mr Richard Bacon  
Stephen Barclay  
Jackie Doyle-Price  
Matthew Hancock  
Chris Heaton-Harris

Mrs Anne McGuire  
Austin Mitchell  
Nick Smith  
Ian Swales  
James Wharton

**Amyas Morse**, Comptroller and Auditor General, **Robert Prideaux**, Director, Parliamentary Liaisons and **Karen Taylor**, Director, National Audit Office were in attendance.

**Paula Diggle**, Treasury Officer of Accounts, was in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL Tackling inequalities in life expectancy in areas with the worst health and deprivation (HC 186)

*Witnesses:* **Richard Douglas**, Interim Permanent Secretary/Chief Operating Officer, Department of Health, **Dr Ruth Hussey**, Regional Director of Public Health/Senior Medical Director for NHS North West and DH North West, and **Mark Davies**, Director, Health Inequalities and Partnerships, Department of Health.

**Q1 Chair:** Can I welcome everybody to the Committee? We have with us today a group of people from the Ugandan Finance Committee. Welcome to you all. I'm looking forward to meeting you later on this afternoon. It's good to see you here, and hopefully you'll get some idea of how we try and hold the Executive to account here in the UK. Welcome to the officials who are giving evidence today. Now, looking at the saga of this area of policy, in 1997 the Government come in and say they wish to make a priority, and commit themselves to reducing health inequalities. In 1998 you get the Acheson report. In 2000 you get a CSR with a target to reduce inequalities. In 2002 that target then gets refined—I like the word “refined”—and, I think, becomes less ambitious. In 2003 you do a plan of action. In 2004 it becomes, yet again, less ambitious. By 2006, that's nine years on, you decide to make it a top NHS priority; you establish a team. And yet, the data show that it's been abysmal. While everybody's health has got better, and of course we welcome that—and something would have been terribly wrong with the massive increase in expenditure if we hadn't had better health outcomes for the total population—the inequalities, the gap between the richest and the poorest, or the healthiest and the least healthy, widens. I don't think there's anybody in this room who believes this shouldn't be a priority; it isn't a politically contentious issue. And it was at the heart of what the previous Government were all about. So what on earth went wrong?

**Richard Douglas:** Well, I think it's clearly a fair criticism to start off with, that we were quite slow off the mark on this; from the point of having had the Acheson report, the creation of strategies, the creation of targets, we didn't move as quickly in terms of having the mechanisms in place to deliver that target in the same way that we had for a number of other ones.

**Q2 Chair:** But hang on a minute; things went slow? I want to stop you on that one; we're talking about 13 years, and the evidence and the data we're all working on is from 2006 to 2008. My guess is that, when the other data emerge, there will be no difference because you've got the recession in the middle of that, so that will probably worsen health inequalities. I can understand slow being three or four years, but we're talking about it finally having become a priority in 2006, and then performance didn't even improve. What is “slow”?

**Richard Douglas:** Well, in terms of slow, I was talking about the movement towards bringing this in as a priority in our performance management system and making it central to performance management in the NHS.

**Q3 Chair:** When was it a priority?

**Richard Douglas:** In 2006, when we brought in, in terms of performance management in the NHS—

**Q4 Chair:** From 1997 to 2006?

**Richard Douglas:** I think the big difference from this, and from some of the other targets we were looking at, was when this target was set, it was not clear how we would deliver it. For most targets that were set, there was a very clear view about what the delivery mechanisms would be and what the evidence base was as to how we would deliver it. In the case of health inequalities, we spent a lot of that time, in the early part of the decade, collecting the evidence base and identifying those interventions that would work.

**Q5 Chair:** How long did that take?

**Richard Douglas:** Well, this was most of the period from 2000 through to 2004–05.

**Q6 Chair:** Hang on, we've lost a couple of years. We came in in 1997, so in 1998 we get the Acheson report, which sets you a framework. Between 1997 and 2000, nobody did anything.

**Richard Douglas:** Well, the initial target was set in the spending review of 2000. So we'd set the target in 2000.

**Q7 Chair:** No. In 1997 it was a policy objective. You don't necessarily need a Treasury target to make progress, but in the first three years nobody did anything.

**Richard Douglas:** No, I wouldn't say that people did nothing on this, but what we had not done was fully identified the interventions that would work at that point. I think you've got to recognise that this was a target and an aim that everyone considered, at the time, to be aspirational and new. No one else in the world had done this, and we were starting, effectively, with a blank sheet of paper. Now, you need time to develop the evidence base to work out what will work on that.

**Q8 Chair:** I'm really sorry Mr Douglas, but it just seems to me—I can accept this is all sort of theoretical—to be a bit of claptrap. Of course you need an evidence base. In the Report, we have an evidence base: NICE tells you what works. Even when we know what works, people don't do it. Even if I'm kind to you and say that in 2006 you started doing something, I find it hard to believe we'll find any difference—that's not good enough. So, did you think it was a silly target? Why didn't you tell Ministers it was a silly target? It is despairing in a way.

**Richard Douglas:** I don't think anyone said it was a silly target, or thought it was a silly target. What we were clear on, at the point the target was set, was that it was an aspirational target, and we didn't know at that time what we would need to do to deliver it, and we were very clear at that point with Ministers that we weren't clear.

**Q9 Chair:** And that took you until 2006?

**Richard Douglas:** To fully develop the evidence base, then to start to roll that out to the performance management system in the NHS. It really kicked off in about 2005–06.

**Q10 Chair:** Nine years?

**Richard Douglas:** There was activity going on then, but actually activity directed specifically to how you deliver that target. That evidence base was really developed in the first part of the decade.

**Q11 Chair:** I'm just shocked. It seems to me that you're a pretty strong command-control Department. I mean, you control the money, right? So who is accountable for this? You know, Ministers, "It's an aspiration, it's not a silly target." It takes us nine years—that is just gobsmacking—to establish an infrastructure that could deliver. Who is accountable among your mass of civil servants.

**Richard Douglas:** Well, at the end of the day the Permanent Secretary and Accounting Officer is accountable, as in all these cases.

**Chair:** Well then, either somebody should have told Ministers right along—I mean, literally every ruddy year; every time there's a target set—that they can't deliver, or somebody, or a whole group of people, wasn't doing the work that they should have done to bring this forward to start implementing the target, and somebody should be accountable.

**Q12 Chris Heaton-Harris:** Just following on from that, I wonder if you can remind me how many people work in the Department of Health centrally.

**Richard Douglas:** At the moment, 2,300 to 2,400.

**Q13 Chris Heaton-Harris:** Okay. In those nine years, roughly how many people would have been working on designing these sorts of targets to drive this government priority?

**Richard Douglas:** I'd probably have to ask my colleague on my left. Mark?

**Mark Davies:** Well, the team for which I'm responsible has about eight people in it. Of course the team within in the Department of Health is very small but we work very closely with—

**Q14 Chris Heaton-Harris:** Okay, but what about pre-2006?

**Mark Davies:** I think it was slightly larger. It was integrated with other parts of the health—

**Q15 Chris Heaton-Harris:** So a key Government priority for health had no real focused team until 2006.

**Mark Davies:** It did have a team working on it, yes, but it was integrated into broader public health.

**Q16 Chris Heaton-Harris:** So how would they feed up their information into more senior civil servants?

**Mark Davies:** The work that was done to set the target was obviously based on work that analysts did; not necessarily as part of the central team, but as part of the broader analytical community that we work with and is part of the Department and indeed part of the wider health system.

**Q17 Chris Heaton-Harris:** So, did it go anywhere, realistically? Was it just a group of you talking to each other? I mean, did it feed up the chain? Did the Permanent Secretary get to know these targets or what was being drawn up?

**Mark Davies:** Yes, of course. The targets are set by Ministers, and the targets are agreed by Ministers. They took advice and agreed they should have an aspirational target, and one that they knew would be challenging that was about closing a gap when we knew that closing that gap would be a challenge to the system.

**Q18 Chris Heaton-Harris:** So did anybody actually mention to Ministers that, rather than closing in on their aspiration and their target, in most areas they were moving away from it?

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**14 September 2010 Department of Health**

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**Mark Davies:** Ministers know exactly what the performance information is. We publish it and make it publically available. Ministers see it before it is made public, so they know exactly how the system is progressing. We give them that advice and they see it.

**Q19 Chris Heaton-Harris:** So essentially there's no need for this middle bit of management, or the top bit of management, if you're just forwarding factual information about what's happening at the grassroots and not really formulating ideas on how you can drive these things forward. I'm really keen to know what your team was doing.

**Mark Davies:** The tool we give to primary care trusts to analyse their data and understand how they can make the biggest difference in tackling health inequalities—the national tool—is commissioned by us and overseen by us. We commission the national support team, and we set the terms for that team, which is a team of experts that goes in to help the Spearhead primary care trusts to identify their own problems and take action. So we do the things that you'd expect civil servants to do, which is to commission the support and make sure that the system is aligned as far as possible to supporting the delivery of this objective. Then we report up to Ministers, and obviously they direct us.

**Q20 Chris Heaton-Harris:** Okay. Yes, you've got this wonderful reporting line, and maybe a group of people working on it, but at the same time some very key, important political and cross-political-party aspirations are not being delivered. The obvious question is why didn't you move more quickly in trying to solve that problem, and why is it still going in the wrong direction?

**Richard Douglas:** I think it would be wrong to say that all we do is passively collect the data and then pass it up to Ministers and say, "Oh, it's a shame, it's not going in the right direction." What we look at each time, and work on with colleagues in the wider NHS—it's not just the team that sits within Mark's areas—is to try and understand what's driving the adverse movements. What are then the interventions we can make that can help either mitigate the adverse movement or move things in the right direction? So, as Mark says, what we developed over that period was the work of the national support teams. We developed toolkits for the NHS to allow them to look at health inequalities in their own areas and decide, from that, which were the best interventions to deal with the problems in their areas. We then tried to link it through to other elements of our performance framework. So this has not been just passively looking at a problem.

**Q21 Chair:** Can I just ask you something? In figure 7 on page 24, it says that London is actually getting better. Have you done research on that; do you know why? Can you tell me why?

**Richard Douglas:** Sorry, figure 7?

**Chair:** Page 24.

**Richard Douglas:** There is a mix. If you look at all the spheres—

**Q22 Chair:** Have you done research on why? Do you know why?

**Richard Douglas:** There are individual pieces of research on individual areas of the country, and what you'll find is different things are driving change in different ways in different parts of the country. So, looking at some elements of London, Hammersmith is one of the ones that I've been looking at with the team that shows very significant improvement. But if you look below that, it looks as though quite a lot of that is down to population changes. So when you have a fixed place, you can have change in the population.

**Q23 Chair:** So there is nothing to learn from London's better performance?

**Richard Douglas:** Well, no; what I'm trying to say is that in different parts of London, and in different parts of the country, you can see different things driving improvements.

**Q24 Chair:** What I'm interested in is that the evidence base here suggests that London is doing better, therefore there must be reasons for it, some of which, you say, are population change. There might actually be things that the GPs and PCTs are doing there. Do you know? Do you pass it to others? Have you done that work?

**Richard Douglas:** Yes. There are interventions that are happening in different parts of the country that work for the particular problems in that area. We then make sure other people know about those.

**Q25 Chair:** Just give me one example of what you've learned from that. You've got the worst one, here—let's take Yorkshire or the East Midlands. Do you have one example of an action that was happening in London under GPs and PCTs, which can't all be population, that you've now ensured that Yorkshire and the East Midlands are doing?

**Richard Douglas:** Across all the PCTs, the types of interventions—and they are referred to in the NAO Report—are areas around control of cholesterol and smoking cessation. So there are a number of very specific areas where, looking at the characteristics of that population, if you make those interventions, you will make improvements.

**Q26 Chair:** I know. And are Yorkshire and the East Midlands now doing it?

**Richard Douglas:** Well, what they will be doing is using the toolkit we've produced for them, looking individually in each of their PCTs at what's driving the health inequalities in their area, and then trying to apply those interventions that work in their area.

**Q27 Chair:** Do you know whether they're doing it? Are they doing the intervention on cholesterol and whatever it was—I can't remember which other one you used so let's just take cholesterol. Are they actually doing it? Can you say yes or no to that?

**Richard Douglas:** I can't say yes or no for every single PCT in Yorkshire. What I can say is that there is very clear guidance about what works. They've got support teams that will go in and help them do it. They've got a toolkit that will help them.

**Austin Mitchell:** But Yorkshire has got less money than London.

**Chris Heaton-Harris:** And the East Midlands.

**Richard Douglas:** Some parts of Yorkshire will, if you look purely at cash per head of population, but the costs in London are significantly greater.

**Q28 Ian Swales:** I'm just going back to Mrs Hodge's original point about the time it took. There was a big report published in 2002—a joint study by the Department of Health and HM Treasury. You then published a programme of action in 2003, including 82 indicators for improvement, yet you say it took until 2006 before these actually became priorities and part of the performance management system. So how do you explain the specific gap, from the publication of the programme for action in 2003 to what seems like the start of action in 2006?

**Richard Douglas:** Well, I wouldn't say there was no action before 2006. In 2006 we actually upped the action and operated in a different way with the performance management system. So there was action taking place before then, but not in the systematic way that we had in 2006–07.

**Q29 Ian Swales:** Was three years about the least time you think it could take to implement this programme? We're now reviewing what happened. What is your view about that three-year timescale?

**Richard Douglas:** If I look back at this with hindsight, and it's always difficult doing this, I think we were slow off the mark. I mean, looking at this compared with where we were with some of the other targets and priorities, I don't think we moved as quickly as we should. Now, there are all sorts of reasons for that. Part of it is that it is a lot more complex issue. Most of the other targets are a lot simpler to deliver. This is a very complex area, with a number of factors influencing it, and it is a more difficult thing to do. So there was a fundamental issue with difficulty. Could we and should we have moved with more pace? I think that's a fair criticism.

**Q30 Mrs McGuire:** I want to take us back to why it took so long to assemble the evidence, as you have indicated Mr Douglas. The inequalities in health agenda is not a new one. Indeed, people have been mapping out inequalities in health certainly since the 1970s and probably before that. In 1997, it was identified as a priority; you've indicated that it was aspirational. Why did it take so long to assemble the evidence when, frankly, the evidence was staring everyone in the face that you could move from one side of a community that was essentially better off to the other side of the same geographical area where people's life expectancy was up to 15 to 20 years less than on the other side of the street? That wasn't new. You didn't need to assemble a great deal of evidence to make the case. Why did it take so long?

**Richard Douglas:** In a minute I'll bring in Ruth, who is a public health specialist, but I think the evidence around the extent of inequalities was staring everyone in the face, so the comments you make are absolutely right. People knew there were inequalities in health outcomes. Where the evidence base was a lot less strong was about what the NHS could do through interventions to help reduce those inequalities. So it's a movement from just mapping and saying we know what they are on to precisely what you do about that? Ruth, is there anything you'd like to add to that?

**Dr Hussey:** I absolutely echo the knowledge and awareness about wider health inequalities as having been around for some time; in the early 1990s I worked in Liverpool and spent much of my time making the case for action on health inequalities. What happened after the Acheson report was a realisation that we needed to focus on what the NHS can do. Through that period—I have to say, in the period after 2003–04, the strategic health authority that I worked in at the time developed a performance framework—there was very much local innovation, local focus, and recognising this was a big issue in our part of the world. It was when everybody had developed different ways of doing it that we realised that there were a few things that could be focused on, and then we moved into a national performance framework. You need innovation to understand the mix of things, and during that time what was developed was a set of tools or ways of looking at the differences. Even within my region, I can take two parts of it and find one where the disease pattern is considerably different to that in another part of the region. So, it is knowing what the NHS should really focus on, and the tools to assist with this have been very well received. It has enabled and empowered local areas to know how to understand the mix of things that are going on, because the mix of population, geography, economics and the types of needs are quite different in different parts of the country. I think that the national focus really helped to say there is a set of things that you really need to apply here, but it did take time to do it.

**Q31 Mrs McGuire:** So it took six, seven, eight, and even up to 13 years, to identify that smoking cessation and an increased use of statins and cholesterol-lowering drugs was the way forward? You're telling me it took 13 years to identify that? I put it to you that, frankly, if we were dealing with the conditions of people who were able to articulate campaigns and could lobby their politicians, we would not have had such a time delay in getting some action. Would that be a fair comment?

**Dr Hussey:** I think there was a period of helping people to understand what was underpinning health inequalities, and certainly I spent a lot of time locally trying to persuade people that this was a really important policy issue to focus on.

**Q32 Mrs McGuire:** Who were the people you were trying to persuade? Was it the people who were dying 12, 15 or 20 years earlier than they ought to have been, or was it the general practitioners who perhaps

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14 September 2010 Department of Health

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did not see this as a priority? Who were you trying to persuade? The disadvantaged people knew they were dying 20 years earlier than everybody else?

**Dr Hussey:** Absolutely. I've worked for many years with local communities looking at and supporting action on their health needs. I think it was about getting a sense of how all the policies had to work together to address a whole range of different health inequality issues. We focused on education with healthy schools programmes; we focused on health at work. A whole raft of things were focused on in the 1990s, fuelled by the Acheson inquiry which really helped to get people to understand that everybody had some contribution to make to tackling health inequalities. I think that the area that needed more focus was the NHS itself, and for example, at that time the research was emerging about how many people should benefit from statins. There was a debate in the 1990s: where were the thresholds of risk; how would we prioritise? So that was an emerging understanding and, through the early 2000s, there was a sense of trying to build momentum to focus on the things that we knew really should be pushed because they were so strongly evidence-based.

**Mrs McGuire:** Frankly, articulate, middle-class people have known for many years that if they had a problem with blood pressure or with cholesterol, there were specific routes to assist them to manage those conditions. Why were the more disadvantaged way behind the curve on this? Frankly, I just cannot understand why it took so long to get to a point where we were delivering not the better health outcomes, but just the mechanism for dealing with some of the disadvantages.

**Chair:** There are three people who want to comment. I think James, Austin and then Matthew.

**Q33 James Wharton:** I'm interested in how this has been targeted at areas in particular, because we've explored already somewhat the issue of tackling the problems that are particularly found in deprived communities, communities where there are low levels of health outcomes now, and the whole purpose was to drive that up. How were the Spearheaded areas chosen? What was the mechanism through which you identified the areas you wanted to go into and deliver this programme, and the areas you didn't?

**Richard Douglas:** In terms of identifying the Spearheads themselves, perhaps Mark?

**Mark Davies:** We used a set of criteria based on levels of life expectancy in males and females, levels of cardiovascular disease, levels of cancer and a broad definition of deprivation. We used those to identify the 20% of areas that met those criteria most obviously. So we took a decision, and that was based on the fact that, previously, we had been looking at health authority areas which were in what we call the lowest quintile of deprivation or disadvantage. Every year those were changing, so we decided to settle upon a fixed group of areas that we could concentrate activity on. Those were the ones we called Spearheads from 2006.

**Q34 James Wharton:** I just wonder whether it may be worth exploring, or certainly looking at, the way policies like this are implemented in future, and a lower level of targeting at areas. I look at some of those areas that are Spearheads. I represent Stockton South in Teesside, and Stockton on Tees is an area which has been targeted. When I look at my constituency, I know there are areas which are really some of the wealthiest areas in Teesside where these issues don't arise, and of course there are also towns within the constituency—significant urban development areas—where this sort of programme would be perhaps more appropriate. And also, when we look at the findings of the Report, we find that 52% of the deprived areas are not within the Spearheaded areas, so it seems not only that where we are or have been targeting we have picked up some areas that are perhaps not in as desperate a need as others, but then you are missing out a huge chunk of deprived areas which could benefit from this.

**Richard Douglas:** Absolutely on that. I think I made clear that the PSA target was focused very much on the Spearheads, but that didn't mean that people weren't looking at health inequalities more widely within their areas. The variation can be massive. One of the examples that we always come up with is somewhere like Guildford that people think that there will not be health inequalities in Guildford. The life expectancy differences within Guildford are about six years between different areas.

**Chair:** The sad truth of this Report is that you've focused, because I assume someone thought if you focused you might be more effective, but in focusing you've carried on being ineffective, so people died because we weren't taking these very simple actions that Anne talked about. Austin.

**Q35 Austin Mitchell:** I mean, it's a mess—it's a tragedy really—because here is a major social problem, a scar on our society, that the Government wanted to do something about, and you all wanted to do something about, yet the action was too slow. Our Chair gave a dramatic list of actions which were too late and where evidence wasn't collected, and now having gone down that path too slowly, it's now all going to be thrown up in the air and changed to another path before we have even got the evidence as to whether this was ever going to work. So that's a tragedy. Now, if I give you some possible explanations, I'd like you to pick which was the most important reason for this failure: one, is it that Ministers didn't push it hard enough; two, is it that you lot, the officials, were pussyfooting and saying, "Oh, it's all too difficult, it's going to be too expensive, what the hell are we going to do?"; three, is it that the health service was too big and cumbersome to produce effective action in this area, and too fragmented; or, four, is it that you didn't want to be part of a nanny state by dictating to people what they smoked, what they ate, what they drank, and how they behaved? Which of those is the most important explanation of the slowness in doing anything?

**Richard Douglas:** I don't think I would say that any of those four were the most important explanation.

**Austin Mitchell:** Well, they must all have had a bearing.

**Richard Douglas:** On the pace at which we moved, as I said before, I think we could have moved quicker on this. But the thing that has the most bearing on it is being clear about what the NHS can do to help change this, and then being clear about how do you go about doing that within the system that we've got? So, it is the "what to do" and then the "how to do it", and it was absolutely clear on that.

**Q36 Matthew Hancock:** Can I come in on exactly that point? We've just heard quite a passionate explanation of how, on the ground, people did know; in your words, there was "so strong an evidence base" for what worked in this area. There was clearly high-level ministerial ambition, because that was set out in 1997 and 1998, with then a formal target in 2000. So there was the strong evidence base that you said that you spent nine years collecting, and there was the ambition at the top, and there was a group of people on the ground who were already trying to do this. However, Dr Hussey, you said something like—I can't remember the exact words, and I don't want to misquote you—"The problem was getting it into the NHS as a whole." So, how can an organisation that didn't put a very large team on it—you said after 2006 you had the team of eight, and beforehand you declined to name the size; I'd be interested in how many full-time equivalents were working on this programme before 2006—spend nine years without making any significant progress? The problem was, you said, that you had to get an evidence base; we've just heard that you had one.

**Richard Douglas:** I think what Ruth was saying is that it was people like her and the teams out in the NHS that were developing the evidence base in their areas. What we then needed to do was to take that up to a different level and make sure it was spread across the NHS. I don't think that Ruth was saying that we had ready there, at the very start, all these different sets of interventions that we knew exactly how to apply in each area.

**Matthew Hancock:** But you've ended up with—

**Richard Douglas:** It was people like Ruth, and people in the NHS, who were developing the evidence base.

**Q37 Matthew Hancock:** But the time periods over which this was happening are exceptionally slow. Eventually, it got into the performance management system in 2006. I might note, and we'll come on to this later, the fact that the GP contract, which is absolutely critical to this, was signed off, sadly for everybody, in 2005. Even if you'd managed to do it in eight years, we would have avoided part of the catastrophe.

**Richard Douglas:** I don't think I can go any further than what I said before about how we tried to gather the evidence base from what worked locally.

**Q38 Matthew Hancock:** You've admitted that you were too slow. What we really want to try to get at is why you were too slow so that in future these problems can be avoided. I mean, did anybody lose their job over the fact this is too slow and people are dying because of it?

**Richard Douglas:** I'm not aware of any individual losing their job.

**Q39 Matthew Hancock:** So there was no accountability.

**Richard Douglas:** I don't think it means that there was no accountability just because someone didn't lose their job over this.

**Q40 Chair:** Do you know there was accountability? Was there accountability?

**Richard Douglas:** There was clear accountability to our Ministers.

**Q41 Chair:** What does that mean?

**Richard Douglas:** There were changes in the way we ran and managed this approach. There were changes in how we structured the teams, and there were changes in the way responsibilities were undertaken within the Department. So there was a shift in what we did and how we managed the Department.

**Q42 Chair:** So people were shifted round the system, and Mark Davies was appointed?

**Richard Douglas:** We moved the responsibility, and changed the way in which we managed this within the Department.

**Q43 Chair:** When did you do that?

**Mark Davies:** 2006. It was at the setting of the—

**Chair:** 2006? Nine years after the first commitment to this area of policy.

**Mark Davies:** That was when the public service agreement target was set, and we then set up a governance arrangement in the Department of Health through which the Permanent Secretary took responsibility for our public service agreement, of which this was part. I think I'm right in saying it was the only public service agreement where a Permanent Secretary was what they call the senior responsible officer—the lead officer.

**Chair:** A bit late.

**Q44 Mr Bacon:** Mr Douglas, what is the answer to Mr Hancock's question? Why were you too slow?

**Richard Douglas:** My answer to it is that this was a new area for us. It wasn't an area that we'd focused on before. It was more difficult than any of the other areas we were looking at. But what I'm saying is now, looking back with hindsight, I think we could have gone with more pace. Now, whether that would have meant that we met the target—

**Q45 Matthew Hancock:** My question was why.

**Mr Bacon:** And *ditto*.

**Matthew Hancock:** You have said several times that you've accepted that it was too slow. We'd heard that a lot of the work was going on on the ground. My question is: why were you too slow?



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14 September 2010 Department of Health

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**Richard Douglas:** I don't think that we put sufficient resource into actually dealing with this in the very early stages.

**Q46 Chair:** Centrally?

**Richard Douglas:** Centrally.

**Q47 Mr Bacon:** Do you mean money or people?

**Richard Douglas:** I think people and focus, at the very early stage of this, and really trying to turn this into something similar to how we looked, at the time, at whether it was cancer or coronary heart disease. We had a very clear leadership there with the clinical director and we focused very clearly on what things we needed to do to make this target. Now, I don't think we had that same—I know we didn't have that same—focus on health inequality.

**Chair:** Go on Anne, quickly, and then Chris.

**Mrs McGuire:** At the end of all this evidence gathering—at the end of this time period—you've come up with three major interventions which were about lowering cholesterol, dealing with high blood pressure and smoking cessation, which frankly could have been identified on the evidence base that Dr Hussey said was there in 1997. And according to the NAO Report, had these interventions been made in a more coherent way, it would have cost about £24 million, out of a total budget for Spearheads of £3.9 billion, on those three interventions, which are the primary interventions.

**Q48 Chris Heaton-Harris:** I looked at part 3 of the NAO Report. The big question here is: is there an ability of the Department of Health to influence change, because what I'm feeling is no. You don't ring-fence money for Government priorities. I would have said it is a very embarrassing chapter for you. Is there any point in having all these people in the centre of the Department of Health talking about toolkits, at the end of the day, if you're not going to influence anything?

**Richard Douglas:** Well, I think there is ability for the Department of Health to influence change, and it has influenced change.

**Q49 Chris Heaton-Harris:** How?

**Richard Douglas:** Well, the issues about the setting of incentives in the system, and I assume we'll come on to issues about the GP contracts. There are ways in which we can influence by providing support and help to people. We can influence by providing the information for people that allows them and helps them to do the right things. We can influence by guidance. Ring-fencing of money isn't the only way of exerting influence.

**Q50 Chris Heaton-Harris:** Those first four things you could do by Google, now; you can just Google in "what are the key influences on stopping people from smoking" or whatever, and you can find a batch of information on there. What's the point of you?

**Richard Douglas:** From the point of view of the NHS, the sorts of tools we've given to people first of all allow them to look at the characteristics of their

population, and then at how different types of intervention would influence life-expectancy, so that they can start to quantify and make this real.

**Chair:** You're not answering the question, Mr Douglas.

**Chris Heaton-Harris:** I didn't want to keep jumping in, sorry.

**Q51 Chair:** No, well done, because I don't think you're answering the question. That's what they need to look at, but where do you add value in that?

**Richard Douglas:** We add value, or we have added value, by providing the tools to help them do that and by providing the guidance. Other people can provide that.

**Chair:** Maybe it's circular.

**Q52 Chris Heaton-Harris:** I know. And there is a body of evidence about the areas where you stepped in and offered, although I'm not even convinced the toolkit actually got spread out particularly widely. I can't see where you've made a positive impact, and I was just Googling what Labour Ministers were saying in 1997, and I think, actually, the new Labour Government had identified certainly smoking cessation as a very key priority. And yet, nine years later, you get to 2006, and it's gradually identified within the Department. In the meantime, God knows how much money might have been spent on public health initiatives and whatever, and a general awareness in the population, and yet still in these areas we're heading backwards, I don't see where you are adding any value.

**Richard Douglas:** Well, as I say, my view—and Ruth can comment as someone who's out in the NHS on this—is that what has been done, particularly in the last few years, and the work the support teams have done have added value to the NHS. It has helped them identify—

**Q53 Stephen Barclay:** Just following on from Chris' point about smoking. Paragraph 4 of the Report says that there was a "cross-cutting review in 2002 and it identified, and this is the point Anne is raising, that the evidence was known. In 2002, they identified "reducing smoking in manual groups" as one of the interventions. So you're trying to explain the delay on the one hand with the lack of evidence, while at the same time arguing, or recognising, you were slow to act, and there seems an inherent contradiction. Either you had the evidence and you were slow to act, or you didn't have the evidence in which case it was justified. What I'm interested in, in the myriad of documents that you produced, is did you set out—for example in the programme of action in 2003—the missing evidence, or what it was that you didn't have in that document?

**Richard Douglas:** I couldn't be clear what was in that document; I don't know whether Mark could help on that.

**Mark Davies:** The programme of action set out action that could be taken across Government, so not just within the NHS, to address health inequalities. It was a broader programme that set a

series of ambitions, many of which have been met in terms of investing in early years and employment activity.

**Q54 Stephen Barclay:** Sure, but if your evidence is saying, “We couldn’t act until 2006, we didn’t have the evidence,” and you’re producing a programme of action, it’s a bit of a misnomer, isn’t it, to say there is a programme of action, but we can’t act because we haven’t got the evidence? Would it not have made sense, in that document, to say, “These are the areas where we don’t have evidence.”?

**Mark Davies:** We then sought the evidence and applied it from 2006.

**Q55 Stephen Barclay:** But did you set it out? Ministers were under the impression that action was being taken, so where were you setting it out? I mean, your evidence today just seems totally at odds with those earlier publications, so I’m trying to understand why were you not saying at the time, “We don’t have the evidence.”?

**Richard Douglas:** If you take something like smoking cessation, we had the evidence, clearly, that smoking, and differential rates of smoking, was a major contributor to health inequalities. But then there are issues about how do you best target smoking cessation at those groups of people that you need to target? What are the interventions that help most in helping people to stop smoking? And they’re different across different groups of people. So it’s not only the evidence of what are the contributors to health inequality; it’s how can you change those behaviours—what you can do around those actions to help reduce health inequality.

**Chair:** And you’ve got evidence on that, and on figure 18 on page 42 it looks like people were doing the thing that was ineffective. One last question on this, and then I’m going to move to GPs.

**Q56 Ian Swales:** Stop me if this is not where you want to go, but we were talking about what you can do and Chris picked that point up. Clearly one of the things you have been doing is allocating financial resources, and I don’t know if you want to go here now, but one of my questions is: one of the things you did was to allocate extra money to the Spearhead groups based on their need, yet even in this financial year—2010–11—two thirds of those Spearhead areas are not getting their full needs-based amount. Particularly when you exclude London it’s an even higher proportion, so what do I tell my constituents who are £4 million short this year on their needs-based allocation?

**Richard Douglas:** On the allocation form that we use with PCTs, when a PCT gets an allocation it’s based on both what their target is, which is what the formula will drive out for us, and it’s based on where they actually are now. We try and move them from where they are now to their target. The only way you could get everyone to target now would be by making significant cash cuts in some PCTs’ allocations to pay for increase elsewhere, because this is a zero-sum.

**Q57 Chair:** Except that expenditure grew over the past 10 years.

**Richard Douglas:** Over that period we did move people towards their target allocations. Every time we set allocations, there is a choice to be made between how quickly you move people to target and give significant extra sums to some PCTs, and how much you protect every PCT that is facing the same cost pressures across the system. That choice is made at every allocation round. No Government, in my recollection, have ever made a decision to cut in cash terms any PCT’s allocation.

**Q58 Ian Swales:** Whose decision was it that this was a zero-sum and that you had no way of reallocating?

**Richard Douglas:** It must be a zero-sum. All the formula does is allocate a share of a total.

**Q59 Chair:** But hang on. The money spent on health went up year on year on year. We doubled the expenditure on health, so it is not a zero-sum. What you are doing is changing the share of the cake against a bigger cake.

**Richard Douglas:** Yes we are, and over that period there were significant movements for people towards their targets; some people were moving at 9% or 10% a year towards target. However, if somebody starts from 15% to 20%, you will struggle to get everybody there, and Ministers make a choice.

**Q60 Matthew Hancock:** But if you’re 15% to 20% below target, and you’re moving some at 9% to 10% per year, it takes two years. And what’s more, are you frustrated now that given the tighter fiscal circumstances in the future, you didn’t make more progress when there were huge increases year on year on year?

**Richard Douglas:** It is a choice that Ministers make in each allocation round about what the balance is, how much they give everybody, and how much they target towards those that are furthest from target. I’m not blaming Ministers at all. It is an informed decision based on the advice they get, but that choice remains with them, and it has always been there.

**Q61 Austin Mitchell:** Can I just ask why the north has moved more slowly to target than the south?

**Richard Douglas:** I don’t think that the north moved more slowly towards target.

**Austin Mitchell:** It says on the regional notes we’ve got, and this is for North East Lincolnshire, that the PCT, which is a very good one in North East Lincolnshire, was 2% below target based on need, and Yorkshire generally was 3.1% below target. PCTs in the south weren’t that far below target.

**Chair:** Ours was.

**Richard Douglas:** There will be some that will be.

**Q62 Austin Mitchell:** But as a whole the concentration of below target was in the north.

**Richard Douglas:** The pace of change is exactly the same across the country. We have the same policy across the country at each allocation round.

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**14 September 2010 Department of Health**

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**Q63 Chair:** Can I move you on, because I think we've dealt with that point. GPs are obviously central, as the work that they do is central to any hope of achieving a reduction in inequality. Now, if I just turn you to page 36, figure 14—and I think lots of us round the table would say this with great feeling because we represent areas where we don't have enough GPs—what completely shocked me about that figure was that we have too many GPs in the least deprived areas, and far too few in the most deprived areas. Going back to what we're trying to establish in this particular session, if there's one purpose to the National Health Service, it's to use its moneys to effect change. If you'd only used your moneys to pay GPs double, whatever it took—a higher relative rate in the most deprived areas—that would have been probably the most effective thing you could have done to tackle inequality. How on earth did you ever allow, in your allocation of resources, this disparity in outcome in the presence of GPs in areas to come about? It's just shocking; how did that ever happen?

**Richard Douglas:** There has always been disparity of this type. That is not making an excuse for this; there have always been more GPs within the least deprived areas. Now, what we have done is try to take action—

**Q64 Chair:** But if you don't give them the money, they won't go. If they haven't got the money and the budget to earn because they're not needed—the money's not with the PCT—that's the easiest way of trying to get redistribution.

**Richard Douglas:** But the allocation is there within the resources that we put out to PCTs. The PCT resource allocation reflects needs; the issues have been attracting GPs to these areas, and we have over past couple of years moved to a position where we've procured, or supported the procurement of, I think 112 practices, targeted around these most deprived areas in recognition that this is the thing that really matters.

**Chair:** I know that there has been action, because I'm in one of those areas that has suffered. We've tried salaried GPs, we've tried linking to universities, we've tried private practices rather than NHS practices—we've tried the lot. What you haven't done, which was the obvious thing, was switch the money; you could have had a differential in GPs' salary rate, which would have been the clearest incentive of getting through the work in the most difficult areas. You just didn't try it. It hits you when you look at that graph and think, "Bloody hell, what on earth is happening that we're spending all this money in the least deprived areas, and GPs only go there because there's a salary for them, but not enough money in the most deprived areas where the GPs are not going?" Ian has a similar situation.

**Q65 Ian Swales:** Again, it's a specific point but I hope we can all learn from the general. According to the figures I've been given, that graph on page 36 shows the average is just under 60 GPs per 100,000, and the figure on the left hand there is 52. According to the figures I've received, the number in my area is

25, the lowest in the country, but Redcar and Cleveland—lest anybody think that a GP would have to live amongst the smokestacks of Teesside—includes part of the North York Moors national park. It's a beautiful part of the country. Why can't we get doctors?

**Richard Douglas:** I don't know the particular circumstances in Redcar and Cleveland, and I would be guessing if I tried to come up with the reasons for that area. I don't know whether any of my other colleagues could particularly advise on that.

**Mark Davies:** No. I think, of the new GP practices that were procured after 2008, that two of them were in your constituency. I think that is a recognition that there was a problem.

**Q66 Ian Swales:** Again, it's a specific point but I hope that people can learn from it. What did you actually do when faced with that situation? You talk about new practices; just talk us through what you actually did in order to do something about it.

**Richard Douglas:** We provided additional targeted resources to create and set up 112 new practices.

**Q67 Ian Swales:** So, money.

**Richard Douglas:** So we provided money and support for that. That was the principal purpose: identify those areas that are most significantly under-doctored in this sense, and then provide the resources to help deliver those practices.

**Q68 Ian Swales:** So is that for buildings, or do you help with salaries? What's the package?

**Richard Douglas:** It provides the money for the practice, and that will then go recurrently, so it will go into the baselines for that PCT allocation. So it would be added to the PCT allocation in future.

**Q69 Chair:** On page 34 paragraph 3.19 it says, "GPs in the poorest areas received less remuneration per patient on the indicators than those working in areas where there was a low prevalence of diseases." So they got less money.

**Richard Douglas:** That was a particular issue with the way that the GP contract operated up until this year, which was linked to how people are paid for prevalence. Effectively we had a dampening mechanism in there that has now been removed.

**Q70 Nick Smith:** So how are you going to make sure that the future payments in GPs' contracts reward actions to tackle health inequalities? You've already said you haven't got enough GPs in the right places. How are you going to make sure that the doctors you have got in the right places are rewarded for doing the work that's important on health inequalities? How are you going to make sure that those GPs help the neediest groups—the target groups we most need to focus on?

**Richard Douglas:** The key mechanism for this will have to be around the GP contract. As we move into the new system that the Secretary of State announced in his White Paper, we've got to look at

a more outcome-focused basis for the GP contract. That's something we are going to have to negotiate and discuss with the medical profession.

**Q71 Nick Smith:** What do you mean by that?

**Richard Douglas:** Well, what we'll try and do is change the contract so that it is more clearly focused on those outcomes that really matter.

**Q72 Nick Smith:** For example?

**Richard Douglas:** I cannot give you an example of how, specifically, it will change, because that will be a matter for policy and then for negotiation.

**Q73 Nick Smith:** So you don't know?

**Richard Douglas:** Well, not in terms of where we will go on the next stage of negotiation. This depends on us, first of all, getting to a position where, with the new system the Government have announced—

**Q74 Nick Smith:** Why don't you know?

**Richard Douglas:** Well, we're about to embark on a totally new system—a very different way of managing the NHS—so we will have an outcomes framework that the Secretary of State will agree with an NHS board that will set a number of outcomes that the NHS is expected to deliver.

**Q75 Mrs McGuire:** Can you not give us a hint what one or two of those outcomes might be—just a wee bit of a hint?

**Richard Douglas:** We'll consult on the outcomes. They will be clinical outcomes that will reflect the quality of care that people receive, the safety of care they receive, and their experience of dealing with the NHS.

**Q76 Chair:** And health inequalities?

**Richard Douglas:** Health inequalities will be on the consultation that we've put out, and we've sent out a document called the "Outcomes Framework" in consultation. Inequalities will be embedded in each of those different outcome indicators. So the intention is that for every outcome indicator for health care, there will be a health inequalities element, and people will be able to look at those outcome indicators at different levels of population, by different groups of people, so we are absolutely clear that it is the framework we want for the new NHS. Now, the new GP contract, as it's renegotiated, will have to reflect how that incentivises delivery of the outcomes that are agreed at the top level.

**Q77 Stephen Barclay:** On Ian's points, you were quoting figures for today, in terms of the lack of GPs in a deprived area, and you've already conceded that the Department was very slow to act. I just want to get your thoughts on whether you're still being quite slow, because the NAO Report in 2008 said: "The new contract"—this is for GPs—"has not yet led to a measurable improvement in moving services into deprived or under-doctored areas". It referred to the fact that "the Minimum Practice Income Guarantee has meant that the redistribution of funding to the

most deprived and under-doctored areas has to date been limited." So that was an NAO finding in 2008, but yet I think you're just saying to Nick, "Well, we've still got further work to do." Is there any urgency on this?

**Richard Douglas:** Yes, there is. I mean, there's further work to go on more widely on the GP contract, but some of the issues that are referred to in this Report that affected the relative remuneration of GPs for extra patients in deprived areas, such as how we dealt with prevalence, we have dealt with and we've changed those elements in the contract. So the NAO comments around prevalence and how that affects payment to GPs have been dealt with—the contract has been changed for that. What I'm saying is that as we move into a different approach to the management of the NHS, the GP contract and the outcomes that it measures will change in line with that to keep consistency throughout the whole system.

**Q78 James Wharton:** Just to explore the GP contracts issue a little further—I appreciate that there are other topics that we want to move on to—you said that there was a dampening mechanism, which seems inherently sensible if you take away the policy objectives that we're discussing here. It seems sensible to say that while you'll get a certain payment per patient, there needs to be some mechanism to actually dampen that so that you don't get ridiculous amounts being paid to GPs in extreme circumstances, but that mechanism has now been removed. I'm assuming that you cannot say to a GP in a very good area where there are a large number of GPs per patient, "We're going to reduce your pay because we're putting the pay up for GPs over there." So, is there a danger, and what measures—what steps—is the Department taking to make sure they don't lose control of GPs' pay?

**Richard Douglas:** The dampening measure was very much around large practices with low prevalence of disease, and it was trying to protect those in a sense, particularly things like practices at universities where there was quite low prevalence of the types of things we were looking at within the quality and outcomes framework. So it was that degree of protection. As we revise the contract over the years, there is some rephrasing between people. So it's not a matter of always growing the total sum and growing payment for everybody. There is some rephrasing between practices.

**Q79 James Wharton:** In the process that you're going through now, is it fair to say that you're confident that you're going to keep good control of the levels of pay remuneration that GPs get, because of course there have been lots of reports in the press in recent years about a small number of GPs who've been able, through the contract that now exists, to make what seems to me, and I'm sure to the general public, very large sums of money? That has been a cause for public concern at a time when spending is very much tighter than it has been in recent years. Are you confident you are going to be able to keep control of it?

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14 September 2010 Department of Health

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**Richard Douglas:** Yes, with the mechanisms we have. Most of the big increases in overall GP pay occurred at the start of the introduction of the contract. Since then, there has been greater control over that.

**Q80 Chris Heaton-Harris:** I'm just wondering how much confidence we can have that tackling inequalities will go into any new GP contract or provisions, given that you'd been working on tackling inequalities for eight years before the last GP contract, and it didn't really seem to have too much in that. So I'm interested in the communication between different parts of your Department now, as in those negotiating the GP contract—this very big piece of work that could have helped deliver the priorities of the Government of the day—in what actually happened, and in whether Mr Davies' section, previous to Mr Davies being there, had any dealing with the people negotiating the GP contract and advised them in this area.

**Richard Douglas:** Going back to 2005, I couldn't be certain about who was involved in that, but, at a senior level, either the Permanent Secretary or other people at a senior level will be aware of the links between the different bits of policy. Again, reading this Report now, I think there is clearly an issue about whether we had all our policies properly aligned around health inequalities, whether it was around the contract negotiations on GMS, and even whether it was around the health inequalities elements of particular strategies: coronary heart disease and cancer. One of the key lessons for us is, when you're doing lots of these different things, making sure there is that line-up and that it all joins up.

**Q81 Chair:** Whose job is it?

**Richard Douglas:** Well, it's the job of all of us in the Department. It's our job definitely at the most senior level—the board level—to be aware and make sure those linkages are there, but all staff in the policy teams should be aware of what the priorities are and how they get built into the different levels.

**Chair:** On a very simple level, from my own constituency, had you sorted out the GPs, you'd have cut the hospital spending. Every time I walk into an A&E, a third of the people sitting there are there because they can't see a GP. It's just so simple. I don't think it's this great big rocket science stuff; it's just really, really obvious. Austin then Nick, and then we're going to move, I think, on to the last section of questioning.

**Q82 Austin Mitchell:** Can you tell us how far this problem of the deprived areas being under-doctored is compounded by the other problem that there is, in these deprived areas, a higher incidence of single-doctor practices, with possibly a higher proportion of them being immigrant doctors. I'm not criticising them, but I do get the impression that we wouldn't have been able to keep the doctor level going in Grimsby had it not been for Pakistani and Indian doctors, who are now not being allowed to stay after

their training, so they're going to be less available to go to the deprived areas. So how far is that a problem in the deprived areas?

**Richard Douglas:** I haven't got the figures with me, but historically we have had more single-handed practices within deprived areas. What has happened over the last few years is that there has been a significant reduction in the proportion of single-handed practices; practice sizes have generally tended to increase across the country, so we have a lot fewer single-handed practices. I don't know whether from your area, Ruth, you'd want to comment particularly about that.

**Dr Hussey:** Well, I think it is a changing trend. Just to say, the investment that was put into new GP practices has seen 34 new GP practices established in my region.

**Q83 Austin Mitchell:** But it's noticeable in my region that the new group practices—these fantastic places like the Starship Enterprise—are in the better-off areas, not in the heart of the deprived areas.

**Dr Hussey:** I think the policy and the initiative were very much targeted at disadvantaged areas, to the extent now that, in our region, there's only two areas left that would be regarded and classified as under-doctored at the end of this policy. By the end of this year, we'll have 38 new GP practices, so I think there's been a significant investment. In the north-west, we spend just under £1 billion a year on primary healthcare services, and that's a 6.6% increase from the previous year. So there's a clear sense, and a momentum, around investing. The other point I'd make about GPs is that while the GMS contract is a national contract, PMS—personal medical services—is a flexible contract that can be negotiated locally. I think it is very relevant to mention that just under 35% of practices in my region are contracted through PMS, which gives local flexibility to specify what you want, what services, how they're organised.

**Q84 Austin Mitchell:** That's true, but it doesn't come into effect until 2011. Can you supply us with statistics on the incidence of single-doctor practices in the deprived areas?

**Richard Douglas:** I'm sure we will be able to; I haven't got them to hand but we could provide a note on that.<sup>1</sup>

**Q85 Austin Mitchell:** Just one further question. How far is it really a case that the Department has been pussyfooting with the doctors because it doesn't want to enforce anything on them—in a sense it's nervous of them—and it's left all of the dirty work to the primary care trusts?

**Richard Douglas:** I don't think the Department has been pussyfooting with doctors and leaving hard work to other people. I think, clearly, if we want the medical profession to work with us, we've got to work with them. It's not an issue of pussyfooting; it's about having a proper working relationship with people.

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<sup>1</sup> Ev 18

**Q86 Austin Mitchell:** So that would account for the fact that you didn't include these kind of improvements in the contract until 2009.

**Richard Douglas:** As I say, looking at this, I think, we should have made sure that we fully aligned what we were looking for in the GP contract and what we were looking for on health inequalities. But we were trying to achieve lots of different things with the GP contract as well, so it's getting the balance. I don't think it's got anything to do with pussyfooting.

**Chair:** Nick.

**Q87 Nick Smith:** Thank you, Chair. I want to return to this issue of GP contracts and where we go in the future, on the basis that people will do what you pay them to do. I just want to be absolutely clear that, for the future, you're going to emphasise smoking cessation and reducing blood pressure and cholesterol in the next GP contract for deprived areas.

**Richard Douglas:** I can't be precise now about what will be included in the detail of the next GP contract. That's a matter for negotiation.

**Q88 Chair:** Are they there? You're obviously negotiating, but I don't see why you can't tell the Committee whether those are priorities on the basis of the style of your negotiation.

**Chris Heaton-Harris:** Or maybe Mr Davies can tell us how his team is influencing any debate, and whether they're having a cross-departmental conversation?

**Mark Davies:** It is a cross-departmental conversation. Thank you for raising it. We work very, very closely with the primary care team. We work very closely with other people responsible for other aspects of the NHS, including, for example, the team that led on the commission policy, so the world class commissioning policy that currently applies to primary care trusts has in it a measure about tackling health inequalities locally.

**Q89 Chair:** Is it there?

**Mark Davies:** It is there, yes.

**Q90 Chair:** In the negotiation on the GP contract?

**Mark Davies:** No, sorry, this is about world-class commissioning.

**Q91 Chair:** But is it there, on the agenda, in your negotiation with GPs?

**Mark Davies:** Well, the negotiations will take place at a national level, and if we say things here we might—

**Q92 Chair:** Is it there, on the national level? It just needs a simple yes or no.

**Mark Davies:** Well, what I would say is, the Secretary of State has made very clear his commitment to tackling health inequalities.

**Q93 Chair:** So yes or no?

**Mark Davies:** He has said, in the White Paper, that he will hold the NHS Commissioning Board to account for tackling inequalities in the outcomes of health care. It is quite clear that the primary care—

**Q94 Chair:** Yes or no? Sorry to keep asking, but it's either there or it's not there.

**Mark Davies:** I'm afraid I can't pre-empt what the Secretary of State will want to say following the consultation.

**Q95 Chair:** You've told the Committee you've embarked on these negotiations. Is this an area which is in those negotiations?

**Chris Heaton-Harris:** Are you confident your team's views are being reflected by those negotiations?

**Mark Davies:** Absolutely right. What I would say is that, across the Department of Health, health inequalities as an issue, over the last three years, has become absolutely central to everything the Department does. So we have dealings in every part of the Department; everyone is now looking at doing—apart from anything else—proper equality impact assessments on the work that they do, and I would say that our connections and the way that we work with the primary care team—

**Q96 Chair:** Okay, I think we're not going to get a straight answer. Ian.

**Mark Davies:** That was an answer to your question.

**Q97 Ian Swales:** Can I just be very clear, because you were talking about health inequalities and health care inequalities when you were talking there. This is about life expectancy inequalities. Are you actually saying that the priorities have actually moved subtly, do you think, because this is a much more broad-based need?

**Mark Davies:** Exactly. Our target has been around life expectancy, and we know that life expectancy is but one element of health inequalities, so I think the ambition is set out in the White Paper not only to tackle inequalities in health care outcomes—and that, I think, means more than life expectancy—but to make the Department of Health a Department for public health, health inequalities and social care, because they're central to the Secretary of State's ambitions for the Department of Health. So I think it does move on from just life expectancy.

**Q98 Chair:** I'm going to move us on to the future a little bit, which is what we've started talking about. As I think you've gathered from this Committee, I don't think there's a soul in the world who wants health inequalities to widen, so do you think the new arrangements that are now being proposed will widen or narrow health inequalities?

**Richard Douglas:** They provide the opportunity to narrow health inequalities.

**Q99 Chair:** How?

**Richard Douglas:** If you look at the overall structure that's been set up, and the features of it that are really relevant, there will be this transparent outcomes

14 September 2010 Department of Health

framework by which the Secretary of State will hold the NHS Commissioning Board to account, and that will include reduction in inequalities as a central feature. There will be a duty on the new NHS Commissioning Board to promote equality and reduce health care inequalities. There will then be responsibility under that for them to align their incentives, their approach to the allocation of resources, as we discussed just now, to contracts around these duties around reducing healthcare inequalities. On top of that, resources for commissioning care will be placed in the hands of GP consortia, and I think, as people have said already around the table, that GPs are actually central to this agenda. They know their local areas and the things that will influence locally. I think on top of that, looking down the NHS side, we will be creating a new public health service that will focus on health improvement. Within that, we will have a ring-fenced budget that is allocated to local government to take on the responsibilities that PCTs currently have for local health improvement. That will sit under the control of a director of public health within local government and will help—as we all know in this—to bring together different determinants of health and health inequalities. By having the money within local government, with a director of public health being responsible for it, it allows us to look across the piece at health inequalities. Finally—all this, of course, is subject to consultation and legislation—we’re establishing health and well-being boards at a local level, which will be run from local government, and there will then be the opportunity to scrutinise both what the NHS is doing to help reduce health inequalities, and how the new public health service responds to that. The structure is set up in that way.

**Q100 Mrs McGuire:** I just want to tie something that you’ve said back to the conversation we’ve just had about GP practices and the new approach on GP consortia. If we’re starting from a position where the least deprived areas have significantly more general practitioners, what confidence can you give the Committee that the new, devolved responsibilities to GPs are going to recognise some of the issues that we have been discussing this morning? If you’re already starting from a base where we have major difficulties in terms of enticing GPs into the most deprived areas, how are they going to commission the services that are needed to deal with health inequalities?

**Richard Douglas:** I’ll say a few words about that, but then I’ll invite Ruth to come in so that she can maybe talk about her local area and how this is developing. The first thing is that the NHS Commissioning Board will have a responsibility to establish the system and to set up the consortia in a way that supports the reduction of health inequality. That responsibility will sit very firmly with an NHS Commissioning Board, which will hold the consortia to account. It will be its responsibility, within the overall amount of resources given, to allocate those resources in such a way that it meets the Government’s objectives. But Ruth, I’m not sure whether from your local area you can add to that?

**Dr Hussey:** Just to add the importance of local understanding of the health problems of any given community, the proposals that are out to consultation include the establishment of health and well-being boards. My understanding is that there would be an expectation they would produce strategic needs assessments, and there would be a mechanism for the GP commissioning function to be part of the decision making to meet the needs of the local community. I think what’s important is that, in some areas, cardiovascular disease mortality is coming down very well, and it’s really being focused on, whereas we know there might be other new threats to health that are emerging that need new attention: for example, in the lifestyle area, alcohol and the harm related to that. So the JSNA—joint strategic needs assessment—process enables the conversation locally to say, “What are the health problems that needs attention,” and that would enable, if the proposals were followed through, that local decision making.

**Q101 Mrs McGuire:** I don’t know whether I have explained myself properly. You’re starting from a base where, as Ian’s said, he has probably less than half the national average of GPs in his patch, and we’re going to encourage a voluntary coming together of GPs. Under the current system, we have not been able to encourage, force, entice, cajole, or pay GPs to move into the areas that are most deprived. How are these new voluntary consortia going to be encouraged, forced or cajoled to recognise that it’s not all nice patients that come to them with conditions that can be managed? There are some really difficult challenges out there. If we don’t encourage a crossing of the boundaries, so to speak, in terms of health inequalities under the current system, how are we going to do it under the new system when we are devolving so much responsibility to GP consortia? Like will probably associate with like. This isn’t Dr Finlay we’re talking about here.

**Richard Douglas:** I think the key thing on this is that although the GP consortia would be responsible for commissioning, the commissioning of primary medical care will be the responsibility of the Commissioning Board itself, so the board itself will need to establish the appropriate distribution of GPs and practices around the country. That won’t be a matter for the consortia; that will be a matter for the Commissioning Board itself.

**Q102 Stephen Barclay:** Page 30 of the Report says that “many Spearhead PCTs do not receive their full needs-based funding allocations”, and I think this is the point that Anne is raising. By what date do you expect that finding to be addressed? In other words, when will those areas receive their full needs-based funding allocations?

**Richard Douglas:** I couldn’t say until the decisions are made following the spending review and the next allocation round. In November or December, we will announce allocations for PCTs.

**Q103 Chair:** You must be planning this. Are we talking about one spending review period or two spending review periods?

**Richard Douglas:** If I was to say that everybody would get to exactly zero—no distance from target whatsoever—that has never happened in the history of resource allocation in the NHS, and the system has been going for an awfully long time. That is partly because during the period in which you allocate, populations change, and elements of the formula change that can shift people up and down. I'm clear that we will aim to get people as close to target as we reasonably can, but it will depend on the amount of money that goes into other allocations.

**Q104 Stephen Barclay:** That comes back to this urgency point, doesn't it, because paragraph 3.9 said that actually in 2009 it went the wrong way, so the "application of a new funding formula in 2009–10 resulted in some Spearhead PCTs falling further below their target allocations"? We have had all this delay while you were evidence gathering. We finally get the evidence, and then the funding actually goes away from some of those areas on which we were gathering the evidence.

**Richard Douglas:** Well, I don't think the allocations and distance of target are anything to do with urgency at all. That is a matter of choice as to how much money do you put into everyone across the whole system to allow them to maintain their services, and how quickly do you reach the target. It is not an urgency issue; it's a policy decision that is made at a point in time.

**Q105 Ian Swales:** And it is urgent if you're not getting the money that you need, isn't it? That is the whole point of the formula.

**Richard Douglas:** It is urgent if you're not getting the money you need, but conversely you will see, also on that Spearhead group, that there are a number of Spearhead PCTs there that are over target. Some of them are over target by a very significant amount, and I don't think, of the under-targets, there is any one that is under by more than 6%; some of the overs are into their mid-teens. If you were to look at balancing, and say, "Well, we'll move all the Spearheads to target now," from some of those PCTs you would be reducing their funding by about 12%, 13% or 14% overnight.

**Q106 Nick Smith:** Given we think that the GP consortia probably aren't in the right place at the moment, how will you ensure that they play a part in tackling health inequalities in the future? And, secondly, on the issue of prevention, how can you make sure you spend more money on prevention? At the moment, it is only 4%.

**Richard Douglas:** Okay. I mean, in terms of whether there is enough focus by GP practices on inequalities, apart from the overall issue of the outcomes framework, the outcome we'll expect from them—I think one of the big drivers of that focus—will be the establishment of health and well-being boards in local government, so to the extent that

health and well-being boards, as Ruth said, will lead on joint needs assessments across an area, I think it is important.

**Nick Smith:** Because it is someone else.

**Richard Douglas:** Because what you're doing is you're bringing together local government and GPs.

**Q107 Nick Smith:** I'm asking you a question about one organisation, and what you're saying is actually that someone else is going to do it.

**Richard Douglas:** No, I'm not. I think what I'm saying is, if you have health and well-being boards that will scrutinise the plans of GP consortia—they will be held to account locally for what they deliver—generally there will be a greater focus on health inequalities from local government than I think most GPs have seen in the past. If they are held to account by a body within local government that will be headed up by a director of public health, there is more scrutiny.

**Q108 Chair:** But they are not answerable. The GPs will not be answerable.

**Richard Douglas:** On the consultation around the health and well-being boards, what we have made clear is that the health and well-being boards will lead on the JSNA.

**Q109 Chair:** GPs will not be accountable to a health and well-being board run by local government.

**Richard Douglas:** What you will have is the health and well-being board will scrutinise consortia commissioning plans, so they will have a responsibility for looking at the commissioning plans and commenting on them.

**Q110 Chair:** Can they sack a GP?

**Richard Douglas:** They won't be able to sack a GP, no, but that is not the only way—your ability to dismiss—of holding someone to account, I suggest.

**Q111 Chair:** Who do I go to in my constituency under this great new set of arrangements? Who is accountable? Do I need to go to 10 people to find somebody accountable for not reducing health inequalities?

**Richard Douglas:** You would go to your health and well-being board and you would look to your GP consortium. You would look to those.

**Q112 Chair:** So the health and well-being board can be sacked if things get worse? Are they the ones who get sacked? Sacking is the extreme, but who is it who is actually accountable?

**Richard Douglas:** Well, in terms of local democratic legitimacy, it will be the health and well-being board.

**Q113 Chair:** But the money comes from the NHS, through this agency—the Commissioning Board—to the GP. The local health and well-being board has absolutely zero control over that.

**Richard Douglas:** It will be able to scrutinise the commissioning plans of GPs. It will have responsibility to do that.



14 September 2010 Department of Health

**Chair:** It has zero control. You're setting up a whole structure, and at the end of it our successors are going to be sitting here in five years' time and it's going to be totally unclear whose responsibility this is.

**Q114 Mr Bacon:** Mr Douglas, you say it will be able to scrutinise them; I accept that what you say is true. Once it has scrutinised them, what does it then do?

**Richard Douglas:** It will be able to influence—

**Mr Bacon:** How?

**Richard Douglas:** Well, partly, if it has concerns, by making those concerns clear to the consortia, and talking with the consortia about change; and partly by making that public, so that there will be a local public debate around this. It's trying to put this, and the responsibility, closer to local people and closer to local government.

**Q115 Mrs McGuire:** Have you ever tried to deal with a GP that is causing a problem? The answer to that is no? Or yes, and you have failed?

**Richard Douglas:** Not in my official life.

**Mrs McGuire:** Right, okay.

**Richard Douglas:** Sorry, there were two parts to your question; I've forgotten the second.

**Q116 Nick Smith:** The second question was about spending more money on prevention; at the moment it's only 4%. Are you going to do more?

**Richard Douglas:** What the Government are committed to is a ring-fenced public health budget that will, as I say for first time, provide ring-fenced money around public health. At the moment there isn't any protection for public health. There'll be a public health White Paper coming within the next couple of months with proposals around the public health service in that and about how the ring-fenced money would actually work. But this is a major shift from where we were before; public health money will be protected in a way that has never happened in the past.

**Q117 Chair:** Above 4%, or at 4%?

**Richard Douglas:** Well, we've got to decide at what level it is. The 4% number is a number that came from a report by Health England. It depends what you include on public health—there are lots of elements in there.

**Q118 Chair:** So what does that mean?

**Richard Douglas:** Well, what we would expect to do is to see public health spending at least protected.

**Q119 Chair:** So at least 4%?

**Richard Douglas:** If it was defined in exactly the same way as the Health England report that's been referred to.

**Chair:** Okay.

**Q120 Jackie Doyle-Price:** I just want to expand on this. Obviously 4% is a very low figure but, frankly, is actually spending more money on that the best way of achieving the outcome? Because it takes us back to where we are with the GPs. If you look at

those figures on page 36, where we see there are fewer GPs, we see that there are higher hospital attendances within these key areas but fewer visits to GPs. Ultimately, aren't we going back to exactly the same problem again? It's all very well looking at saying, "Well, we're not perhaps spending enough money on prevention," but is not that a sticking plaster for what is the real problem here: how do we incentivise GPs to go where we really need them?

**Richard Douglas:** It's both, and I'll bring in Ruth on this in a second. It is not just a matter of spending money on public health and prevention; it is also about improving access to services and improving NHS services. But you need to have both of these elements, and they operate on different time scales. A lot of prevention and public health operates on a far longer time scale to prevent those problems appearing in five, 10 or 15 years. The things that influence the target within a short period of time tend to be the interventions that the NHS does. But Ruth, you wanted to come in on that.

**Dr Hussey:** Several things. The first point is that the 4% figure, as Richard has explained, comes from a particular report. When we look at the spend locally, it's very variable. We're currently going through last year's spend to update our understanding of the range of spend on prevention of a defined set of services; it varies around the 4% figure—some below and a few slightly above that nearer 5%. So the first thing is that I don't think we should say the right answer is 4%. I think it depends, firstly, on what is deemed to be in the national public health service. I think that policy is still under development, and I would agree with the point that the whole of the NHS spend also needs to be mindful of what the NHS can do to address prevention. In every health contact that people have, there is an opportunity for prevention. Whether it is through primary care or even through hospital care, there is something that can be done to invest in the long-term improvement of the individual's health. I think I'm agreeing with the point that it is not just the public health service and the prevention spend. I think the issue is that a ring-fenced budget enables that commitment to the longer term. The payback on some things is reasonably quick, while on other things it takes a few years to get the return and impact on health improvement. I think that's where the idea comes in that protecting some resources for that longer period would be helpful. I think a lot of policy work is under way at the moment to enable an informed proposal through the White Paper on public health, which I think will be later this year.

**Q121 Matthew Hancock:** Can I just pick up on this point and probe a bit deeper, because I was struck by, in our earlier discussion, the conclusion from your evidence that there were three key interventions on smoking cessation, statins, and drugs to address cholesterol, and I was struck because two of those three are highly medical interventions into an area that is also dominated by lifestyle. I think we all appreciate that this is extremely complicated, and it ties in with the resources issues because lifestyle is a determinant of need. Do you think that this new

structuring of the public health budget will help the NHS, as an organisation, to ensure that every health intervention has a lifestyle-enhancing impact, as well as reaching simply for the shorter-term medicinal responses to these complex problems?

**Dr Hussey:** My understanding is that the statements that have been made so far—it is all out to consultation, obviously—are that health outcomes will be key and health inequalities will be key, and so the follow-on from that would be to address some of those things that are underpinning it. So my expectation is that that will work through as the proposals are further developed.

**Richard Douglas:** And those three interventions are variable, but if you think in terms of the PSA target, they are things that operate on quite a short time scale, so within a 2010 target. Some of the others actually go out a lot further.

**Q122 Matthew Hancock:** But they are sort of sticking a finger in the dyke really, aren't they? They are short-term interventions that don't address the long-term underlying problem, so do you think the new system will be better at addressing those underlying sort of problems?

**Richard Douglas:** Well, as we are now trying to design it, yes, because it will provide that protection for health improvement moneys, which is about the longer term. The only danger always on this is that if you ring-fence money, does it make it different and does it make it separate? Do people think that, in Ruth's comments, it should no longer be part of everything you do because it's a ring-fenced pot? That is the thing we have to guard against.

**Q123 Ian Swales:** I just have a question about how in touch with the ground your organisation is, in terms of prevention. I'm referring to figure 18 in the Report which shows that you spend the most money on the least successful way of people stopping smoking, which doesn't surprise me because I know locally that things like groups about smoking cessation, which is the one at the top of the list, male weight management groups and so on, which our local PCT started doing, are an enormous success. They just happen in community organisations, like the hall that I happen to be on the committee of. And these are very simple things that cost very little money and have a big impact. How good is your research base, and how much is the prevention agenda well targeted, would you say?

**Richard Douglas:** Could I ask Ruth to come in on this because it is one that we discussed earlier and Ruth's got some views from the north-west?

**Dr Hussey:** I think what we're trying to embed in the way that we approach some of these behaviour change services, if we could call them that, is an understanding of what local people want in terms of support for those behaviours, and we've a number of examples now where, by doing proper social marketing work with local communities and understanding their needs, people have recommissioned the whole way in which they delivered services. I think you've got a balance then between saying, "The best evidence-based approach

is this particular method," but actually what we are hearing from the local community is they value the drop-in service. I can think of one PCT where people wanted local drop-in centres; that was how they wanted to engage with the service. By listening to that, that particular service actually had a dramatic impact: an improvement in the use of smoking cessation, in this case. So I think it is a balance between how to engage people best, and then try to encourage people to use the better methods.

**Q124 Ian Swales:** Sorry, just a supplementary on that. Psychologically, I can well imagine that a lot of people like to have a one-to-one chat. It will not necessarily get them to stop smoking, but they will say they like it for sure. The most effective way is closed groups—it says so in this evidence here. So you have to be pushing this agenda as well as just responding, don't you?

**Dr Hussey:** Absolutely, and what we've been doing is making sure people are listening to local people in terms of what they are saying, trying to drive value for money in the smoking services, and we've driven down the spend per head in the region by 8% in the previous year. So, we are conscious that these services have to work, and have to work in the way that has the most impact. The other thing we've been doing is trying to drive up actual recruitment into the services, and that's where we've been successful because we've listened to people, so we are getting people into the services. Sometimes there isn't a single method; sometimes people come through again. Not everybody wants a structured programme, but you're absolutely right: if that is known to be the best evidence base, there's a balance between pushing that as the only offer that you make to people against what would suit them best to engage with the service. I think that's a local debate, but I'm very mindful that, overall, what we have to do is drive improvement in the overall package of services that we're offering, in terms of value for money. One of the areas I'm encouraging, again locally, is to say, "Well, let's look at not just smoking cessation; let's look at a number of lifestyle factors, because sometimes they're interconnected within people's lives, and can we do better integrating some of those wellness services in a different way?" People are really very clear that, while we could argue for more and more investment—and clearly we would, given the scale of health challenges—we are also very clear that we must drive a better, tailored package of support to individuals and communities, and that it is best value for money.

**Chair:** Austin then Chris, and then I think we're almost drawing to a close.

**Q125 Austin Mitchell:** I think the Chair is right that we have a worrying situation here—says he unctuously. Let us take the situation in North East Lincolnshire, where we have, as I said earlier, a very good primary care trust plus—it is very good. It has done significantly worse than average, both for England and for Yorkshire, which is a fairly heavy drinking area, on smoking, healthy eating, and obesity. It has performed better, just, than the

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14 September 2010 Department of Health

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regional average on binge drinking, which could be due to the fact that as I get older, there are fewer groups standing around in pubs saying, "Let's have another toast to our MP!" But it is locally rooted, and it's very energetic. Now, I note that in the Report, paragraph 3.14—that is page 32—says that while practice-based commissioning was introduced in 2004: "Few services that aim to prevent ill health have been commissioned using practice-based commissioning." We've got a good primary care trust and we have that power for GPs. Now we are transferring the whole business of commissioning to the GPs who will not have the same imperatives as the primary care trust, supervised by a national board that has not got the local knowledge, the local power, or the local initiative—it won't be able to fire or suspend GPs as our primary care trust has done from time to time when doubts about its effectiveness have been raised—and has got to be looking at the whole national picture. It is not going to be able to push things along in the way the primary care trust has done in our area. It is a worrying situation, isn't it?

**Richard Douglas:** Well, I think there are two or three elements to this. One is that the Commissioning Board will be able to hold consortia to account. Now, you're absolutely right that they won't have the detailed—

**Austin Mitchell:** The consortia are interested in cash.

**Richard Douglas:** They won't have the detailed local knowledge that the PCT has. But that detailed local knowledge will be there in the local authority. It will be there with the director of public health.

**Q126 Austin Mitchell:** But he hasn't got powers.

**Richard Douglas:** But what they have got the power to do is look at the commissioning plans of GPs. The other element, and we talked here about a few incentives around prevention—

**Q127 Chair:** It's a bit like PAC Reports; we can scrutinise until the cows come home, but actually we don't have the power to hire or fire. It is exactly like us. So what, we scrutinise, we do a Report. How often are the recommendations followed? I had a session with somebody yesterday who said not one of the recommendations in a PAC Report had been implemented.

**Richard Douglas:** Well, I wouldn't want to comment more widely, but I think all the ones you recommend for us we do implement. On this, I think the other element is the talks here about incentives around services that aim to prevent ill health. One of the purposes of pulling out this health improvement budget from PCTs and rooting it into local government is to provide that degree of protection, and also what I should have said on this is that that will be targeted at those areas of greatest need. So when we look at the allocation of the money around the local health improvement budgets, there will be a health premium that targets the areas of greatest need.

**Austin Mitchell:** The target hasn't worked effectively up until now; we've still got less money in North East Lincolnshire than the targets.

**Q128 Chris Heaton-Harris:** I have to say that Dr Hussey has given me some kind of confidence that, on the ground, there are some quite good things happening, and things seem to be moving forward in the right direction. I'm pleased that Mr Davies has got a Department that's looking at this, but I'm slightly concerned that, while you've acknowledged that there is a problem in the Department on how it failed to meet the target in the past, you haven't actually explained to us why that happened and what has actually changed to make sure these things don't happen in the future. I'm not particularly convinced that you've told us how you'll ensure that GPs take responsibility for their target in the future in this particularly needy group, and I'd like to think we're all gradually learning the lessons of the past, but I wonder if you could address those points. I'm equally interested in how, in the future management structure of your Department, best practice will flow across, and this information will feed up.

**Richard Douglas:** Okay. Just in terms of what we've changed, and just some of the lessons we have learned from this, if I go back five or six years ago, the Department was quite siloed in its organisation. You would have lots of little strands doing different things, and they did not fully come together. We pretty fundamentally changed the structure of the Department and the way that it operates now. We have fewer separate blocks, we have a departmental board that properly brings all of these different things together at a senior level. I think the silo structure of the Department has changed, and that has been critical in looking at how you align a whole set of incentives where people are doing different things around pay, allocations and price setting—how you make sure that thread runs all the way through. I think that structural change has happened. In terms of what else has changed, I guess we've learnt around the dissemination lessons that have come up from Ruth and people. It is the use of NICE guidance around public health interventions, which wasn't there in the past. So we have got that there within NICE. I think the other is to give people the sort of practical toolkits—I hate the term "toolkits" and people generally don't like it—but something practical that people can use that you can say, "If I do this, this will happen, it will save this number of lives." Now, I think it is when you actually do that, and get away from saying, "We have a change in the percentage gap of 3.5% to 3.6%," and you say, "How many lives will we save in this area," that's the type of thing that makes the difference, and I think that's what we've learnt. In terms of the new system, what we're clearly doing is trying to structure that around outcomes with inequalities issues built into all of those, and this protection of the long-term health improvement budget. Sorry, that was quite a long answer, but I was trying to pick up on all the issues.

**Q129 Mr Bacon:** I just wondered, Doctor, you're the Regional Director for NHS North West. That is the SHA basically, is it?

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14 September 2010 Department of Health

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**Dr Hussey:** Yes. The way the regional posts are constructed, they cover the Department of Health in the region and also the NHS bodies—the Strategic Health Authorities.

**Q130 Mr Bacon:** So you are Department of Health North West as well?

**Dr Hussey:** A bit of both.

**Q131 Mr Bacon:** What's your salary?

**Dr Hussey:** Gosh. I think it is £170,000.

**Mr Bacon:** You think? Most people know what their salary is.

**Austin Mitchell:** It's the politics of envy.

**Mr Bacon:** It's not the politics of envy, I just would like to know, because there are a lot of people in the health service, in what one would call the netherworlds—except they're higher up—between GPs and hospitals and the Secretary of State in the Chamber next door, who seem to get paid a great deal of money. There are a lot of them, and it is an area I'm interested in and don't know a lot about. How much are you paid? What is your salary?

**Dr Hussey:** I think I've answered.

**Q132 Mr Bacon:** You think it is £170,000? You just sounded a bit unsure.

**Dr Hussey:** I'd need notice to check to the actual pound.

**Q133 Mr Bacon:** In the region of £170,000?

**Dr Hussey:** Yes.

**Q134 Mr Bacon:** Thank you. Mr Douglas, what's your salary?

**Richard Douglas:** £140,000.

**Q135 Mr Bacon:** £140,000. And Mr Davies, what's your salary?

**Mark Davies:** £90,000.

**Mr Bacon:** £90,000. Great. Thank you very much.

**Q136 Chair:** Okay, well thank you for this session. I think my conclusion out of it is, I think we do know what works, although it might have taken us 13 years to get there. I certainly think, and some feel, that the NICE guidelines being implemented—people having to do them—would be helpful. The final thing I say is: how are you going to know it's better, and when?

**Richard Douglas:** The how will be that you will see a turnaround in that gap, and you will start to see a narrowing of health inequalities. That is the only way we'll see how it's achieved.

**Q137 Chair:** And who in the end is accountable?

**Richard Douglas:** The Secretary of State and his Department will be accountable for that.

**Chair:** Okay, thanks very much indeed. Thanks for your time.

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#### Supplementary memorandum from the Department of Health

Q84 Austin Mitchell: *That's true, but it doesn't come into effect until 2011. Can you supply us with statistics on the incidence of single-doctor practices in the deprived areas?*

Answer: At March 2010, there were 371 single-handed GP practices in the quintile of most deprived areas based on the Index of Multiple Deprivation. Single-handed GP practices represent 22% of practices in the most deprived areas. The number of single-handed GP practices in the most deprived areas has fallen over the past five years: at March 2006, the number stood at 567, representing 34% of practices.

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