



Health Committee

Oral evidence: [Work of NHS England](#), HC 1219

Tuesday 29th April 2014

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Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; Charlotte Leslie; Andrew Percy; Mr Virendra Sharma; David Tredinnick; Valerie Vaz;
Dr Sarah Wollaston

Questions 1-139

Witness: **Simon Stevens**, Chief Executive Officer, NHS England gave evidence.

Q1 Chair: Let me begin by welcoming you to your first session with this Committee as chief executive. Your predecessor was a regular visitor and I suspect you may be as well, but you are extremely welcome. Before we get into the substantive policy questions, could I begin by asking a personal question which relates to crowd sourcing that some of my colleagues have done on questions that they would like to hear put to the new chief executive of NHS England? It relates to your previous personal financial interests with American Healthcare and whether any of those have been retained in any form.

Simon Stevens: The answer to that is none whatsoever. It is seven years since I last worked for that organisation in this country, and I was clear at the time I was appointed I would have no business dealings with them for at least the next year. That is the position that has been agreed formally with the board of NHS England.

Chair: Thank you. Does anyone want to pursue that?

Q2 Dr Wollaston: When you say “at least the next year,” does that imply that there would be in the future?

Simon Stevens: The board will have to review that going forward. I am more than happy to be bound by whatever they decide.

Q3 Chair: In terms of the role you fulfil as chief executive of NHS England, your predecessor was regularly referred to, till the day he left, as chief executive of the NHS, which is a position he had previously held but did not hold, clearly, since the legislation

changed. I would be interested to hear your view about how your role differs from the historic role of the chief executive of the NHS and whether you think the institutional arrangements of NHS England—what was originally called the Commissioning Board—reflect a commitment to commissioning that works or whether it needs to change.

Simon Stevens: I have inherited a system that has been designed by yourselves and colleagues, and as the chief executive of NHS England I am responsible for discharging the duties that are laid by Parliament on NHS England specifically. At the highest level of generality, that is to promote a comprehensive health service for England but also to specifically discharge responsibilities by ensuring that the money that Parliament votes for the National Health Service is being spent well, either directly through our direct commissioning responsibilities or through the clinical commissioning groups that control two thirds of the spending that flows through the NHS vote. So there clearly is a commissioning responsibility, which in English really means the planning and funding of care, but over and above that I think we do have a wider shared responsibility for ensuring that the NHS works and that the arrangements that have been set up are more than the sum of their parts.

Q4 Chair: You describe it as a wider responsibility to make sure that the NHS works. That goes significantly beyond the description others would provide of a commissioner function. I wonder how you see your role—whether it is through the CCGs or as a commissioning authority in your own right—and how far into the management and the issues facing the provider management you feel it is right for you to go.

Simon Stevens: I think this is going to be a team effort, so clearly we are—and I personally am—going to work closely with the hospital systems in the forms of Monitor and the Trust Development Authority. We have a shared responsibility with the Care Quality Commission around the safety and the quality of care that is being discharged. This is a shared leadership responsibility that exists across the National Health Service, recognising that each body also has a distinctive role to play in addition to that partnership role.

Q5 Chair: But given that you said in the speech you made on the day you were appointed that there is a compelling need facing the health care system to change the way care is delivered—

Simon Stevens: Yes.

Chair: —is that a responsibility that rests primarily on you as commissioners or primarily on the providers to bring you solutions?

Simon Stevens: Let me be practical about how I would answer that question. We know that there is a lot that has to change about the National Health Service over the next five years or so, and for that to happen we have to have a series of very focused conversations in different parts of the country about what that is going to mean for primary care services, social services and hospitals. That is not a conversation that NHS England can have in isolation from the other partners involved. We are going to have to have that conversation very closely with GPs, hospitals, voluntary organisations, social care and the public in each of those geographies to map out a sustainable course for the NHS.

Q6 Chair: When people say there is a requirement for a system leader, your answer would be, yes, that is NHS England.

Simon Stevens: My answer would be that there is a requirement for system leadership at every level. Certainly, I personally—and we as an organisation—will play a central part in that, but I think the system as designed is also intended to give patients themselves at a local level much more clout in the way that services are organised and to create more clinical leadership, which is why all the effort was put into creating the 211 clinical commissioning groups with strong GP and other clinical leadership there as well. In an organisation as big and complex as the National Health Service, I do not think you can say that any one organisation, let alone one person, is solely responsible for guiding the direction. There has to be a shared commitment. But do I have personal responsibility for wanting to get us to a place where the NHS prospers and is sustainable? I certainly shoulder that responsibility very clearly.

Q7 Valerie Vaz: And we say, yes, you do. Someone has to be in charge. There has to be a named person to do that. I was interested to hear what you said. By the way, welcome.

Simon Stevens: Thank you.

Valerie Vaz: We are not as bad as people say we are, but the public like us and they like us to ask very intense questions, because, after all, this is public money that we are looking at and we want an efficient service. You mentioned that you inherited the system, but you have gone on record as saying you really like the Health and Social Care Act, have you not?

Simon Stevens: I said that I think the idea that front-line doctors and nurses should have more clout inside the National Health Service is a good thing. The idea that patients' preferences and needs should shape the way care is delivered is a good thing, and I think the idea of trying to put some operational daylight between the day-to-day running of the National Health Service and the Department of Health itself is a good thing. To the extent that we are able to deliver that, that will be beneficial.

Q8 Valerie Vaz: That is the theory. You have now come in—I know it has been a very short time—and you have seen the practice. What do you think about the Health and Social Care Act and how it is working with all those three parameters that you have mentioned?

Simon Stevens: If you start with the CCGs—and I know the Committee has taken a thorough look at this question in the past as well—just talking to a number of my friends who are GPs around the country, some of whom I would describe as “glass half full” types, I have been surprised that, generally speaking, they have been more enthusiastic about the CCGs than they were about the primary care trusts that preceded them. There is a sense of a possibility to really drive change in a way that was not there before, and, to tell the truth, I was personally a bit surprised about that. I thought there might have been a sense that this was just a change of headed notepaper with enormous disruption on the back of it. So I think there is potentially an opportunity—which is not there across the

board—for CCGs to drive change. I do not think we have, frankly, got that completely right just yet.

In answer to your question about the current state of play, CCGs probably will do well when they can have more responsibility for some of the primary care services in their area. I think we are going to need to make some changes around the way specialist commissioning for specialist services is done as well so that we have that population focus rather than a three-way split in the local resourcing between the primary care services, local hospital services and specialist hospital services. Part of what I am doing now in my first few weeks is just working out how we can evolve the system a bit to get some of that in place.

Q9 Valerie Vaz: But obviously you have looked at it before because you have made comments that it was a good idea at the time. Can I suggest to you very gently—it may be that it is your friends’ views, but obviously we hear different things in our constituencies—that you do go wider than just your immediate friends about what is actually happening with the service, and go down to patient level and user level when you do that? You touched on the specialist commissioning. Could you just say what is happening to the budget with the specialist commissioning?

Simon Stevens: Yes, I certainly will. But to answer your first point, I completely agree, and that is why I spent my first day out and about talking to patients up in Tyneside. I have been in Wakefield since then talking to patients and GPs, who were not my friends but they are now; I will be in Birmingham tomorrow doing the same, obviously London as well, and I will be in Bristol shortly. I am going around the country using this first period of time to really get myself listening to people who are what I would describe as highly supportive of the National Health Service but also some of our biggest critics. Part of what needs to happen across the health service in general is that we have to get better at listening; I am trying to do that myself and it is how I am spending my time.

As to your specialist commissioning question, part of the issue is that the way specialist commissioning was established was probably an over-extensive view of what should be defined as specialist. Some things in that category could arguably be commissioned more locally, and so one of the things we have to look at is how we do that. We also have to do that in the context of a strategy for how we think specialist services should develop across England. Work is under way on that, but it is still at an early stage.

Q10 Valerie Vaz: In terms of the budget, where are we on that—overspent, underspent?

Simon Stevens: The budget for last year, as I understand it, was overspent, and part of the reason for that—

Q11 Valerie Vaz: By how much, could you state for the record?

Simon Stevens: I think it was around £400 million.

Q12 Valerie Vaz: £460 million I think the figure is. Anyway—

Simon Stevens: No, I do not think it is £460 million. We will report our best estimate for the 2013-14 out-turn position at the NHS England board meeting on 15 May. I think, relative to expectations, it is nearer to £400 million. Part of the issue was that, because what was defined as specialist commissioning was different from April 2013 than what had gone before it, the actual process of separating from the old primary care trust budgets which part of it is specialist and which is not was hard to do, as I understand it, on day one. So there was, in effect, a misclassification of spending between those two responsibilities going forward as to what would be NHS England versus what would be the CCGs. That was part of the issue. But I think there are a number of other issues going on there as well and this is one of my early priorities to sort out.

Q13 Valerie Vaz: Just to pick up what you said about listening, it is very good to listen but it is also important to respond to what people are saying.

Simon Stevens: Yes.

Q14 Valerie Vaz: There are some concerns, say, for example, from Macmillan or various other groups, that you do the specialist commissioning and the CCGs do the rest of the care. Do you see some sort of conflict in how people respond to the specialist commissioning from NHS England and the local NHS care? Are there things to be ironed out there?

Simon Stevens: As I said, I think there are, and for some of what is currently defined as specialist it would make more sense to do that closer to what the clinical commissioning groups are doing locally. For some parts of it as well we need, in the jargon, to look at what the care pathway is so that we are not just buying, for example, bariatric surgery for people with severe obesity independent of the question about whether we could be doing more to help people stay at a healthy weight in the first place and various points along the way. We have to rethink some of that. Having said that, quite clearly there are some very specialist conditions where you do have to plan on a much broader population base than you can do with a local area. It is entirely right, therefore, that we involve 75 different groups of clinical experts across the country in helping us shape what those services should look like.

Q15 Valerie Vaz: You will be pleased to know there is some secondary legislation that has just come out whereby local NHS England groups are working together with CCGs. Apparently that was not in the Act before.

I have a final question before other colleagues come in. Do you know why you overspent on the specialist commissioning budget?

Simon Stevens: I think, for the reasons I just set out, it was in part because the original split of responsibilities between CCGs and the specialist commissioning budget was hard to get right, in part because the scope of services is probably too great, and in part because the information flows to support some of the management that you would expect were not in place at the start of the last financial year.

Valerie Vaz: Thank you.

Q16 Dr Wollaston: On that point, looking at the impact of that within my local CCG, they suddenly found, in year, that they had £4.5 million taken away within a financial year. It was completely unexpected, and that has had quite devastating knock-on effects on the other things that they wanted to be able to do. Can you reassure CCGs that that is not going to happen again—that, in year, they are going to suddenly find that the specialist commissioning overspend trumps what they are doing?

Simon Stevens: I would answer that in two parts. I don't think there is going to be a re-re-baselining of CCG versus specialist commissioning budgets in 2014-15 in the way that there was in 2013-14 to try and get it right.

Q17 Dr Wollaston: I am sorry, but do you mean they are going to stick at what they are this year or are they going to go back to what they were originally?

Simon Stevens: They absolutely are not going to go back to what they were originally, because the truth is that this hospital activity has and is being delivered for people living in the area of your CCG. One of the underlying questions that have to be solved here is that, at a time when the NHS budget is only just growing in real terms and yet specialist commissioning activity is growing by perhaps 5% or 6% last year, it is a circle that is going to have to be squared.

Q18 Dr Wollaston: But, equally, the CCGs' expenses are growing by a significant amount as well, are they not?

Simon Stevens: Not by 6%. Whether that is the right choice for the NHS to make is a decision that I increasingly want to share with CCGs rather than taken in isolation from them.

Q19 Dr Wollaston: Can you give them some reassurance that next year it is not going to happen again that they are going to suddenly find, in year, that there will be a clawback of money that they were not expecting?

Simon Stevens: I am four weeks in, and this is right at the top of my agenda to get a good fix on what is going on. I obviously don't want to put CCGs in that position, but I have some further due diligence to undertake before being able to set out completely what the arrangements for specialist commissioning will need to be going forward.

Q20 Dr Wollaston: Will you move to a longer cycle so that they are not having to plan yearly cycles? Will they be able to move towards having three-yearly financial planning?

Simon Stevens: The CCGs?

Dr Wollaston: Yes.

Simon Stevens: CCGs have been set allocations for two years, 2014-15 and 2015-16, but obviously we cannot set an allocation for three years because Parliament has not voted us the resources that far ahead.

Q21 Rosie Cooper: Welcome to the Committee. The Committee recommended ring-fencing social care budgets locally and using health and wellbeing boards as the mechanism for integrated commissioning of health and social care. You have described the need for better ways of blending health and social care, learning from other health care systems. Can you describe what they might be and also the practical short-term improvements that you think you could envisage implementing to alleviate what are growing immediate and urgent pressures on health and social care?

Simon Stevens: Yes, and I think I also said I thought there was great benefit in those two funding pools working together. But, equally, putting two leaky buckets together does not make a watertight funding solution. So I entirely take your point about the pressures in adult social care as well as in the health service.

If you look at what has been happening to emergency hospital admissions, for example, over the last decade or so, you can see that there has been quite a large increase in the proportion of people admitted for a quite short period of time. In fact, I think the NAO estimated that over the last 15 years or so there had been a 124% increase in the number of people admitted as an emergency for just one or two days, and only 7% of that increase was explained by the fact that the population was getting older. That tells me that there is something not quite working right at the boundary between care at home and care in hospital, and that, equally, when frail, older people are admitted to hospital, often they find it being suggested to them that they move into a care home on discharge rather than going back to their own home. I think the question has to arise, “Is that because there is not appropriate support back at home?” About 90,000 older people a year are admitted from their own home to hospital as an emergency and then, on discharge from hospital, go into a care home. In many cases, that might be appropriate, but in some cases I suspect it is the absence of other alternatives that is driving that.

The point I was simply making, as I think the Committee has made in the past, is that for this group of frail, older people the system is not necessarily working terribly well right now and we have to change that.

Q22 Rosie Cooper: Absolutely, and perhaps at some point I might have half an hour of your time to talk about just that.

Returning to leaky buckets, I know you have not been in post very long, but have you actually read the document on which the case for transferring large sums of health service money to local authorities is based? I am told it is called “Local Government Association Whole Place Community Budgets: A Review of the Potential for Aggregation,” July 2013, done by Ernst & Young.

Simon Stevens: I confess that I might need to add that to my reading pile, but if this is the foundation for the thought behind the Better Care Fund, then obviously I am familiar with that.

Q23 Rosie Cooper: My next question—and perhaps you could just take it away—is, do you believe the evidence is sufficiently robust, given the reference to “leaky buckets,” and do you stand by the current plans in respect of the Better Care Fund? Do you really think this is where we are going to go?

Simon Stevens: Yes. Maybe I could even be so bold as to recommend one back for you that you may not have seen that is in a similar vein to perhaps the scepticism that you are exhibiting. It is a review by York University published last month looking at the published evidence internationally on whether integration schemes in this country and elsewhere do or do not have an impact on reducing hospital admissions. Frankly, the answer they came up with was that it is a pretty mixed picture, which is, in a way, being polite about it. It is pretty clear that there are all kinds of ways of doing these things that do not work. Having said that, I think it is also pretty obvious that there are ways of doing it that could indeed get it right. The example I just gave around the impact that the absence of home-based care is having on emergency admissions helps make that case. Likewise, if you look at the big differences between parts of the country in the emergency admission rate to hospital, you see that this is not explained purely by the health needs of the patients involved. Something else is going on there; there are some missing pieces to the jigsaw in some geographies.

So I do think it is a laudable goal to try and bring health and social care support, particularly for frail, older people, together in various ways, but I also think that the evidence shows that, if you try and do this without properly focusing effort on the people to whom it is going to make a real difference and you have not got baseline services in place such that you are just filling in individual gaps without looking at the totality, you may not have much of an impact. Therefore, I conclude that the Better Care Fund has to deal with some of those realities if it is going to be successful.

Q24 Rosie Cooper: Absolutely. Would you support carrying on with more transfers of money into the Better Care Fund, or would you try and consolidate the work that is going on the ground? I would actually invite you—it is not in my constituency, but I live in Liverpool and my father began what has amounted to nine months’ hard work for me—to look at Liverpool community health trust. That is where people are trying to muddle through. The TDA have just removed the chief exec and the chief nurse, and I understand that the HR director has resigned. It would be very valuable for that organisation if there was a mutual exchange. It would be really good if they heard your views on how they go forward and they told you how it really is on the ground. But would you still carry on putting more money into this without really trying to sort out best practice?

Simon Stevens: Unless you make a start, you are never going to learn the lessons you need to in order to answer the question that you have established. But, looking at 2015-16, there is going to be a further £1.9 billion transferred into the Better Care programme, so I think the onus is on everybody across the country—the health and wellbeing boards, the councils, the CCGs, the NHS England local teams and the acute hospitals—to make sure that the plans for that are robust and are likely to deliver.

Q25 Rosie Cooper: My final point is this. Do you believe health and wellbeing boards and your local area teams have the power to deliver what you hope they will deliver? In Clare Duggan, we have a superb chief exec, but in Lancashire we have one who is significantly less able. Either way, they do not have any power to make things happen. They have to try and persuade. With regard to health and wellbeing boards that do not have any real power and votes—they can write strategic needs assessments and do all of that, but they don't make the decisions—and local area teams which are your outposts, and you described earlier on in our conversation how you were going to be responsible and accountable, how does all that work when all those bits don't have power?

Simon Stevens: I think the health and wellbeing boards do have significant power in respect of the Better Care Fund programme and the sign-off for them. One of the things that I want to see or ensure during the course of the next month or so, as people take a hard look at the plans that have been produced, is that there is a credible set of assumptions about what that money is going to be used for. In particular, I would like to see local hospitals much more closely involved in the conversation about the extent to which those funds are going to help reduce emergency admissions, where that is in a patient's interest, next year.

Q26 Rosie Cooper: Thank you. Cheekily, can I ask if you will give an undertaking to go to Liverpool community health trust?

Simon Stevens: I would be delighted to. I am going to be in Manchester and Salford next week; I am not sure I will necessarily be able to go then. I realise Liverpool is an entirely different centre of excellence, which I look forward to visiting.

Chair: You will have to go back on another day.

Rosie Cooper: Thank you.

Q27 Barbara Keeley: I have a follow-on point about long-term conditions and I would also like to ask some questions about carers following on from the discussion we have just had.

In our inquiry into long-term conditions we were told that 70% of the NHS budget is spent on 30% of patients—those with long-term conditions. If we are to maintain a viable, comprehensive NHS service, surely spending that more effectively is almost the key issue because it is £70 billion out of the NHS budget. If I were to give you just one example—this is an example from Salford and I am pleased to hear you are going there next week—in the early stages of the Nicholson efficiency savings the then PCT axed a pilot of active case management. If anything was likely to contribute to the daily wellbeing of people with long-term conditions, it was that pilot, and yet that was considered to be an early win—"Let's cut that."

Some of those decisions, it seems to me, have not been very wise and have just been made in the rush to make those savings. Could you give us your first thoughts on that? Is that the key issue, and do you have any first thoughts on how to spend more effectively on long-term conditions?

Simon Stevens: Yes. I think your analysis is absolutely right. As you say, 70% or so certainly of hospital admissions and, on some calculations, the NHS budget overall was spent on the 30% of people with the highest needs. There are going to be various things we have to do in order to better help those people, one of which is making sure that the new GP contract, which has just gone into force this month, produces stronger support for the kind of folks that you are talking about. What the new GP contract says for this year, which is agreed with the medical profession, the GPs, is that the 800,000 people with the highest needs across the country are now going to get a personal care plan and easier access to a named GP and the kinds of case management and proactive support that perhaps was happening in that pilot that you described before.

Q28 Barbara Keeley: Until it was cut.

Simon Stevens: Right. That is going to be part of the answer. But it is not just going to be what GPs do. I think it frankly illustrates a broader point, which is that at the moment we have an artificially segmented set of supports for the people that you are describing. We have community nursing; we have GP services; we have social care; we have carers and voluntary organisations. Then, of course, there is the ambulance service and the A and E departments when things go wrong, and so on. The truth is that they are just not very joined up at all around the needs of the patients requiring that high-intensity support. Part of what we have to do is solve that.

Q29 Barbara Keeley: Let me come on to carers. You talk about “the amazing commitment of carers” in the same sentence as—I think we will come on to them later—voluntary organisations, and you were probably in post in Downing Street when the first carers’ strategy was produced in 1999.

Simon Stevens: Right.

Q30 Barbara Keeley: There is enormous pressure on carers now more than ever, with £2.7 billion gone out of the adult social care budget. Macmillan Cancer Support have looked at the carers of people with cancer, and they are an interesting example in that only one in 20 of them have a carer’s assessment but 70% of them have come into contact with health professionals, GPs and hospital doctors. This is a question I put to Ministers and we do not agree about it, but what plans do you have in NHS England for improving the extent to which we identify who are those carers and support them? Dumping the duty on to local authorities—it is my prediction that that is what the Care Bill does—is not going to work, because Macmillan have told us that 70% of carers are in contact with health professionals, but only 5% of them are really in contact with local authorities and having care assistance. So, in fact, the duty is not in the right place for where these developments are going. That is the first point. I have a couple more, but can you deal with that one first?

Simon Stevens: As you say, there are at least 6.5 million carers across the country doing a hugely demanding and important job. I am going to be meeting with some of the carers’ organisations next week to talk about exactly the question you pose, which is: how can NHS England support the work that they are doing both nationally and locally? I think that the glib but probably wrong answer to the question that you pose about how the NHS can

help is to suggest that GPs in some way are going to take on significant extra responsibilities here when GPs are already working incredibly hard under pressure. But there is, nevertheless, as Macmillan rightly point out, an issue about how the health service as a whole identifies that people are carers and then supports them. That is one of the questions I am going to be talking to the carers' organisations about next week.

Q31 Barbara Keeley: I have been putting in freedom of information requests to ask CCGs if they have carer strategies. Some of the responses have been quite interesting. One came back and asked me what I meant by the term carer, which, frankly, is a bit of an appalling answer. Quite a number have referred me to the county council or have talked about having joint strategies, some of which are out of date. It is an interesting point you might raise with them. I think, personally, that we are not going to make progress in this until NHS bodies start to see it as their responsibility. It is interesting that, when asked about a strategy, they will shuffle an inquirer off on to the county council. But there is some interest in NHS England's commitment to carers action plan. When do you think that will be published?

Simon Stevens: Next week.

Q32 Barbara Keeley: Next week; that is really good. What are you going to do around that to ensure it will have impact? In terms of the funding that has been taken out of social care and the reliance we have on these 6.5 million carers, this is the minimum we could be doing. With services cut away from under people's feet, identifying and supporting carers is absolutely the least you can do for them, and yet we have not done it in the Care Bill: we have dumped it on to local authorities. I think the more you could do, that would be really helpful. Also, could you tell us what plans you have on that and just how those linkages are going to work? If you are in the position where even a smallish proportion of CCGs do not really see it as their job—I know that some GPs do not see this as their job—and yet there are those 6.5 million people all across the country who are doing an absolutely vital job which you seem to be impressed by, there is some work to do here, I think.

Simon Stevens: There is work to do here. Our next phase of strategy on this, which we will publish next week, will set out some of the next steps we are taking. I doubt that it is the comprehensive answer yet that is needed, but we will signal that we need to get very serious about this agenda for all the reasons that you say.

Q33 Barbara Keeley: Would you like to see CCGs all have a strategy to support carers?

Simon Stevens: If you say, "Should they have a strategy?", often in the NHS, in my experience, that just generates paper. What we really want is CCGs and everybody to take sensible action to support carers in a way that would make a difference. Whether that has to be written down in a strategy is up for discussion.

Q34 Barbara Keeley: As a final comment from me, if you have a CCG that has to ask, “What is the definition of a carer?”, when it is actually defined again and again in legislation, you have got some way to go with some of them.

Simon Stevens: It sounds that way.

Q35 Charlotte Leslie: Thank you very much and welcome again. One of the elephants in the room often if you are talking about integration seems to be reconfiguration of services. Attempts by all Governments to reconfigure services to close hospitals down are always met with howls and have not always been successful because perhaps sometimes the objective evidence that is needed to justify things in difficult situations is not there. How do you think reconfiguration necessities and issues can be addressed? Do you have a plan or strategy for how we might do it better in the future?

Simon Stevens: The first thought I would have is that the NHS, like every health care system, has been doing this for decades. This is not a new thought. If you think back to the start of the NHS and the result of discovering antibiotics to treat tuberculosis, lots of beds that were previously full of patients with tuberculosis went away. You then think about changes in mental health treatment and learning disabilities, when a lot of long-stay institutions were replaced by more humane alternatives. The arrival of short-acting anaesthetics meant that day surgery came along. Then there is the fact that people who had diabetes used to have to be admitted to hospital for their insulin management. Medical advances are going to drive these changes. That has been the history of medicine at least in the 20th century and I am sure is going to continue to be so in the 21st. The NHS has been quite effective at reshaping itself over the years in doing that. Now, I don’t in any sense mean to suggest that there are not controversies around the way in which the next set of changes in any area may be on the cards. I just say it to remind ourselves that this is a challenge that the NHS has successfully risen to in the past and I think can continue to do so.

Q36 Charlotte Leslie: The implication of what you have just said is that the layout of services that we have, in terms of where specialist hubs are located, is more or less okay because the NHS has changed with medical advances. Is that your position? Do you think we more or less have a map of hospital services where we need it at the moment, or do you think a radical change needs to take place to make especially specialist services safer?

Simon Stevens: You have to decompose that into its constituent parts. A number of things that are currently being done in hospital will probably in future be done in community settings or at home. If you think about the way A and E services are organised, which is obviously a particular point of controversy, the urgent and emergency care strategy that my colleague Professor Sir Bruce Keogh advanced and has spoken to you about effectively says that, in terms of major emergency centres and emergency centres, roughly speaking, probably the same number are going forward as now, but with 40 to 70 major emergency centres on a network basis to other hospitals.

There are particular instances where it is very clear that there are clinical benefits from specialisation. Having met stroke patients at Charing Cross hospital recently who had benefited from the eight hyper-specialist stroke services that now exist across London, and

with the big increase in stroke survival on the back of that, there will be instances where that case is unarguable.

Having said all of that, I probably have a slightly different point of view than some. I believe that, when you look at other countries and compare us with them, you would say that we already have a fairly centralised hospital system and it may well be that, if we get really creative about what it would take to sustain local hospitals, it may not always be a question of merging or closing in the way that some have seemed to think.

Q37 Charlotte Leslie: I have two more questions. Do you think there needs to be much greater cross-party consensus when we are looking at issues like this so that it does not become a political football? Obviously health is a very emotive issue.

Simon Stevens: That is really a matter for the Committee rather than for NHS England.

Q38 Charlotte Leslie: Do you think it would make your job easier? It would not be telling us what to do. It would simply be describing whether a landscape would be more conducive to sensible decisions or not.

Simon Stevens: A consensus on any major-change topic would always be welcome, but, fundamentally, I think the question is: is the case being made in a defensible and rational way locally? Are the doctors and the communities willing to stand up and support that? I am sure lots of other things will fall into place when that occurs.

Q39 Charlotte Leslie: Do politicians need to change their behaviour?

Simon Stevens: I think it is not for me to—

Charlotte Leslie: You can be as blunt as you would like to this Committee.

Simon Stevens: —rise to that invitation.

Chair: Neatly done—like a politician.

Q40 Charlotte Leslie: I can see why you got the job.

Finally, I will use an example from my local constituency. We have recently had a super-hospital built with fewer beds than were at the previous hospital. I have raised concerns about this and said, “Are you sure, with a growing population in the area, with an ageing population as well, and with a more diverse population with more complicated needs, that this optimism is justified?” Do you have concerns that we have one of the lowest ratios of beds per person, and do you share the optimism of those who responded to my question, “Have you been over-optimistic?” I do not see this miraculous care in the community that is supposed to mop up all the people who will no longer need to be in hospital beds. Have we got it right or have we been dangerously over-optimistic?

Simon Stevens: The answer to that has to rely on a careful assessment of the needs of the people of Bristol: the GPs, clinical commissioning groups and the planners of those services need to sit down and answer the questions you have set. That is certainly not

something that is prescribed nationally. Having said that, on your specific point about whether we are under or over-bedded relative to international comparisons, I suspect the data you are referring to are the now three years out of date OECD 2011 figures. When you look at the acute in-patient lengths of stay data in that same OECD dataset, it shows that we are by no means an outlier. We are somewhere in the middle of the pack. You can look at other countries—France, Sweden and the US—that have lower average lengths of stay than we do, and we know that, even forgetting international comparisons, there is big variation across England. So, is there an opportunity to ensure that people are only in hospital when they really need to be in hospital, and is that a continuing opportunity in front of us? The answer is, yes, it is, but how big a further change there is, even when you have solved for that, will really depend on medical advances. If you take cancer care, for example, there are a lot of things where you used to have to be admitted to hospital for your cancer treatment that now you can get, such as your chemotherapy, on a day case and in some cases at home. Those are the things that are ultimately going to answer the question. It is not going to be some sort of central plan for England.

Q41 Charlotte Leslie: Are you happy with the bed-to-patient ratio as it stands at the moment?

Simon Stevens: The occupancy rate, in effect.

Charlotte Leslie: Yes.

Simon Stevens: I think it is at around 85%-86%, something like that. It has not changed much over a period of time. If you go back to 2000, when we have had the biggest cash injection the NHS has ever seen, and also the most extensive budget squeeze, you have lost hospital beds at an equal rate during both periods.

Chair: Andrew Percy wants to come in briefly. I am sorry; I missed out Sarah, and Andrew wanted a quick one on the back of this one.

Q42 Andrew Percy: On configuration, I am reassured that you think we already have a very centralised health system. That is certainly what it feels like to those of us who represent rural areas. I have three points really. First, what is your vision for the future of rural health services in this changing field? It is all very well centralising services, but when those services are 60 miles away from where they had previously been, as they are for some of my residents, suddenly it does not feel like you have access to the health service—not your local health service—any more.

Secondly, how are you going to reassure people that, when configurations do happen, they happen because of patient outcome improvements rather than because of the financial squeeze? It is all very well, and we have this conversation all the time about the massive financial squeeze, but when it comes to reconfiguration, we say to people, “But it is all about better patient outcomes.” The public don’t buy it because they understand that what is probably really motivating it is the financial pressure.

Thirdly, leading on from that—and they are all related—if we are going to have configuration, I noticed that the joint report by the King’s Fund, York University, I think it was, and possibly the Nuffield Trust, highlighted the possible need for some kind of transition fund or protection to hospitals as you try and create these community services. In my area we have seen the hospital beds go, we are seeing new intermediate care facilities being constructed or in the planning phase, but they are going to take some considerable time to come. There is a lag between getting this proper home care, as we saw when we went to Denmark and Sweden—proper intermediate care facilities out in the community—and taking the beds out. We have whipped the beds out, but we have not provided people with proper home care support. There are three questions in my one quick question.

Simon Stevens: Maybe I can try an all-enveloping single answer. Over the next six months or so, one of the things I want us to do in every part of the National Health Service across England is to answer those three questions in a locally-based way. At the moment the NHS is not only doing its plans for the next two years but also beginning to set out its plans for the next five years. That is supposed to be complete by the end of June. But most people think a bit more time would probably help with that process. My view is that we are not going to find a single answer that works right across the country. We are going to have to have different answers for rural areas, urban areas and for the peripheries of conurbations and so on. Part of where the NHS has sometimes not got it right in the past has been when we have had too much of a cookie-cutter approach to what the care delivery model needs to look like in all parts of the country. I am sure that we will find that, in order to make things work in your area, we are going to have to change things in a different way than what we would have to do in order to build on the excellence that exists in Salford, for example. Finding the right way of having that conversation and answering that question over the next six months, so that by the autumn the NHS has a clear and articulated point of view as to what needs to change over the next five years, is something I am committed to.

Q43 Andrew Percy: But there is still an attachment to buildings, and buildings tend to be in urban areas. That is why, when we look at all these configurations and you see what is happening, it is all about concentrating on particular sites on the current estate, reducing the size of the estate, and that estate is generally located in urban areas. That is why I think an increasing number of people in rural areas are feeling that their health services are being taken from them and are not being replaced with proper community services. So long as we are talking about the financial challenge all the time, people will not buy that it is about improvements for patients. It is something NHS England has to respond to.

Simon Stevens: Yes.

Q44 Chair: Do you want to come back on that?

Simon Stevens: No. I take that point.

Chair: I have called these in the wrong order. Sarah is next and then Rosie.

Q45 Dr Wollaston: I want to return to the point you made about the importance of primary care and the personalisation agenda. There are four aspects of that I want to touch on. One is the work force issue in primary care because we have a very serious retirement bulge with half of GPs being over 50, and already a shortfall—a 12% vacancy rate—in the south west, which we have never had in the past. First, how are you planning to have a real national drive on addressing the work force shortfall? If we do not have the work force, we cannot deliver what we want from primary care. That was the first point.

The second point is: are you going to allow CCGs to have much more flexibility around co-commissioning of primary care services? You briefly touched on that, and it would be nice for CCGs to know whether that is definitely going to happen in the future, and also about the greater flexibility for roles within primary care teams and for doctors themselves to have greater flexibility over their whole career so that more of them can shift sideways flexibly into primary care in generalist roles to fill that gap. And, of course, there are the personal lists. We always used to have personal lists. Suddenly it has been reintroduced as this new idea for older people. Why not just shift back to the system that we always used to have, where, as a GP when I first went into practice, I had a personal list? Do you think that is the way to go for all patients and not just this small number?

Simon Stevens: Taking your last point first, there is nothing stopping practices having that system. For the highest-need patients for which practices are responsible, that will now be again, as you say, the system they are responsible for. I think it is, hopefully, an uncontroversial matter of medical history that it was the GPs' representatives who wanted to do away with that as part of a condition for negotiating the new 2004 GP contract. So I am sure that is something that is a subject of lively debate within general practice, given your other point, which is that there is a lot of benefit in teamwork in primary care. Making sure that practice nurses, therapists, pharmacists and others are part of that whole team is something that, in theory, those flexibilities allow. I don't think there is a silver-bullet answer to that question.

More fundamentally, on your point about general practice work load, my view is that GPs are working incredibly hard and are under pressure as a consequence. There has been a 21% increase in the number of GPs since 2000, but that is a far smaller proportionate increase than the increase in the number of consultants in hospitals, which has been more like 76%. There is an interesting question as to whether we have the balance out of kilter there and, if we have, what are we going to do about it going forward? One of the answers, I think, is to enable CCGs to have more impact over the decisions that are made about spending in primary care services—not just GP services but primary care services. So, as to your second or third question, I will indeed be setting out an answer to that, at least in outline terms, on Thursday of this week.

Dr Wollaston: Thank you.

Q46 Rosie Cooper: If I may, I would like very briefly to address Charlotte's question or even put the meat on the bones between that and your response. That gap is the patient's experience. Acute trusts are under incredible pressure; the beds are full. In Liverpool, I have evidence in the trust I was talking about that the community trust's rehabilitation beds are containing patients with acute needs who have been inappropriately

admitted to those beds because there is nowhere else for them to go. I was in the Royal Liverpool hospital visiting somebody who was on a medical assessment unit. They were told they were being transferred to ward 8B. The porter arrived when I was there. They were taken up to ward 8B to be told, “Sorry, the bed has gone,” and then all hell broke loose.

So there is a gap. I heard your answer which said they should be determined locally, but the truth is that the budget is determining it, not medical need, and we are trying to fit quarts into pint pots. These are the kinds of things we are talking about. It is okay saying it will be all right, but that is what is happening to the patient—the person whom you are saying you want to be fully involved. They are ending up in inappropriate beds; the beds are not there when they need them; the staff are racing round trying to get people out. Either the whole medical system or the doctors are getting it completely wrong. All of this is happening despite medical advances, despite fledglings of integration. What about now?

Simon Stevens: I agree, of course, with what you are saying, and when I come to Liverpool I look forward to finding out more specifically about what is going on at the hospital, with the community trust, the primary care services and social services as well. I am not in any sense disputing the fact that there are significant pressures on hospitals and community services. I am saying that part of those pressures arise from the fact that the pieces are not always working terribly well together and, as a result, therefore, people do sometimes end up getting the wrong type of support at the wrong time. This is our opportunity to try and do something about that. I am not claiming that, once we have done something about that, it will as a result solve all the other problems that we have.

Rosie Cooper: The reason for my fear is that we are currently rebuilding a new Royal Liverpool hospital which has fewer beds than the number we have now—and that is under great pressure—which is why it is really important to bring it up. But that gap is there and that is what patients and their families see. You can’t then sell them the idea that everything is wonderful, when what they see doesn’t work in the same way. But thank you.

Chair: Barbara wants to go on to the subject of money.

Q47 Barbara Keeley: We don’t get very far from it, do we? The King’s Fund has reported that trust and CCG finance directors are increasingly pessimistic about their financial situation, obviously, in the fifth and sixth year with what they would see as little or no real funding increase, and particularly with the introduction of the Better Care Fund and the effect that will have next year. The question is around how concerned you are about the funding situation for the next two financial years. If we take Salford as an example—and you said you were going there next week—I know the CCG, as I have been in discussions with them, is in a situation of trying to help plug gaps that the council is now facing. We may have a wonderful hospital there in the Salford Royal, and we do, but Salford council has had £100 million taken out of its budget, and this year is changing its eligibility so that 1,000 people locally will not have the care packages that they did have. That is the reality in probably many more places, but that is an example. It is not really surprising that trusts and CCG finance directors are very concerned about that. They are facing a situation of having to plug those gaps.

First, you tell us how concerned you are, and then the King’s Fund has said that the next Government will face a decision between increasing funding or reducing services. Is that

something you would agree with and what ideas do you have? The King's Fund has suggested a two-year financial plan to help across that difficult time with no increases in the Better Care Fund being introduced. What are your thoughts on that?

Simon Stevens: Yes. I should, by the way, declare that I am a former trustee of the King's Fund and a former trustee of the Nuffield Trust, which is not to say that I had any involvement with, or associate myself with, any particular output from those organisations, but obviously I take seriously their analysis.

There is no doubt, since we are now in year five of the longest squeeze on NHS finances that there has been in our 66-year history, that times are tough. There is recognition that the NHS has been, in some ways, fortunate to be shielded from some of the impacts that, as you say, people in local government and elsewhere have had to take as a result of the broader economic situation facing the western world, including this country. I think there is an understanding as to why the NHS has had to respond, but, equally, I think it is clear that for the last two or three years an incredible effort has been put in and that has ensured that the standards of care have, for the most part, remained very high. That is the result of a lot of goodwill and sacrifice on the part of front-line NHS staff, who have maintained significant pride in and commitment to the services that they are responsible for. That has been an enormous achievement under very difficult circumstances. Looking forward, for the year we are in and for next year there clearly are substantial pressures.

Then you asked the question more broadly than that, even, as to five years out. Over the course of the next 180 days or so I am going to work with other national bodies, with CCGs locally and local government partners and so on, to fundamentally try and answer the question, "What are the things that the NHS can now do in order to further contribute to putting itself on a sustainable footing, and where will that get us?" I expect to report publicly and independently on where that thought process has taken us by the autumn.

Chair: Valerie?

Valerie Vaz: Competition.

Chair: Hang on. Before you get to competition, Andrew, did you want to talk about money?

Q48 Andrew Percy: I would like to talk about money because I haven't got any.

The strategy document "The NHS belongs to the people"—and it follows on from Barbara's point really—in July 2013 predicted that the funding gap in the next Parliament could grow to £30 billion per year. We all know the Nicholson challenge and its history, and when I go and see my trusts, as you would expect, they say that the Nicholson challenge has in some ways been valuable because it has allowed them to identify waste and changes that perhaps they would not have done without it, but they also say that they are getting to the point where, for them to continue to meet these savings, it is going to become unsustainable while maintaining the estate and maintaining services, which comes back to the rural point again. This is across a very large rural area, serving a rural population that is not very wealthy—of course another misnomer is that people think rural populations are wealthy—

and which has a high incidence of industrial disease and all the rest of it because of the nature of the economy locally.

Given that there is this £30 billion, where do you think the Nicholson challenge—or what will now be the Stevens challenge—is going to have to be? Is it going to remain at 4%, or are we going to have to see that increase to 5% or 6%?

Simon Stevens: The first thing I would say, Mr Percy, is that, if you look back over the last two or three years, there has been a huge effort across the NHS which has successfully dealt with the financial positions for the most part, recognising that there are significant pressures. The estimates that I have seen suggest that about £15 billion of savings have been made over that period of time. That shows some successful approaches to dealing with the constraints so far, which is partly why the quality of care has, for the most part, remained extremely high. But you rightly make the point that that is getting us to where we are now, and, looking forward, what are the prospects?

The £30 billion, I think, makes sense as a calculation if you take the assumptions that feed into it. Everybody knows—but just for the sake of reminding folks—that that essentially assumes that NHS spending remains flat in real terms until March 2021 on the one hand and, on the other, that demand continues to grow at, roughly speaking, the pace that it has done historically, taking account of the fact that we are an ageing country and that there will be another 3 million or so people living in England at the end of the period than there are now, according to the ONS projection. If you take those two assumptions between demand on the one hand and the funding situation on the other, then, purely as a matter of maths, yes, you get a £30 billion gap, and then the question is what is it going to take to make significant inroads there? Again, I think it is just a matter of fact to say that, as we speak, most of the analyses that have been produced by NHS England, Monitor, the King's Fund, the Nuffield Trust, and so on, show a pathway to getting about half of the way there. That is the question that still has to be solved for and that is one of the things that I am going to be forming my own judgment about over the course of the period now through to the autumn.

Q49 Andrew Percy: Do you feel that the quality of care in the NHS or the breadth of services and care that are offered in the NHS can be maintained without additional funding, which I think was Barbara's point a moment ago, if this challenge is met? Of course it could be increased if we have national insurance rises, which will cost the NHS if we have bigger pay awards, and that would obviously have a further effect. Do you think the quality of service can be maintained, basically, without extra cash?

Simon Stevens: If you are asking me to look out to 2021 and the decisions that the next Parliament and potentially the Parliament beyond that will make, there are significant uncertainties about how well the economy will be doing. What is absolutely clear is that, for the NHS to thrive, the British economy has to do well. That point of connection has always been there in the tax-funded service since the day that the NHS came into existence in 1948. So the prospects for the British economy over the second part of the decade are very important to being able to answer your question. If it is the case—as hopefully it will be—that strong economic growth returns, then I think, for medical, economic and social reasons, most independent commentators would predict that the nation would probably be spending more in real terms on health care by 2021 than it is now.

Q50 Chair: But you will be coming forward within 180 days, I think you said, putting some numbers around this.

Simon Stevens: I will be giving a broad sense of what the country will face over the next Parliament and some of the efforts that the NHS will be able to make towards contributing to those.

Q51 Dr Wollaston: I have a question around finance and resourcing ideas for today. The single biggest group of questions was around mental health, looking at the particular challenges to mental health services around how we achieve parity of esteem, when in fact the tariff deflator is affecting mental health services disproportionately. Could you answer that question about how we are going to achieve parity of esteem, when in fact mental health services are taking a greater hit?

Simon Stevens: If you just start at the highest level of generality, you would say that already we are not doing enough, and historically have not done enough, with mental health services. One way of quantifying that is to say that probably the NHS spends 13% or 14% of its budget on mental health services, and yet some estimates suggest that maybe 24% or 28% of ill health experienced by us as the people of England relates to mental health problems. So there is a disconnect that has been there for a long period of time.

Interestingly, the question that you asked, Dr Wollaston, connects with the question that Mr Percy asked as well. It is not just a question of the NHS relying on the British economy to do well. Actually, the British economy in part relies on the NHS to do well in order for economic growth. That is a connection that is very evident in mental health services. The OECD recently produced a report—I am sure you saw it—suggesting that the cost to British GDP was about £70 billion from mental health, and that plays out in all kinds of ways in terms of sickness absence and unemployment, not to mention the distress that families and individuals experience. So there is not only a strong humanitarian case but a strong economic case for more investment in better mental health services.

Q52 Dr Wollaston: With respect, you have not answered my question. In a sense, you have re-stated what I am asking you—that that is how it is. How do you see, in your role, that we are going to change that? Are you going to change the tariff deflator? Where are you going to take money from to put into mental health to address some of those issues, or do you see the current situation continuing with 13% to 14% of the total spend being in mental health? Is there going to be a change driven by you in this area?

Simon Stevens: The first thing to say is that there are some specific things that the NHS is now embarked on that it would be very important to get right in order to be able to take the kind of steps that you are talking about. One of them relates to support for people with anxiety and depression. There is a programme called IAPT—improving access to psychological therapies—that has been going for a number of years now but, frankly, we need to see more of. It is a great programme, and, given that depression and anxiety affect many people across the country, if we could get it extended more broadly, it would have a measurable impact. That is a specific thing which has widespread support that we should be putting effort into over the course of the next year and beyond.

I also think that part of the answer to the question comes from right where we started, which is reconnecting the funding streams so that these kinds of judgments can be made in the round. Part of the reason why mental health services have probably not had the attention that they should have—and you talk about the tariff position recently—is because some of these services are on the receiving end, as it were, of the impact of higher spending in acute physical health services, and we have to reconnect those spending pots to have a more holistic view as to how we are using our money.

Q53 Dr Wollaston: To press you a bit further, you referred earlier to the bed-occupancy rates as being particularly high in mental health. Therefore, if you are diverting more money into IAPT, where is that going to come out of? Just pressing you further on the tariff deflator, are you going to change that? They cannot achieve all of these ends, let alone the concordat—the Crisis Care Concordat—and addressing issues around 136 and CAMHS, without having more resources. Just putting it into IAPT is not going to sort the issue. If they need more funding—a greater slice of the cake—is that something you are going to address?

Simon Stevens: In aggregate, there is no more funding in the National Health Service. Let us remind ourselves that the National Health Service, having been protected from the chill winds that are affecting other parts of public spending, nevertheless is more or less constant, in real terms, in the budget that is available. If you are going to do more of something, then you have to do less of something else. My point was that those judgments should, wherever possible, be made in the round and locally, rather than in a fragmented way and partly nationally.

Q54 Dr Wollaston: Thank you. On the subject of “less of something else,” in your speech you talked about the renewable energy of the voluntary sector and communities. But one of the casualties in all of this has been in the voluntary sector providers, looking at keeping people out of hospitals. In the same vein as Rosie Cooper, if I could be cheeky, I would ask if you would come and visit a couple of voluntary sector providers in my area, an organisation called Dartmouth Caring and another one called Cool Recovery, of which I am a patron, that helps people with mental health problems, keeping people out of hospital and helping with early discharge. Demand on their services has never been higher, but unfortunately there is no money now from the CCGs to give them even a small amount to keep going. Some of these organisations, we are hearing around this table, are in great difficulty. Is that something you are going to address—how we get even a little bit of funding into some of these voluntary sector organisations to allow them to continue with their work?

Simon Stevens: I would love to come and have a chance to meet them and see what is happening in your constituency. Obviously, the system that has been established for the flow of funds through the National Health Service is such that two thirds of it is channelled through local clinical commissioning groups. The answer to the funding decisions for local services in your area is a matter for the local clinical commissioning group for the most part, but I would love to come visit with them as well and have a chance to chat.

Dr Wollaston: Thank you.

Q55 Chair: You are going to have long travel arrangements.

Simon Stevens: I already have, so I am just piling it on.

Q56 Rosie Cooper: Returning to the financial situation, I want to ask you about acute trusts and CCGs in the sense that many acute trusts have forecast that they will be in debt at the end of the year. I wonder how you see the danger that those trusts will focus their attention on just maintaining and keeping on going—and even taking short cuts, God forbid—rather than working smarter, working on the integration agenda and even, in some cases, where it is necessary, the reconfiguration agenda, so that they can provide the best possible care for an area. But then, on the other hand, CCGs are facing, for all practical purposes, a freeze until, what, 2016 as a result of Better Care transfers? In this situation, notwithstanding the comments we heard before about money being removed from CCG budgets in year late on, do you think NHS England needs to prioritise things that it believes really matter, or should it continue to press a broad-based set of agendas through the traditional forms of planning guidance, and risk almost achieving none of them?

Simon Stevens: When you say “things that really matter,” what sorts of things do you have in mind?

Q57 Rosie Cooper: For example, we talked about your specialist commissioning and how you deliver that. We talked about being £400 million or £460 million light. Are you the best people to be doing it and how should that be done? What are you really telling people out there that they need to provide and concentrate on so that they don’t have money ripped from them because you are overspending on your parts of it? That is the essence of what I was getting to.

Simon Stevens: Okay. That is kind of a big question. There are some things that are clearly fundamental for the National Health Service and for CCGs to get right, and one of them is to ensure that where care is being provided it is of a high quality and that it is safe. That is something that has come very clearly into view since the very terrible events at Mid Staffordshire. Whereas previously people might have tried to cut back on some of the things that would make a difference there, there is now much greater transparency about what is happening inside hospitals, including, from June, people beginning to publish what their nurse staffing looks like, including independent oversight, transparent publication of quality results and so on. The quality, safety, dignity and compassion requirements are fundamental and are something that everybody has to pay pre-eminent attention to. There are a set of things that are of great concern, rightly, to the public, including being sure that in an emergency you can quickly get access to care—your A and E department or 999 ambulance—and ensuring that where you need an operation it can be done within a reasonable time. That is something on which the NHS has made enormous improvement over the course of the last decade and a half. There are pressures there that have to be focused on very carefully over the next several months, particularly around waiting times for hospital surgery.

Then there is, if you like, preparing for the future and ensuring that we do have a system of out-of-hospital care that works, ensuring that we are taking prevention seriously, and ensuring that we are not just thinking inside our own institutional buckets but are working with carers’ organisations, voluntary groups, social services and so on. The reality is that

we have a lot of work on. There is not one single thing that people have got to get right. We have got to get a lot of things right and that is going to take a real concerted effort.

Q58 Rosie Cooper: But as to what you get for your money in integrated care—the actual interface between social care, local authorities and the health service—there is not, almost, a national currency and prices for this work. For me, they are key areas at the heart of the integration agenda. I wonder whether it is not time to consider—and this is the bit I was really leading to—other alternatives based on joint provision but the funding being arrived at from a capitation basis, almost, so that care is funded by a capitation figure rather than everybody playing about with, “You get a bit of this here and a bit of that there.” Each authority is almost doing different things and local health systems are just handing over. Who is doing what any more?

Simon Stevens: Are you talking about capitation not just for the NHS budget but for adult social care as well?

Q59 Rosie Cooper: It is adult social care really—that last bit.

Simon Stevens: Yes. Obviously there, then, the question arises, which I know the Committee has previously addressed, as to whether or not there is a national specification, as it were, as to what each local authority has to spend on adult social care. Unless you answer that question, it is hard to see how you could make the capitated social care prerequisite practical across the country. But be that as it may, going with the spirit of the question, as it were, my view is that, for the reasons I was talking about with Mr Percy, we have to have much greater flexibility in terms of the kinds of models that we are operating across the country—horses for courses rather than one size fits all. As a result, that is going to mean that in some areas I absolutely will be up for creating different types of budgetary arrangement and care organisation than anything we have previously seen before where there is good reason for thinking that it connects to the issues that patients are facing and gets us future-proofed for the challenges we are going to face.

Q60 Chair: Before we leave money, can I ask you one question that came up in the sessions we held on public expenditure last autumn? Considerable concern was expressed to us about an approaching cliff edge that begins this time next year—2015-16—with the introduction of the Better Care Fund, which is clearly the Government’s attempt to promote the kind of change that you are describing, and which the Committee has endorsed, but which creates significant overnight issues within the acute sector or in the NHS, but particularly probably in the acute sector, where a £1.9 billion transfer to social care clearly creates losers on the health service side of the fence. Are you concerned about that and, if so, what are you doing about it?

Simon Stevens: The way I think about it is in three elements for the £1.9 billion. One element is money that is actually going to be reinvested in NHS care, so that is not money that is going to move outside NHS services. It may be in community health services rather than hospital services, or it may be in hospital services in some places, but that is one piece of it.

A second piece is a share of the £1.9 billion that is going to be spent in social care or other non-NHS organisations, including carers' organisations perhaps and the voluntary sector, which nevertheless will produce some offset on people being admitted to hospital who could have been supported in their own home.

Q61 Chair: That is the key, is it not?

Simon Stevens: The third piece is the share of the £1.9 billion that is buying useful things outside the National Health Service but which does not produce a direct offset on demand flowing into hospitals. The relevant question is what is the relative size of those three buckets? The discussions are still ongoing at the local level as to the planning that is being done by the health and wellbeing boards. It is the third category, if you like, that represents the additional pressure that we have to solve in 2015-16 in CCG-commissioned services.

Q62 Chair: Is that right? Surely all three of those categories create pressures in the acute sector because that is money that is currently being spent in the acute sector that will not be spent from 2015-16 onwards. One of your early answers this afternoon was to draw attention to the evidence that you described politely as being mixed about the success of community-based initiatives in reducing demand in the acute sector. If we are transferring £1.9 billion from the acute sector into various forms of community activity and we are not increasing the budget for the health service as a whole, then it is pretty critical that those investments in community services do indeed lead to a reduction of demand on the acute sector, otherwise what is plan B?

Simon Stevens: I would slightly take issue with your suggestion on that three-part categorisation. The £1.9 billion is coming from CCG-commissioned NHS services, so it is not coming from the acute sector per se. I think only about half of CCG spending is on acute services. So the source of the funds, as it were, is potentially quite broad based. The application of the funds to those three categories to the extent in category 2 that it does produce an offset on what would otherwise have been admissions to hospitals is then a legitimate saving for hospitals. But it is not my point of view that this is in some way all going to net out with a beautiful one-for-one return on the investments that are being made from 2015-16. There will be a part of the £1.9 billion that does represent additional pressure that we have to solve for in the round for 2015-16, but I do not think that that, in itself, means that this is bad public policy. We are trying, I think, in public policy terms overall to improve the support for a group of people who, even if it does not produce reduced A and E or emergency admission, nevertheless will be better supported than they otherwise would have been. That is a test that I think these plans will meet.

Q63 Chair: The Committee in its report made clear that we agree with the policy but think that people need to be clear sighted about the implications of carrying it out.

Simon Stevens: Yes. Maybe, Chair, I could add one additional point. There has been some suggestion that somehow this thing would only be justified if £1.9 billion of social care investment produced 15% reduction in hospital emergency admissions. For the reasons I have just said, I do not think that is the correct way of thinking about this.

Chair: Thank you. Can we come now to competition policy?

Q64 Dr Wollaston: I have one additional very quick point to make on this. Have you made an estimate of how much of that money will be taken up by the demands placed on it from the Care Act? There is a concern that some of this money is being spent and has been accounted for under lots of other funding streams.

Simon Stevens: As we speak, the process of looking at the plans that have been produced, how the money is being used and what it is going to result in is under way. So I can't answer your question right now.

Chair: There is one more question on money from Mr Tredinnick.

Valerie Vaz: He has been very patient.

Q65 David Tredinnick: I sometimes think I am living in a parallel universe because I represent the small but growing minority of people who use complementary and alternative medicine, which I have been doing for donkey's years here—the homeopaths, the herbalists and the acupuncturists. We generally—I think I can speak for them—would go to a homeopathic box before we go to a doctor, if we can, for chest complaints, headaches or stomach upsets. We might use herbal medicine or we might use acupuncture to relieve muscle problems or carpal tunnel syndrome, as I have. Evidence shows that doctors who use homoeopathy or herbal medicine generally have a 25% reduction in their drugs bill. Never mind the merits of the treatments themselves, it seems to me that the health service is missing a—

Simon Stevens: That is a crucial rider to your statement, I would suggest.

David Tredinnick: —huge trick in terms of its costs by not trying to look at these more seriously and widen their use, and take the pressure off doctors, such as the good doctor on my left here, by getting this resource for the people whom you want to empower anyway—namely, patients and carers. What is your view of this small but growing diaspora and the use of alternative medicines?

Simon Stevens: I think “diaspora” is a good way of thinking about it in that there clearly is a spectrum of interventions that fall under that label of complementary therapies. I think it is fair—but you might think it is deeply unfair—to say that there is a stronger evidence base for some than for others. The rise of acupuncture, for example, I think is now becoming much more mainstream, and, in my view, it is right that GPs and others in the right circumstances should be making those kinds of treatments available on the National Health Service. On the other hand, at the far end of the diaspora, there is more uncertainty as to whether the NHS should indeed be funding those interventions, and in the system that we have established that is a matter for GPs in their referral decisions and for the local CCG.

David Tredinnick: Thank you.

Chair: Competition policy. Valerie.

Q66 Valerie Vaz: Before we get to that, I want to save you a trip up to Walsall Manor hospital. We need £14 million because we have had to absorb—

Simon Stevens: I am going to be in Birmingham tomorrow—in east Birmingham and central Birmingham.

Valerie Vaz: —the A and E from Stafford hospital and we have been put under a lot of pressure. I have raised this point a number of times. Money was given out to certain hospitals but not to Walsall Manor and we really do need it. So I can get that out of the way.

Turning now to competition, what do you see as the role of competition in the provision of health services?

Simon Stevens: I said on my first day in this job that my goal for myself and for the NHS is that we should think like a patient and act like a taxpayer. The prism through which I view that question is, “What will be in the interests of patients and what will be in the interests of taxpayers?” I take a pretty pragmatic view of this, which is that, under some circumstances, as patients, we do want a choice of where we are treated. Historically, we have had that choice as to which GP we register with. Women have had a choice about childbirth. For the last decade or so patients have had choices about where they get their operations. I also believe that, under particular circumstances, where care is persistently problematic and we need to do something different, then, as a taxpayer, the right way of answering the question “Is this good value as an alternative?” is to make sure that that has been properly tested in a transparent, proportionate and non-discriminatory way. But do I think that it is the answer to what has to happen inside the National Health Service? No, I do not. I think it is just one of the things that, on occasions, will benefit patients and be good for taxpayers.

Q67 Valerie Vaz: What is your view of competition and the Health and Social Care Act then?

Simon Stevens: My view is as I have just described it, I think.

Q68 Valerie Vaz: Is it driving it? Is it encouraging it?

Simon Stevens: One way of answering the question, I suppose, would be to say that we are right now in the final stages of this year’s contracting round between CCGs and hospitals for the 2014-15 care that they are going to fund for their local populations, and I am not sure that we have seen very significant differences in the way that they have gone about that task now compared with a year ago or two years ago.

Q69 Valerie Vaz: So you do not think that there was a role for competition in the Health and Social Care Act.

Simon Stevens: I thought you were asking, “Has it made a difference?”

Q70 Valerie Vaz: No, no. I said, is it driving it?

Simon Stevens: My answer is that, in terms of how CCGs are behaving in this annual contracting round, it does not seem to have made a significant difference, no.

Q71 Valerie Vaz: Right. So you have heard nothing from CCGs, or perhaps the *Health Service Journal*, about the fear that some CCGs have that they are having to put their services out to tender.

Simon Stevens: There clearly has been uncertainty about what the right way of responding should be—absolutely. I completely see that. I was just making a different point, that the response to the uncertainty—

Q72 Valerie Vaz: Just answer my point.

Simon Stevens: The response to the uncertainty does not seem to have been that people have been putting all of their services that they are now commissioning for their populations this year out to tender.

Q73 Valerie Vaz: “All of their services.” Is there some sort of fear that that is what they have to do? Maybe you have not had a chance to talk to them.

Simon Stevens: I am just saying, in terms of the behaviour that we are actually seeing, there are some services where people are doing that, but across the board it seems pretty similar to previous annual commissioning rounds.

Q74 Valerie Vaz: So your message to the CCGs is, “Don’t worry about it. You don’t have to put things out to tender where you don’t need to.” Is that what your message is or could your message be?

Simon Stevens: My understanding is that the legal framework is essentially the 2006 public procurement regulations that were transposed into UK law back then, and that continues to be the case. I know there was a lot of debate at the time of the legislation, but I don’t think the underpinning public procurement rule set has substantially changed.

Q75 Valerie Vaz: I had understood that at least 57% of the CCGs have had some sort of challenges or questions informally about putting their services out to tender.

Simon Stevens: It does not seem to have resulted in them putting all their services out to tender.

Q76 Valerie Vaz: No, but the fact that that is what is happening. I know you are early in the job, but are you aware of how much legal advice they are taking, how much they are spending on this?

Simon Stevens: At a time of uncertainty, obviously people do need insight and guidance as to how to respond. I suspect that, with the passage of time, people will see that what

they were most concerned about is not something they actually have to be spending that kind of money on.

Q77 Valerie Vaz: You are basically reassuring them that they don't have to do that.

Simon Stevens: Obviously each case has to be looked at on its merits, but, if the claim was that CCGs had to start putting all of their health service purchases out to public procurement, that is clearly not true and is not happening.

Q78 Valerie Vaz: Would it be helpful if I sent you the article then?

Simon Stevens: This is an article in—

Q79 Valerie Vaz: It is in the *Health Service Journal*.

Simon Stevens: I am an avid reader of the *Health Service Journal*.

Q80 Valerie Vaz: So have you read it or not?

Simon Stevens: I almost certainly will have done, but the *Health Service Journal* is always packed full of great stuff, so I may have—

Q81 Valerie Vaz: I am just concerned that it is out there, people are concerned, this has been something that has come through since the Health and Social Care Act was enacted, and you do not seem to be aware of that.

Simon Stevens: No, I am just observing that, 18 months on, perhaps some of those initial concerns are now being grounded in the reality of what is and is not actually required.

Q82 Valerie Vaz: Okay. Hopefully, they will be reassured by you. Was there a handover period between you and David Nicholson? Did he discuss any of those—

Simon Stevens: There are two ways of answering that question. One is to say yes, there was effectively a six-month handover period because I took the job in October that started 1 April; so, yes. Another way of answering the question is to say that there was a handover period that was of about one second between midnight 31 March and 1 April.

Q83 Valerie Vaz: No, I mean discussing what is going wrong in the health service or what is going right in the health service.

Simon Stevens: Yes. Obviously, of course, I have chatted with David about that, yes.

Q84 Valerie Vaz: Did he tell you that he told us that he thought there might be a need for a change of legislation to stop this very fear?

Simon Stevens: I think the context for some of David's concerns—

Q85 Valerie Vaz: It is a yes or a no. Did he mention to you that there might be a change in legislation needed?

Simon Stevens: I am well familiar with the reference that you cite, but I think the context for that in part was a concern about how easy it would be for hospitals to merge. It was not so much about procurement practices in CCGs, although that is obviously a relevant thing that we have got to get right as well. I think there again, as individual cases are established, it will become clearer for people what they do and do not have to do. I probably had a slightly different take on, for example, the issue that arose in Bournemouth and Poole, where I thought that it sent a clear signal to hospital managers that they need to be very precise about what the supposed benefits of a merger are going to be before they embark on that process. That is no bad signal to send.

Q86 Valerie Vaz: How will that fit in with the Government's current move towards integration? That is obviously going to be part of the factor, is it not?

Simon Stevens: I think integration is more around hospital services, community services and primary care services, rather than integrating by virtue of merging one DGH with another.

Q87 Valerie Vaz: It will be certain services, will it not? You will have to look at things in the round. You cannot just do them—

Simon Stevens: Yes, absolutely. Put it this way: if, in the context of the five-year things that we need to get right, I form the view that any of that is standing in the way of it, I will say so and seek to get it changed.

Q88 Valerie Vaz: Okay, good. Can I turn to something that you mentioned or maybe something that you did? I am not sure if this is right or not, but could you just confirm that you developed a system for ranking 250,000 doctors against national standards of care and then ranked them against value for money, which meant you are effectively listing doctors by price?

Simon Stevens: You are talking now about the US health care system.

Valerie Vaz: Yes.

Simon Stevens: Actually, the public system there and a number of the private providers, as part of a move towards much greater transparency about the differences in quality that exist across the US health care system, have put significant effort over the years into ensuring that we as patients get to know what those people working inside the health care system themselves know. So, yes, that is one of many efforts to do that, not just in the US but also here in England, of course. NHS England is, with the support of the medical profession, committed to publishing surgical outcome data for another 10 specialties. One of the lessons that we learned on the back of the Mid Staffordshire inquiry from Robert

Francis was the need for much greater transparency about these kinds of quality issues. The more we can do that the better.

Q89 Valerie Vaz: We will come on to what you were actually measuring, how much time they have spent, and so on, or what made them such good value for money.

Simon Stevens: I can answer that straight away. In that particular measurement set, the measures were against the quality standards that were established by the different medical specialties across the United States. It was the medical profession that said, “These are the standards that we should be practising at,” and this was just then using the data to say, “And how are folks doing?”

Q90 Valerie Vaz: Do you have any plans to bring it in here?

Simon Stevens: As I said a moment ago, the NHS has been moving down this path at least since 1999 when the Bristol Royal Infirmary inquiry demonstrated that there was data that should have been acted on where people could see that there were problems with children’s heart surgery there. That is when the cardiac surgeons began publishing their own data, and now we are, as I say, extending that to 10 specialties and hopefully going beyond that as well. I do believe that professionals themselves want to know how they are doing relative to their colleagues, and also that we, as the public and as patients, have a right to see that information.

Q91 Valerie Vaz: But that is in terms of outcomes and best practice rather than by price.

Simon Stevens: Yes. We are not doing that, no.

Q92 Valerie Vaz: That is what I was trying to get at. Are there any plans to introduce that here?

Simon Stevens: Sure, yes—the quality piece. That is true.

Q93 Valerie Vaz: That is a no; you are not going to introduce it.

Simon Stevens: We are not ranking by price, no.

Q94 Valerie Vaz: Denis Campbell from *The Guardian* mentioned that you were also looking at independent GPs in a Gove-style free school way—free GPs. Do you have plans to introduce that here?

Simon Stevens: There may have been an element of “lost in translation” there. Again, to take the spirit behind the question, I think there is a case for different types of medical groups working together. One of the strengths that we have had in the National Health Service has been British general practice, but I think one of the prices we have sometimes paid is that there has been too big a gap between what GPs do and what hospital doctors

and specialists do. So, could you imagine a circumstance in which some of those medical specialties were working more closely with GPs in new types of primary care configuration? Yes, you could. I am not sure it would necessarily correspond to that description you gave, but, yes, there are lots of things we should be talking about like that.

Q95 Valerie Vaz: We are talking about existing GPs within the existing service rather than having GPs in competition with each other. I think that was the tenet of what was said here,

Simon Stevens: I see. As a patient, I get to choose which practice I register with. The amount of funding that the practice gets in part depends on how many patients choose to register with it. Whether you call that competition or not, that is just a basic patient entitlement that we have all had since 1948.

Q96 Valerie Vaz: The quote is directly—I think this is your quote— “that the NHS could get its own equivalent of Michael Gove’s free schools in the shape of independent GPs who would compete with existing surgeries for patients.” That was what my question was. Is that something that you are thinking of introducing or you could introduce?

Simon Stevens: Look, I talk with GPs about what needs to happen in primary care. Is it about 40% of GPs that are already on PMS or APMS local contracts? So, you know, I think, to some extent, there is a bit of theology behind perhaps what you are describing. I don’t know.

Q97 Valerie Vaz: I am just trying to find out what your philosophy and thinking is. It is only right because you are in charge of a lot of money and a lot of patients’ care, and we need to know that it is all going in the right direction.

Simon Stevens: My philosophy is that primary care is absolutely fundamental to what has been the success of the National Health Service and will continue to need to be, but, in order to deal with the kinds of opportunities that we have talked about around more modern out-of-hospital care, we are going to have to make sure that GPs have the resources they need and that we do primary, community and social care in a different kind of way. So I think I am open to all kinds of ideas as to what that should look like.

Q98 Valerie Vaz: So you are not ruling it out then.

Simon Stevens: I am not quite sure what the “it” is.

Q99 Valerie Vaz: I just quoted it. I don’t know how many times you want me to read it back to you. The equivalent of having—

Chair: Not too many more, Valerie, if you don’t mind.

Valerie Vaz: I think I am speaking English. I think I understand that I am quoting directly. You don’t seem to be able to say yes or no: “Yes, I rule it out completely,” or, “No,

there are not going to be free GPs or free independent GPs.” You are not ruling anything out. You are not saying no.

Simon Stevens: All GPs are independent. With the exception of GPs who are salaried employees of the community health services, they are independent contractors as a matter of law and have been, again, since 1948. To the extent that what we are talking about is giving the GPs more flexibility to shape services, budgetary clout to do so, the ability to work more closely with community health services, and develop mental health services on the back of budget, all of that kind of stuff absolutely is the conversation we have got to be having.

Q100 Valerie Vaz: And they haven’t got it under the Health and Social Care Act.

Simon Stevens: The Health and Social Care Act changed some things but it did not change some others, and I think we’ve got to look at some of the things that it hasn’t changed.

Valerie Vaz: Thank you.

Q101 Andrew George: David Bennett welcomed your arrival by saying that you were more sympathetic to the role that competition and choice can play. That is, presumably, more sympathetic than Sir David Nicholson. Why do you think he said that and what do you think that means?

Simon Stevens: Well, obviously, he is making a comparison and I can’t judge what the comparison is.

Mr Sharma: But do you agree with it?

Q102 Andrew George: Can I help you by saying that Sir David certainly is on the record on one occasion as saying that competition makes it difficult for health providers to make decisions, that competition law creates uncertainty, which means that those commissioning services tend to revert to lawyers more often than perhaps is good for them? I am filling in some of the words. Competition law equals uncertainty, equals going to lawyers, equals the health service getting into a bad place. The bad place is where he concluded that that tends to go. David Bennett, in contrast—who must know quite a lot about both of you, I guess—made the judgment that you were more sympathetic to competition and choice. Does that mean, because you are in a very powerful position with regard to the shaping of the NHS, that we will see a bigger push in terms of the opportunities for competition within NHS services in contrast to your—

Simon Stevens: I am a pragmatist for the reasons that I explained earlier. The relevant tests are what is going to be good for patients in a particular area and what is going to be good for us all as taxpayers. There will be circumstances where that will make sense. There will be many circumstances where it won’t. I do not think it is a one-size-fits-all solution.

Q103 Andrew George: No, all right; we will no doubt have the opportunity to come back to this at later dates to see how this narrative goes. But one issue that we did raise with

David Nicholson, certainly in the evidence session on 17 December, was the fear of cherry-picking; and I am sure you are well versed in the argumentation that surrounds that particular issue. At that stage he was saying he did not feel that there was any evidence of it going on and urged those who feared that it might to bring evidence forward. Have you looked at this issue? Do you have a view on it? Are you as sanguine about it as he was ultimately, on that issue?

Simon Stevens: This is something that in the context of routine operations has been looked at by the medical profession in the past and needs to be kept under review. That is entirely legitimate. There is sometimes—not in your case, Mr George—a bit of confusion about what we mean by cherry-picking if what we actually mean is that patients should get support in the place that makes most sense for the need that they have. A patient who does not need the full back-up of a super-specialist hospital should not be treated there, and to say that they are being treated somewhere else is not to say that they are being cherry-picked as long as the funding that goes alongside the appropriate place of care for them is commensurate with the costs of their treatment there, not at the super-specialist place. We do not say, for example, that GPs are cherry-picking patients away from hospitals when a GP looks after a patient in their surgery as against referring them to the outpatient department. We say primary care is doing the right thing and looking after the people that it can.

Q104 Andrew George: There is a difference between a patient who needs a hip replacement and one for whom good primary care treatment successfully avoids an unnecessary hospital admission, I would argue, in return. But with regard to the issue of understanding what we mean, if we were to pursue the concern that there might be active selection on the grounds of profitability or through clinically excluding patients with co-morbidities—and that is primarily the theme which I think is of primary concern with regard to the potential for case selection: in other words, you end up with those patients who are easier to treat and therefore the more profitable patients being selected out possibly from those centres that have the heavy costs of having to deal with the more complex co-morbidities—what is NHS England going to do to monitor the potential risk that that theme develops with regard to future services and the potential risk to those centres that need to maintain a level of specialty and capacity to deal with very complex cases, which will be undermined if they lose those patients?

Simon Stevens: To ground it in a practical example, am I right in thinking that your point is that, for example, if a patient is treated in a community hospital in Cornwall rather than in Truro, the community hospital should be reimbursed at a lower rate than Truro?

Q105 Andrew George: No; I am not saying that. You have a private operator. Often it is this same surgeon—let us stick to routine elective orthopaedics—in a private hospital. Because they do not have intensive care and do not have the range of services, they will select patients on the basis of ease and, one might argue, profitability. The private hospital will deal with the easier cases and the NHS hospitals, with all of the facilities, will deal with the more complex ones, and yet the tariff system may not necessarily reflect that.

Simon Stevens: Yes. I think there are several things on that. You are right to raise the matter. It is something we absolutely have to keep under review. The first thing to say is

that it is important that it is patients and GPs who are doing the choosing, not the hospitals themselves. That is an important safeguard in respect of what you have just mentioned. The second thing is that we do need to continue to ensure that the tariff-based payment reflects the health needs, in the round, of the patient who is being treated. To use an orthopaedic patient as an example, the person who has lots of other co-morbidities and is a higher anaesthetic risk is going to need more back-up, safely, and the hospital needs to be compensated for that back-up. You are quite right.

Q106 Andrew George: That is one that we need to keep under review, in my view.

I want to move on to one other area, which is the any qualified provider provisions and what the NHS has done previously—or your predecessor had done previously—in relation to the CCGs having a legacy of decisions made by primary care trusts in respect of a range of services which they were obliged to put out to tender to alternative providers. The any qualified provider system is one which applies across the country. This can range from medical services to audiology through to physiotherapy and others, which you are well aware of. The CCGs have now had a year of seeing how that system works. A lot of them are unimpressed by the way the system works, partly because there is no budget limit and it is less easy for them to manage or ration that particular service financially. Is this an issue which you are keeping under review, because clearly this is an area of both competition law and effective management of resources?

Simon Stevens: Yes; I am sure my colleagues are. I cannot claim it is an area I am keeping under review, but I would be interested in starting putting it under review because I do think, for the reasons you say, it is something we need to learn wider lessons from. I am certainly interested to hear more of that.

Q107 Andrew George: You are not aware of that issue at present.

Simon Stevens: Do you mean around issues with the AQP system in the CCGs because of referral?

Andrew George: That is right.

Simon Stevens: One obvious thought is that it is GPs who are doing the referring, I assume, to the AQP providers.

Q108 Andrew George: No, you can walk in off the street.

Simon Stevens: So it is direct access.

Q109 Andrew George: Not only is it an alternative provision to the mainstream NHS provider but it is also self-referral. You can walk in off the street.

Simon Stevens: Yes. If you take the discussion we were having earlier about mental health and IAPT, that is the sort of programme where, frankly, in order to get people the service they need we probably do need a broader range of people who are able to provide that. So

I think there will be some circumstances where it will make sense and others where it does not, and I would be keen to hear more.

Andrew George: Yes, okay. On the basis of your answer, I would certainly strongly encourage you to look more closely at that issue because I fear that it is an area in which resources are likely to be wasted. It is certainly one about which CCGs, I think, need to be spoken to because I think they have an opinion on the matter.

Chair: Right. The wind-ups are taking place so there are going to be votes fairly imminently. I am going to ask Barbara to ask one question and hopefully Charlotte one question, and then I think we are probably done.

Q110 Barbara Keeley: I will jump to a question on the care.data database, which we have been having an inquiry into and found some quite disturbing things. Clearly, there is a general view, I think—or a lot of people hold the view—that public trust has been undermined by the debacle round the introduction of that database. But some evidence that was given to this Committee, for instance, was about data download to 249 commercial reuse licence holders and then in some cases on to their commercial arms. They were selling that data on; there was uploading of the whole HES patient data on to Google servers in the United States and various things. Really, it was difficult for HSCIC to disagree that they had lost control of that hospital data, and there is a view—to which even some staff at HSCIC had subscribed—that it might be possible in some cases to re-identify patients, although there are not meant to be identifiers. I think we have seen in this Committee what the reasons for the concern are. We put to HSCIC various aspects of that, including, for instance, the idea that it would be sensible for NHS England to announce that it will only re-launch care.data when all problems and concerns have been resolved. Yet I understand that there was the six-month delay instituted and there seem to be signs now that the next phase of that project—the GP data inclusion—will go ahead from September.

I have to say I am still getting a fair amount of concerns being expressed to me as a Member of this Committee, so I put that question to you. Would it not be more sensible for NHS England to wait until it seems that the level of concern has resolved and that public trust has been restored to some extent rather than just having an artificial six-month time scale, because in fact when the six-month time scale was set it was not clear how long it would take to resolve those issues?

Simon Stevens: Yes. I do not think there should be an artificial time scale, as you describe. Clearly, this is an important moment to listen much more carefully to what a range of people have to say about the way this programme should develop. There is, as you know, an independent group chaired by the chief executive of Macmillan Cancer Support that is looking at this now. In addition, the important new protections that Parliament is going to introduce in the Care Bill to safeguard patient data is going to be central to ensuring that public confidence in this programme is in place.

Q111 Barbara Keeley: I have to tell you there were mixed views about whether that went far enough, but a lot of us felt it did not. There is maybe still time for further

amendments in the House of Lords, but I personally did not feel that the measures went far enough.

Simon Stevens: I think your central point that we should not have an artificial start date before we have properly had a chance to consider the concerns that exist, and act on those where we can, is right. Equally, there is great potential benefit for us all, as patients, in getting this programme up and going. I was reminded of that again this weekend when I saw the Sunday newspaper stories about the fact that for many patients—in fact, for a quarter of patients, often with cancer—it is only when they go to their A and E department that their cancer is detected. If we can get care.data right, that will enable us, as a National Health Service, also to work out which GPs or which parts of the country we really need to put a special effort into helping patients come forward quicker to get treated before they present at an A and E department. As a result, they are likely to do much better. So there is a real medical benefit, as well as a research benefit, from being able to act as a National Health Service in the way that I think most people would think that we should do. That is the balance we have to strike.

Q112 Barbara Keeley: If I can say a final thing, it was not those clinical or research uses that were bothering people. It was the market and commercial uses that were bothering people.

Simon Stevens: Yes. That has been, as I understand it, now clearly dealt with by specifying statutorily that data can only be used for health service purposes.

Q113 Charlotte Leslie: Very quickly, I was going to ask you about your assessment of the impact on training of, particularly, surgeons, with ISTCs, cream-skimming simple cases and leaving the complex cases for NHS hospitals and trainees, but I don't think I have time. I wonder if you could perhaps do a note to the Committee just on your assessment of impact on training of junior doctors of ISTCs skimming off—

Simon Stevens: Let me give you a very quick answer on that. More generally, I think one of the things that we have not done right around the NHS—this will be a controversial final note for me to end on—is that too much of the decisions about how hospital services are organised has been driven by decisions about how to train junior doctors, and that is partly as a result of working times arrangements. The Royal College of Surgeons, actually, has been quite thoughtful about that in recent times. So I am not sure I accept the premise of your question.

Q114 Charlotte Leslie: We will argue about that because the training of doctors is your future consultants and your work force.

Simon Stevens: It is, but—

Q115 Charlotte Leslie: And the NHS is not a system; it is the people who work in it. So we can have that debate later on.

Simon Stevens: We do need to train doctors and it is great that we have had a 58% increase in medical school graduates since the early 2000s, but we also have to start with

the needs of communities and patients and then make sure that modern ways of training doctors are in accord with that, rather than reshaping the whole of the National Health Service on the back of training decisions.

Q116 Charlotte Leslie: I disagree, but, moving on very quickly, one of the things that has characterised the NHS coverage in the last year at least is the culture of fear that was highlighted by the Francis report and that was previously highlighted by three reports published in 2008 by three US organisations looking at the NHS. You will have seen the saga of Dr Raj Mattu. What do you think we can do in regard to the kinds of people who, instead of taking his concerns seriously, embarked upon a series of efforts to discredit Dr Mattu, getting in private investigators? What can we do to hold those managers and those individuals accountable for what could have been life-threatening decisions to the patients that Dr Mattu was raising concerns about?

Simon Stevens: One of the things we have to do is set a tone inside the National Health Service that says it is important to take seriously concerns that are raised. I have attempted to do that right from the start, and I will be continuing to do that tomorrow when I meet Dr Mattu in Birmingham and discuss the lessons that the National Health Service needs to learn from his experience.

Q117 Charlotte Leslie: When trusts, managers and, in many cases, doctors are under a huge pressure often from the political class to present a very good image of what is going on in the NHS to the rest of the world, how can we have incentives that make it less convenient and less easy to hide unpleasant truths than to reveal them—what incentive drivers—because goodwill, frankly, has not been good enough?

Simon Stevens: Yes. We have to set a new culture of openness across the National Health Service. We have to ensure that there is independent scrutiny of what is going on inside our hospitals and our primary care services. We also have to take seriously things like the results of staff surveys, friends and family tests that ask quite pertinent questions like, “Would you want a family member or a relative treated in the hospital where you yourself are working?” Those are all, I think, important data points that we have to act on.

Q118 Charlotte Leslie: Do you think accountability for managers in the same way that you have accountability for doctors through the GMC is an important plank of doing that?

Simon Stevens: I think that is a discussion worth having, but, for starters, one of the things that will improve matters is to have more clinicians in management. Whether you want to put in place a new professional regulatory mechanism for the occupation or the job of managers is something that has been debated down the years and so I look forward to continuing the discussion with you.

Q119 Charlotte Leslie: Finally, one of the things I think many of us have detected in the NHS is that there is planet manager, planet politician and DH official, and then there is

planet reality on the ward and of the professionals who are actually doing it and the patients who experience the service. In your role, how do you intend to avoid going native and joining planet politics?

Simon Stevens: There are many planets to choose from there. First and foremost, it will be by spending a big chunk of my time in various parts of the National Health Service and, more broadly, talking to patients, relatives and our front-line staff. But, above and beyond that, it will be by putting in place some of the kinds of mechanisms that are going to be needed in order to ensure that, across the board, as I tried to say right at the start, we do systematise thinking like a patient and acting like a taxpayer.

Q120 Charlotte Leslie: Your predecessor was very forthcoming on what he was going to do if whistleblowing problems were raised with him. Unfortunately, that possibly did not turn out as he had promised. Are you going to be able to take any responsibility if whistleblowing cases and concerns are being raised and there is no other home for them? Do you feel you have any role in helping whistleblowers make their cases heard?

Simon Stevens: It is evident from the fact that in my first week in post I spent time with a number of people who have been whistleblowers, both in hospitals and as relatives of people who have not had a good service from parts of the NHS, and I will continue to do that. The more important point is that we have to find a way of systematically acting on the insights that whistleblowers are able to bring, and I think that the Care Quality Commission obviously is going to be an important part of that. Even more fundamentally, we have to get to a situation where quality concerns are listened to and addressed right at the start rather than building up such that somebody feels they then have no choice but to take the courageous act of being a whistleblower.

Charlotte Leslie: Thank you.

Q121 David Tredinnick: We are getting near the end, I think. In your speech on your first day in post you spoke about boosting the role that patients play in their own care.

Simon Stevens: Yes.

Q122 David Tredinnick: The Secretary of State has himself said that patients should be at the heart of the health service. Are you considering expanding personal care budgets, which seem to have shown that where patients and their carers are given control of the budgets—and they are allowed to spend on some quite unconventional things such as piano therapy, maybe, which is one example I spotted—we can empower people through doing this and reduce costs? Is that something you have considered or will consider? With personal care budgets—

Simon Stevens: Everybody in receipt of NHS continuing care this year will be entitled to ask for a personal budget. That is a commitment that has been made drawing on, as you say, the experience for a number of years now under various pilots that have shown the benefits that accrue in terms of patient experience and also knock-on in terms of more efficient use of resource. There are constraints. There are circumstances where that won't work terribly well, but in the many cases where it will, like you, I look at the evidence, hear what patients say and think we should be doing it.

Q123 David Tredinnick: Finally, you touched on acupuncture earlier on, saying that it is now coming into the mainstream, or words to that effect. NICE have approved acupuncture for lower back pain, but when I last checked there are about 60,000 hospitals in the People's Republic of China who are using acupuncture for a whole range of different conditions. Would it not be a good use of health service money to investigate all the other treatments that acupuncture is associated with, because, at the moment, we are simply limiting NHS funds in respect of the use of acupuncture to a very small range of treatments? Surely it would be a good use of money to try and investigate all the other treatments or at least some of the other treatments that acupuncture is used for.

Simon Stevens: Yes. I do not know what is on the NICE docket for further reviews of acupuncture, but I personally certainly have seen patients successfully receiving acupuncture for a broader range of conditions than lower back pain, including being with somebody who was having an operation, who instead of having an anaesthetic had acupuncture, which was a pretty dramatic demonstration of the power of something.

David Tredinnick: Thank you.

Chair: We are at the stage of the session where every Member virtually has just one very, very short question they want to ask. Andrew first.

Q124 Andrew George: On the issue of continuing care, since you mentioned it, as far as the casework that I have been dealing with is concerned, you have to be virtually dead to get continuing care. Is it within your gift to define what the barrier is to achieving it? It is almost to the point of absurdity. You virtually have to be on your last legs with so many co-morbidities that you are halfway to a box, I am afraid. Is that anything you can do anything about?

Simon Stevens: I wonder whether at this stage of the afternoon I am allowed to say, "I don't know."

Andrew George: I think you did to some of my earlier questions.

Chair: That was a short question—very welcome. Anybody else?

Q125 Valerie Vaz: Briefly, you were a councillor in Brixton and you know the balance in being accountable. You let the officers get on with it, but in the end you are accountable for it. Who do you see as accountable for what goes on in the NHS?

Simon Stevens: I have a personal accountability, including an accountability to you, which is why I am here today as the accounting officer for the expenditure that Parliament votes for the NHS. That is obviously a strong personal accountability and an organisational accountability that we have as well. I am also accountable to the board of NHS England. But in terms of who is accountable for the NHS in addition to me and NHS England, the Secretary of State is principally accountable to Parliament for the overall workings of the system. The Department of Health has responsibilities for a piece of it; the Permanent Secretary is the principal accounting officer for the Department of Health vote overall; and then individual bodies are responsible for the things they distinctively do. So I am sure

when you meet for your accountability reviews with the Care Quality Commission you are discussing the work that they do, which is different from the work that we do.

Q126 Valerie Vaz: The problem that is arising is that I have asked questions of the Minister. Actually, they say it is an NHS responsibility, so I do not get an answer back and I have actually had to ask the Library about what to do. I do not think it is appropriate for me to write to you directly because, obviously, it is not public in the way that written questions or oral questions are. Somehow I feel that there is not that accountability between NHS England and the Secretary of State and us as elected representatives.

Simon Stevens: As I understand it—and I say this having recently had the pleasure of signing some letters back to your colleagues—for those services which are the responsibility of NHS England, I will investigate the questions that you raise with me and will reply to you. For those services that are commissioned by CCGs, the CCGs will do that. Reflecting back on my days working for a health authority or working for an NHS hospital, in a way I am not sure that is that different. You would write to the Minister, but the Minister would often then refer you to the local health authority, and the local health authority would answer the question about the local hospital. It is probably different in different parts of the country.

Q127 Valerie Vaz: No. As an elected representative I was always responsible, and an elected representative is always responsible because we are out on the doorstep having to explain policies or anything else.

Simon Stevens: Sure; absolutely.

Q128 Valerie Vaz: It seems to me that that link does not seem to be occurring with this new structure.

Simon Stevens: The link between—

Q129 Valerie Vaz: The accountability between what you do and the Secretary of State in coming to Parliament.

Simon Stevens: Obviously I do feel accountable, and today is evidence of that, but the Secretary of State clearly has political accountability for the stewardship of the National Health Service and has to account to you through parliamentary processes for that.

Q130 Valerie Vaz: Great. Are you meeting with him regularly?

Simon Stevens: Of course I am meeting with the Secretary of State and lots of people, and would expect to have a constructive relationship with whoever is the Secretary of State in whichever Government.

Q131 Valerie Vaz: That is what I am asking you. Are you meeting with him regularly—once a week, twice a week?

Simon Stevens: I am four weeks in so it is hard to infer a pattern as yet.

Q132 Valerie Vaz: Have you met with him?

Simon Stevens: I have met with him, yes.

Q133 Valerie Vaz: Well, how many times? Gosh!

Simon Stevens: Probably twice, but I might have to check that—something like that, yes.

Valerie Vaz: Please raise this issue with him.

Q134 Rosie Cooper: You mentioned independent scrutiny. What do you mean by those words?

Simon Stevens: Independent scrutiny by you of NHS England.

Q135 Rosie Cooper: No. Charlotte asked you questions about trusts and whistleblowing, and you said everything should be subject to independent scrutiny.

Simon Stevens: Yes. I was particularly referring to the role that the Care Quality Commission is now playing.

Q136 Rosie Cooper: That is great. I was really bothered about that because I asked the Prime Minister a question and asked about the bullying culture. The mechanism that Liverpool community trust used to bully their staff was the HR policy, so I asked the Prime Minister whether we could have a forensic investigation into the HR policies of the trust, historical as well, because that is how they engendered this climate of fear. The problem was that the Prime Minister agreed but said the CQC should do it. When I put that to the CQC, they did not actually have the powers to go back and do a forensic look at HR practices. They look at what is now and the bullying. So Liverpool community trust's response to a very difficult CQC report was to spend loads of time and money on teaching people the answers to the questions CQC might ask them and also to have their own staff annoying the rest of the staff on the front line while they are trying to do their job, short staffed, because they are pretending to be CQC inspectors. This is just daft. It is not independent scrutiny when the CQC can look at bullying but not look at what is underneath it and hold people to account. Now, the TDA have done that, but the truth is the board in all that time allowed all this to go on. Where is the independent scrutiny if it is the board and, in this case, the accountable officer is one of the people who has gone? How can that be independent scrutiny? Where is the back-stop?

Simon Stevens: I think in the situation that you have just described very graphically the back-stop would be either the TDA or the CQC.

Rosie Cooper: Okay. I have to say I was able to prosecute this really hard but that is because I am here. How do whistleblowers do that? Where is the independent scrutiny for them? I leave that as a challenge to you, but it is something that really needs thinking about. As to the CQC's and TDA's powers, there are ways that you will fall through the gap. This hospital was actually fast-tracking to be an FT before I started this. This is nonsense. How did they get away with it? How?

Chair: That is a rhetorical question, I think.

Q137 Dr Wollaston: Mr Stevens, in your opening comments you talked about putting operational daylight between yourself and the Department of Health. Can I ask you if there are any areas where you see there are differences in your vision for the NHS between yourself and, say, the Secretary of State, and where there are disagreements will you be flexing your muscles and saying that this is how it is going to be done, because one of the purposes of the Health and Social Care Act was to have separation?

Simon Stevens: I think I would say two things about that. One is that the goals that are established for NHS England are obviously a matter of public transparency and accountability, so everybody can see what the mandate is that we are supposed to be working to, and, to the extent that there is a debate about whether that is the right mandate or not, that is a conversation that happens between NHS England and the Government and that is publicly transparent as a result. It is not just a question of a series of ministerial submissions, as in the old days, with branches of the civil service or the Department of Health doing or not doing things. It is there for all to see. These are the things that we are seeking to achieve.

The second thing I would say is that I think we do have a responsibility to speak up as NHS England on behalf of patients and with the National Health Service. That is one of the things that I think, come the autumn, as we think about where the National Health Service needs to move over the next five years or so, we will do, and that will be a view from the NHS and from NHS England.

Chair: On that note—

Q138 Rosie Cooper: I am really sorry about this, but five-year plans: politically, you know, we decide what funds are available, so why would you write five-year plans? On Twitter, everyone is saying that five-year plans in a political environment can only be pure fiction.

Simon Stevens: Instead, would the Twitterati prefer a one-year plan?

Q139 Rosie Cooper: A one-year plan would be very difficult.

Andrew George: In 140 characters, yes.

Simon Stevens: I think the answer is because we need to look beyond the end of our nose. We need to answer some big questions about how care needs to change in order for the

National Health Service to do well, modernise and serve patients, and that cannot all be done in a succession of 12-month periods.

Rosie Cooper: Absolutely.

Chair: I think that is the answer to the Twitterati and this has been a long withdrawal, but thank you very much indeed for coming this afternoon.

Simon Stevens: Thank you.