



Health Committee

Oral evidence: Public expenditure on health and social care, HC 679

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

Questions 1 - 159

Witnesses: **Simon Stevens**, Chief Executive Officer, **Professor Sir Bruce Keogh**, National Medical Director, **Paul Baumann**, Chief Financial Officer, NHS England, gave evidence.

Q1 Chair: We are sorry to have kept you waiting. Welcome to the first of our sessions into public expenditure on health and social care. It is also a fantastic opportunity to raise some further points about the Five Year Forward View. We are very grateful to all of you, as a panel, for coming, and I wonder, for the benefit of people listening, whether you could introduce yourselves, perhaps starting with Professor Sir Bruce.

Professor Sir Bruce Keogh: I am Bruce Keogh. I am the medical director for NHS England.

Simon Stevens: I am Simon Stevens, chief executive of NHS England.

Paul Baumann: I am Paul Baumann, the chief financial officer of NHS England.

Q2 Chair: Could I perhaps start with a question about finance—not because we want to focus on things that are not about patient care but because, absolutely, patient care is dependent on the finance of the NHS—about where we are now? There is much in the Forward View about the funding gap opening up, but perhaps we could explore the baseline and also the assumptions that come behind—the figures that are referred to in the Forward View. Perhaps, Simon, are you able to—

Simon Stevens: Yes, certainly.

Q3 Chair: Where are we now? What is the current situation with the funding gap in the NHS?

Simon Stevens: There clearly are real pressures, but if we were having this conversation five years ago, looking out from 2010 to 2015, and saying, “The health service is going to be able to manage with protected but pretty close to flat real spending,” a lot of commentators would have said, “There has been no point in the health service’s history where that has been possible; the wheels will come off.” So it is a huge testament to people across the health service that the quality of care for the most part has remained very strong. There really are substantial pressures, but in some respects things have also improved. I think, seen in the round, the last five years have been a period of pressure but continuing quality of care for patients, with some notable gaps. But right now, as we sit here, the pressures are building in A and E departments, in terms of referrals, GPs are working incredibly hard and hospital finances are also showing the strain.

Q4 Chair: Yes, the strain is showing across the system. At the moment, how many foundation trusts do you estimate are going to be in deficit this financial year?

Simon Stevens: That is obviously a job specifically for Monitor. There are 147 foundation trusts and their first quarter deficit I think was £167 million, but I defer to Paul on that. As far as the non-FTs are concerned—the trusts—I think a third of them are in deficit right now.

Q5 Chair: For CCGs, could you give us perhaps an overview of where we are now? How much is the NHS in debt across the system? Could you perhaps give us some more detail on that?

Paul Baumann: Shall I pick that up? You have dealt with the provider sector. The current expectation on foundation trusts is that round about 53 of that 147 you talked about will be likely to be in deficit at the end of the year. As you know, the forecasting process for foundation trusts is a little different from that for the rest of the system.

Q6 Chair: To be clear, you are saying 53 of 147 you forecast to be in deficit.

Paul Baumann: It is not my forecast, to be clear, because it would be Monitor that would do the forecasting with the foundation trusts. My understanding is that is the latest position and, clearly, they will clarify that in subsequent hearings. But that is my understanding anyway.

Q7 Chair: When we hear the figure of 80% in deficit, where does that come from?

Paul Baumann: That might have been at a point in time—cumulative numbers. Typically what happens, for a variety of reasons, is that trusts tend to be in deficit in the early part of the year and then the rest of the year tends to be a progressive improvement. I cannot recall the 80% statistic that you quote, but I do not think that would be a forecast for the whole year. It might have been a position in time.

Q8 Chair: What about with regard to CCGs?

Paul Baumann: We have, as you know, 211 CCGs, and at this point in the year the forecast is that 18 of them will be in cumulative deficit. That is a similar number—a slightly different composition—to the number that were in deficit in 2013-14. There is about another 15%—about another 30—who are between 0% and 1% in surplus, and then the rest of the 211 are in line with our financial strategy to have at least a 1% surplus going forward.

Simon Stevens: But, in the round, NHS England expects to finish the year in a balanced position.

Q9 Chair: So in balance, overall.

Simon Stevens: Yes. That is NHS England and through CCGs, yes.

Q10 Chair: Are you expecting to have to top slice the CCG budgets as you did in previous years from the NHS England budget?

Simon Stevens: No. We discussed last time the particular situation that arose in specialised commissioning in 2013-14 and the difficulty with getting the baseline for that right, at the beginning of last year. That is not a position that is likely to repeat itself this year, although there are still pressures inside specialised commissioning.

Q11 Chair: Can I ask you to explain in more detail some of the assumptions that underpinned the figures that appeared in the Five Year Forward View?

Simon Stevens: Yes. My predecessor quoted a £30 billion gap as being what would open up if three assumptions held: one, that demand continued to grow for health services at their current rate; second, that funding was flat in real terms; third, that the health service delivered no efficiencies. What we are saying in the Five Year Forward View is that we want to challenge all three assumptions. We think there are things that can be done to improve demand—the burdens that have been placed on the health service—particularly over the medium term, by getting more activist around prevention, public health and other ways of supporting communities with their broader health needs, not just conditions that present in the health service itself.

We believe that the health service can, as a result of substantial changes in the way in which care is provided, generate more efficiencies not through salami slicing but through providing more joined-up care, particularly for people with chronic health conditions. As a result of that, if we get some pump-priming to kick start the changes that we will need in different parts of the country, we think that it is not unreasonable to expect 2%, perhaps even rising to 3%, of efficiencies through this period, which is roughly on a par with what we have managed over the last five years, but the composition of those efficiencies will change.

When you do those two things, we think that, of the £30 billion or £28 billion gap, that perhaps gets you two thirds of the way there by 2021. That would still leave an £8 billion gap between what people might be expecting from the health service and the available funding and efficiency. To close that £8 billion gap, you would need increases each year in

the next Parliament of about 1.5% in real terms, which is not that different from being flat, in real terms, per person, given that we have a growing and ageing population. That 1.5% in real terms is obviously still a big ask. It is about twice the rate of the real terms increase that has happened in this Parliament, but, seen against the medium term, let alone the long term, it is still substantially less than what the country has been able to afford in terms of annual rates of increase for a tax-funded comprehensive health service of the sort that we think the country wants. That obviously is a matter for you, ultimately, to decide—for Parliament to decide—not for the NHS, but the NHS is setting out its point of view on these important questions.

Q12 Chair: Just to be clear, when you are talking about £30 billion as the worst case scenario funding gap, you are referring to £30 billion per year. Sometimes, you hear a lot of woolliness about the way—

Simon Stevens: The wedge opens up and becomes just under £30 billion by 2021.

Q13 Chair: But £30 billion per year.

Simon Stevens: In that year.

Q14 Chair: In that year. Some people were referring to it in different ways.

Simon Stevens: Less the year before and less the year before that, but that is the wedge.

Chair: Right, but we are clear that it is an annual £30 billion gap—

Simon Stevens: Yes, that is right.

Q15 Chair:—if we do not take the action that you set out in the Five Year Forward View, but you are also saying at the moment, as we stand now, although services are under pressure, that the NHS is budgeting the books. In other words, you are saying there is not a funding gap at the moment.

Simon Stevens: There are clearly pressures showing up in providers, but through NHS England and the commissioning system we expect to balance the health service for the year. Partly that is because we have, as a system, made on some measures about £20 billion-worth of efficiency savings during the course of this Parliament and that has obviously gone a long way to helping.

Q16 Chair: But beyond this place, when people talk about the funding gap, they are referring to both commissioners and providers. They are talking about the NHS as a whole.

Simon Stevens: That is right, and that is what we are talking about when we talk about the £28 billion or the £30 billion, the combined system.

Q17 Chair: Today, though, for the combined system, as we stand for this financial year, are you saying that there is going to be no funding gap for this financial year? You have said there is not for commissioners but you have implied there is something different for providers.

Simon Stevens: Yes.

Q18 Chair: I would like to consider the whole system, so is there a funding gap at the moment and how much is it?

Simon Stevens: The health service as a whole will obviously balance the revenue—Department expenditure limit—which is set for us by Parliament, and that is our collective responsibility. Some of that is discharged through Monitor and through the Trust Development Authority, and hence the Department of Health. Some of it is discharged through NHS England. So the first half of the answer to the question is that we will meet the revenue limits set for us by Parliament this year. The second half of the question is that more of the pressures are showing up on the provider side, the Government have made some more money available during the course of this year, but it is also still likely that some of those hospitals themselves will present deficits, come the end of the year. I do not know whether at this point Paul wants to try and put an aggregate number on that or whether that is something on which we will give you a more up-to-date estimate when we come back next time, as the year has further matured.

Paul Baumann: For our position, we will end up this year with a cumulative surplus of £467 million. That is the plan we have for the year. We have pressures against that but our mitigations are just about sufficient to get us back to there. It is important to note that that is £400 million less than we exited last year with. So, in the rather odd way that we look at commissioner finances, that is a reduction in surplus. In other words, we are spending more in year than the in-year allocation. But we end up with a £467 million surplus. Broadly speaking, the last forecast I saw—at least for the provider sector—was about a £500 million deficit in the provider sector. So you can see that, taken together with the Department of Health position, which doubtless has pluses and negatives in it, that gets back to a broadly just about balanced position this year. As you will recall, in 2013-14 it was very slightly on the surplus side. So we are in the territory at the moment where the total vote is very delicately poised between being in balance and not quite in balance. The belief is that this year we can keep it just about on the right side of the balance line.

Chair: Thank you. I am going to hand over to Rosie.

Q19 Rosie Cooper: In order to close the £30 billion gap in funding that is anticipated if no change is made, the NHS would, among other things, be required to achieve efficiency gains of 2% to 3% per year against reported gains of around 1.6% in recent years. My question is about the level of efficiency gain that you have actually managed in the last three years. Is a 2% or 3% gain even beginning to be practicable, is it credible and would it not be possible to rely on existing measures such as wage restraint? Appalling though that is, would it be an answer to your difficulty? I want to come on to ask a couple of other questions in a

second. What other efficiency mechanisms do you have in mind that have not been pursued so far?

Simon Stevens: Sure. Obviously, the Five Year Forward View is a shared perspective from all of the national leadership bodies in the NHS. It is Monitor, TDA, NHS England, Health Education England, Public Health England and the Care Quality Commission. This is our combined view and, as part of coming to the conclusions that we have, we obviously have debated quite carefully the very question that you ask in terms of, “Is it realistic to expect 2%, perhaps even rising to 3%, efficiencies over the next five years?” Our combined view is that, on balance, challenging though it is going to be, it is possible to imagine reaching those levels of efficiency and here is how we get to that answer.

When you look at what has been achieved over the last several years, the net provider efficiency has been north of 2%. The headline rate that we ask for each year through the tariff has sometimes been about double that, but then, with various so-called leakages, about net 2% is what has been achieved. Some work that was done for Monitor has looked at the two sources of efficiency available to providers, one of which is catch-up, that is, “What if the less efficient providers adopted best practice at the level of the most efficient?” They model that gains of perhaps 5% to 5.6% of spending are available, which obviously would be staged annually, so you would not get all of the 5% and 5.6% in one year, but that might give you a percentage point a year for five years. In addition to that, it is not just the catch-up, but there is the fact that it becomes possible to provide care more efficiently as a result of technology, treatment changes and so on each year. The empirical evidence on that suggests that you can probably get another 1.2% to 1.3% of annual efficiency from that source—the so-called frontier shift. If you put catch-up plus frontier shift together, that gives you north of 2% net. So that is one part of the answer.

You rightly make the point that perhaps a quarter or a third of efficiency that has been achieved in this Parliament has come from pay restraint. We argue in the Forward View that that is unlikely to be an indefinitely repeatable strategy as the rest of the economy picks up and as pay pressures build in the private sector. This will not necessarily hit immediately this year or next, but, over time, we know that when the rest of the labour market is fizzing away, if we want to recruit and retain nurses in our hospitals, we are going to have to pay something approaching the going rate. Therefore, our argument is that strategies like pay restraint, come 2020-21, if the economic forecasts are worth the paper they are written on, are going to be much harder than they have been in 2013-14 or 2014-15. Therefore, the question is: what are the new sources of efficiency that can help some of the heavy lifting as those kinds of approaches go away?

Our argument is that there is quite a wide consensus across the health service as to how to integrate care and provide services that better keep people supported, out of hospital and in ways that would not otherwise have occurred. A figure we quote in here is from the Nuffield Trust where they suggest that, if we carry on doing what we are doing, then we are going to need 17,000 more in-patient beds by 2022 just to deal with all the extra emergency admissions, which is the equivalent of building 34 new hospitals. They argue we can do without building those 34 new hospitals if we do the sorts of things we are talking about in here. That is the new sort of efficiency we are going to get, rather than the salami slicing on input costs.

Q20 Rosie Cooper: Thank you. It is really very interesting that your plan—it is not a plan, which is the point I am trying to make—is called a Forward View and not a plan or a strategy. When we have discussed how you make a system more efficient, including when we looked at CCGs, one of the real questions was that you need to invest in order to get those efficiencies out. I was wondering if your scenario 3 requires the delivery of 2% to 3% net savings every year for the next five years, how much investment is required by year in order to deliver those savings, but from year 1, and do you have any costed plans in place at local level that would deliver those necessary savings, 2% or 3%, from year 1?

Simon Stevens: Yes. I do not think we are expecting that the service can deliver 3% from year 1. If we make investments up front, then that will enable the efficiency ramp to increase over the course of the Parliament. But what we have done is looked at different parts of the country, different geographies, where some of the new ways of providing care that we think are part of what the future should look like are already in place. We have looked at the impact that that has had on utilisation and cost and so on. So we quote some particular examples just to give a sense that this is not cloud-cuckoo-land; this is already happening in certain parts of the country but is not happening at scale. Our intention is to use the next five or six months with different parts of the country to look very specifically at their starting position, where they would need to get to and what the costs of transition might look like in order to be able to answer that question come early next year. Having said all that, we know that we are going to need to make investment in infrastructure and we have some sources of funding for that available to the health service if we could put them to work. There is around £4 billion of savings sitting on foundation trust balance sheets. Foundation trusts are at the moment, for the most part, prevented from investing that in primary and out-of-hospital services. That is one of the reasons why we say in here we think in some places that would be a good thing to allow. Monitor has estimated that up to £7.5 billion might be the value of the surplus land and buildings that are sitting in different parts of the health service. We need to put that to work. So there are some opportunities for us here; none of it is easy, but, on the other hand, it is not all just a hand-out.

Q21 Rosie Cooper: Do you have any view about how much you would need to invest? For me, the important thing about this view is that, if you are going to get out of the starting blocks, year 1 is going to be really important. Do you have a plan for how much investment will be required? Do you know locally what the shape of that will be? Really, I suppose, for us as a Committee, when will we know what funding is required? Will that be part of the Autumn Statement? How will we get to know what those thoughts really are in detail?

Simon Stevens: Yes. Our point of view is that there are two bad ways of trying to answer your question. One is for us to sit here and try and come up with a national answer that takes no account of the different starting positions, the different game plans that different geographies and communities around the country have. The other bad answer is just to leave it to each locality to try and figure out for themselves and then see if they can muddle through. That is not going to work either. That is why we are going to use the next five or six months to have that shared national local conversation about what this will look like so that, come next spring—late spring—we will have the costed answers to your questions in a ground-up way.

Q22 Rosie Cooper: So this is going to be a hybrid way of doing it.

Simon Stevens: Yes.

Q23 Rosie Cooper: We talk about allowing people to make decisions locally—local decision making—and there will be no massive reorganisations, yet this is all predicated on what will be a radical change in the NHS.

Simon Stevens: Yes, but the key distinction is that what we are talking about is not throwing all the administrative arrangements up into the air, you know—deck chairs on the Titanic, that kind of thing. That is not what the NHS wants. That would be, in the views of most people around the health service, a big distraction. As we say in here, there are many different ways in which you could organise the administrative tiers of the national health service and in fact most of them have been tried at some point or another down the years. The important point is not, “Is there a right answer?” It is just that there is a wrong answer, and that is to keep changing your mind. We are saying do not let us get too distracted by that, because the much more fundamental thing is that nurses, doctors, therapists, front-line workers, patients groups, communities and local authorities need to see change in the way care is organised, not the headed notepaper.

Rosie Cooper: I am going to stop here because there is something I want to go forward with but it impinges on somebody else’s question, so I will come back if I may.

Q24 Andrew Percy: On funding scenario 3, I think it refers to “flat real per person” increases as opposed to flat real terms increases. I think it is fairly clear what that means, but in the document it does not explain how much the difference would be in today’s money per year between those two. Do you have a figure for that at all?

Simon Stevens: Yes. That is the 1.5% that I am talking about because the ONS predictions are that maybe there will be another 3 million or 4 million people whom the health service will be looking after by the end of the decade. So if it is a fixed pot, even if it is protected against general inflation—and obviously we have many more patients needing our care—the difference between the two is 1.5%.

Paul Baumann: If it helps, I can take you through the numbers. The flat real protection would be round about 2% per annum. It varies slightly in the forward years, but, broadly speaking, 2% is expected to be the inflationary impact that we need to protect for. The population is expected to grow at round about 0.7% per annum in pure head count terms, if I can put it that way. When you weight that for the age and need of the population, that goes up to round about 3.3% or 3.4%, and effectively the document here talks about 1.5% on top of the 2%. In other words 3.5% is what is baked into—

Simon Stevens: Cash versus real.

Paul Baumann: Indeed.

Q25 Andrew Percy: So in cash value, what is that per year?

Paul Baumann: It is 3.5% of round about a £100 billion budget—3.5'ish.

Simon Stevens: Cash.

Q26 Andrew Percy: It is £112.8 billion, is it not, this year—

Paul Baumann: Yes.

Q27 Andrew Percy: —the total NHS budget? So it is 3%.

Paul Baumann: I am sorry, can you repeat that?

Q28 Andrew Percy: £112.8 billion is the entire NHS budget this year, is it not?

Paul Baumann: Yes, so all of this is really focused on the NHS part of that, excluding things like Health Education England, the central budgets of the Department of Health and the odd bods that we have. So, this year—

Simon Stevens: They are not that odd.

Paul Baumann: Thank you. This year, that is about £98 billion. As we go through this period, the resources grow clearly from that. But, broadly speaking, for the purposes of this document, any percentage you have you can take also as being a number of billions because it makes the numbers easier.

Q29 Andrew Percy: Can I continue on that? I could not see any reference to it, but obviously there is a huge debate at the moment around private providers within the NHS and the use of the word privatisation. I do not have a particularly ideological bent one way or another as to whether or not we should be utilising them. Have you made any assessment of the contribution of private or charitable providers to the NHS as to whether they deliver greater efficiencies? Are they cheaper or more expensive and what is their contribution to this that you foresee, moving forward?

Simon Stevens: This does not imply any change one way or another in that respect so it is not premised on there being a big expansion in privately provided care.

Q30 Andrew Percy: But of the expansion we have seen, which was up to 5% under the last Government—it has grown a couple of percentage points under this one—what assessment has been undertaken of the value of that portion of NHS care which is now provided through private or charitable providers in contributing to efficiency savings or to driving down costs? Has any work been undertaken on that and, if so, what?

Simon Stevens: As you say, 94p of every pound that buys health care in the NHS is spent on NHS providers. Slightly less than 6p is what is spent on private providers. Nothing in the modelling here relies on any differential change in that proportion.

Q31 Andrew Percy: Yes, but, of the 6p that there already is of £1, what assessment has been made of how that 6p compares with the 94p in terms of efficiency?

Simon Stevens: If you look at the 6p, of the episodes that are being paid for by the NHS as a result of where patients choose to get their care from a non-NHS provider, half of those are buying orthopaedic operations, eye operations and upper gastrointestinal procedures. So they are now being paid at tariff, that is, the same rate as the NHS providers would be getting for the—

Q32 Andrew Percy: Since the Health and Social Care Act.

Simon Stevens: Yes, that is right.

Q33 Andrew Percy: They were paid more before, were they?

Simon Stevens: The set-up costs for the independent sector treatment centres were, in order to bring in extra capacity at a time when the health service was trying to get waiting times and lists way down, which of course it dramatically succeeded in doing for waits, which were previously two years for a consultant, and then an operation down to an average or median waiting time now of less than 10 weeks. So capacity was expanded, but right now the point is that any provider that is delivering care for the same tariff is providing extra capacity but it is at the same rate.

Q34 Andrew Percy: My final question is, do you think it is time, in terms of funding, for political parties to establish some kind of Royal Commission or cross-party basis on which to approach this funding gap, moving forward? Obviously, we know there is an election coming and figures get traded about all over the place. I am not sure how helpful that is to the NHS. So do you think that this will only be addressed, whichever scenario plays out, if there is a cross-party approach to this funding? Parliaments last five years and this is a gap which is going to go well beyond that into several Parliaments. Is it time we had a Royal Commission on the future funding of the NHS?

Simon Stevens: One way of answering that question is to say: what has been the success of previous Royal Commissions in attempting to answer these sorts of questions? The historian in me would say it has been a very poor track record. Parking these important national choices that we as citizens send you to Parliament to decide, and expecting a kind of expert committee to come up with something, has not tended to work down the years. It did not work on long-term care when Sir Stewart Sutherland did it and it did not work prior to the 1980s or previous to that. In a sense, what we the NHS have tried to do is give you our best objective point of view through this Five Year Forward View; then we respect the democratic process and it is for you individually and collectively to make the argument and the decisions.

Q35 Charlotte Leslie: I have a very quick question on the back of what Andrew said. In terms of a long-term plan, do you think five years is anywhere long enough? The

question I do not look forward to answering as a politician to my grandchildren—if I ever manage to have grandchildren—is when they say, “Granny, why did you put your own election before safeguarding the NHS being free for me at the point of need?”, and I think we are looking at the next 50 years. If you look at the next 50 years, would it not be the case that perhaps you might look at slightly larger changes in the way we think of the NHS, fund it and organise it in order to have our grandchildren having the NHS free at the point of need? Is five years too short?

Simon Stevens: For some things, that is absolutely right, so Health Education England, for example, have a 15-year strategy around what the health work force of the future needs to look like, recognising the time it takes—what is it, 13 years—to train a consultant and broader changes that are required? So for some things that is absolutely right. I suppose we just have sufficient humility to believe that our ability to peer into the misty depths of 50 years ahead in health care is perhaps a little constrained. For now, at least, we are contenting ourselves with moving beyond the debate that will take us to next spring to at least the debate that will take us to the end of the decade. I am sure there is a good debate to be had about other bigger topics, including some of the fantastic changes that are coming to medicine that Bruce can talk about, as we move towards personalised medicine, anticipatory care and so on, but right now we are attempting to show that we the NHS have a game plan that could actually advance health and care in this country and that, in our humble judgment at least, ought to be affordable for the nation.

Q36 Charlotte Leslie: Do you think that will work in the next 10 years? Is that a game plan that you can continue with? If it is not, every five years you are going to be having a panic, “Oh, crikey, what do we do for the next five years?” Do you need to have a slightly longer-term vision? Of course you cannot predict the future, but you can plan for the medium and the long term. Is that work that is being done? This is an excellent Committee for doing that because we are cross-party, but obviously part of the huge problem is that the minute you mention anything about the future of the NHS, the Opposition say you want to eat babies and kill it. Is that something that NHS England is looking at?

Simon Stevens: Yes. For certain elements of what we are doing, clearly the pay-offs are much longer than five years. The work that Bruce is leading—and he might want to speak to it in a moment—on the 100,000 Genomes Project, for example, which the UK is going to be a world leader in, is probably not going to produce a huge clinical pay-off in the next two or three years, but eight, 10 years and beyond it could fundamentally change the way medicine works. Bruce, do you want to say a little about that?

Professor Sir Bruce Keogh: If you go back a few years, the genome inside the cell determines what makes us us and equally it has some determining factor in what diseases you might accrue during the course of your life. The first human genome took 13 years, I think, and \$2 billion to do. We now know that it can be done for under £1,000 and in less than a day and both the money and the speed are changing quite dramatically. That starts to lead us in relatively short order, we think, into territory where you can identify what diseases somebody might be susceptible to. You can also start to define those diseases in a whole new different taxonomy than we have used in the past and a whole different language. The reason for that is that it will enable us to bring targeted treatment to people. For example, when I was training in surgery, there were four different types of breast cancer. Now there are well over 40. There was only one type of adenocarcinoma of the

lung and now there are many types, all defined by the genetic make-up, and the treatment is defined according to that. So there is a great future there and I know that over the last two decades the future has always been almost there, but I think genuinely now we have an opportunity in this country to lead the world, and I think we will. But it raises other issues about the future of health care.

One of the great things about our NHS is that it is for everyone, is funded by everyone and that we all share in each other's risk. The idea that you can identify individual disease risks for people raises a spectre that different people will be subject, if we have different funding models, to different restrictions on their access to health. While people may wonder about the future of our health service, I think we are really fit for this particular type of future where we will share each other's risk and pool the risk. So I would argue that we are really fit for the future.

Charlotte Leslie: Thank you.

Q37 Chair: Before we come on to plan B, could I ask you to clarify something following on from Andrew Percy's point about the "flat real per person" funding? How sympathetic is the Treasury to the argument that we should adjust the funding of the NHS to "flat real per person," because that is an increase in funding, clearly? Have they indicated to you that they would be prepared to move to that model as part of the way of closing the gap a bit?

Simon Stevens: This is an independent report by the national health service, so this is not a Government report or a report from the Department of Health. Obviously, questions to the Treasury, or to anybody else, would be matters for you to raise direct.

Q38 Chair: I just wondered whether you had had any discussions with them as to the likelihood of having an extra source of income. There have been no discussions?

Simon Stevens: I think I saw a reported remark from the Chancellor following the publication of this, but the record would have to be scrutinised to recall precisely the formulation that was used.

Q39 Chair: Thank you. Coming on to the "what if" point, the Forward View sets out the vision of what you would like to achieve, but what it probably does not do is set out, "What if it is not achievable?" In other words, what happens if, say, the Treasury are not prepared to move to that real flat per person funding, you do not achieve the objectives in prevention and you do not achieve the efficiencies through reorganisation? What next? What do you see would happen next? Could you say a bit more about that?

Simon Stevens: You would like me to paint a picture of doom and gloom.

Q40 Chair: Indeed. Let us see the disaster scenario painted for us, laid bare. I guess what people are interested in is what would be the kind of choices that we would face. Have you already decided what the order of those choices would be—the tough choices?

Simon Stevens: Yes. We know part of the answer to that question by looking at what has happened to the health service at points in the past where funding has been very constrained. The reality is that a lot of the progress that we have been able to make over the last five, 10 or 15 years would probably be dialled back, so we would probably have fewer staff. We have added 160,000 more nurses, doctors, therapists and clinicians since 2000. There would obviously be pressures there. There would be pressures as to the rate at which we could begin to provide new treatments as they become available. As to the ambition that we set in outline terms in the Forward View on some of the big health conditions that we can see we have the ambition to do better on, progress would be much slower.

So, in the case of mental health services, for example, for the first time ever in the history of the health service, we have committed to have waiting time standards introduced for some important conditions beginning next year, recognising, however, that that is only just the beginning and we need to go on the journey over the course of the next five years that we have been on around quick access to care that works for physical health services over the last 25 years.

On cancer services, we make the same argument. We can see that there are things that the health service could do better. Despite the fact that our cancer outcomes are the highest they have ever been, they still lag behind what we could do and relative to some other countries. We think that, if we are able to make progress on early diagnosis and standardised quality of care across the country, we could be saving the lives of 8,000 or 10,000 people, or more, by the end of the decade. Those are the kinds of things that are in play.

Q41 Chair: So it would be a case of not being able to make the improvements that you would like to make. You would lose staff, but are there other things that you think would start to happen or that you have been looking at?

Simon Stevens: It will depend a bit, as we said earlier, on the other choices that the Government then in office choose to make, and there are other ways of driving compensating efficiency, at least for the short to medium term. If you look at what other countries have done that have had budget problems in parts of Europe over the last several years, there have been real, substantial impacts on staff and pay and the scope of services that are offered, and so on. The fantastic achievement of the national health service over the last five years is that we have managed to avoid big dial-backs in the offer that we make to the public and in the level of staffing. In fact, staffing in hospitals has gone up over the course of the last year. I think the foundation trusts are now employing 24,000 more nurses and other staff than they were a year ago, partly in order to get the right number of nurses on wards to provide high quality care, given what the health service so graphically saw in Mid Staffordshire.

Q42 Chair: Some of those dial-backs are already starting, I would suggest. In NEW Devon, in my area, they are consulting on restricting access to orthopaedic procedures for people who have morbid obesity. Clearly, they would make the point that that is because the outcomes are worse, but it also means that you could end up restricting treatments for people

who perhaps have one lifestyle choice, whereas you do not restrict orthopaedic procedures for wealthy people perhaps who have made a choice to go on a skiing holiday, for example. So things start to open up about access and health inequality. Does it concern you that we are starting to see those kinds of choices? What kind of grip centrally will NHS England exert to make sure there is fair access around the country when those decisions start happening?

Simon Stevens: Yes. Obviously, it does concern us. That is part of the reason why we are so keen that the health service moves heaven and earth over this next five-year period to play its part, more than two thirds of the gap closing that is required in order to avoid those kinds of situations that you describe. But the health service has come on a long way in terms of more uniformity of care now than there was a decade ago—more transparency, more national standards through NICE and the external scrutiny that the Care Quality Commission is providing. Those are some of the routes that are going to be used to try and ensure that we provide uniformly high quality care across the country, I think.

Q43 Chair: Right. So when you see some areas where there are very stark disparities between how much they fulfil NICE guidance—for example, on the offer for fertility treatment—how much will you as NHS England say that is an unacceptable variation?

Simon Stevens: Formally, I do not think we have powers to direct individual CCGs on the decisions that they make, provided they are consistent with the overall legal obligations that are placed on them, and obviously Parliament has entrusted two thirds of the responsibility for planning and funding care to CCGs rather than to NHS England direct. But we have a responsibility to seek to ensure that within some kind of guard rails, recognising the importance of local clinical-led decision making, the NHS continues to provide a uniform high-quality offer to all of the people in this country.

Q44 Chair: Finally, a question that the public very often raise with us is: are we moving to a US-style system where people have to start paying for care? Have you seen any extension of charging or top-ups in the time you have been away, and more recently since you have come back to work in the NHS? Do you feel there is a risk? Could you answer that question that the public ask us? Are we heading that way or not?

Simon Stevens: I hope not because I do not think that is what people in this country want. I think we have a fair health service that matches the values of the British people and where one of the defining principles has been care according to need, not ability to pay. To the extent there are any deviations from that, they need to be explicitly established by Parliament in statute.

Q45 Chair: So we need a change in the law.

Simon Stevens: I do not sense any appetite for a change in the law to change the charging regime that exists at the margin for dental treatments or opticians and so on. That firmly would be a decision for Parliament, certainly not for the NHS itself or NHS England, and personally—you are asking me a personal opinion—I detect no appetite on the part of the people in this country for that.

Q46 Chair: But you have not seen any extension of charging or top-ups.

Simon Stevens: Basically, no. I am certainly aware of one or two examples where occasionally a CCG has come up with an idea of, “What if we start charging right here?” I think we will be very clear with CCGs where they are proposing anything that is in contravention of the statutory framework that they cannot do it.

Chair: That they cannot do it, in other words. Thank you very much for clarifying that. That is the end from me and Valerie now wants to come in.

Q47 Valerie Vaz: Thank you, Chair. Can I start by apologising because I have to leave early to go to another Select Committee? I am obviously going to start by saying I was disappointed that you chose to go on the “Today” programme and launch this document before coming to the very people who have direct responsibility and accountability to your favourite taxpayer. I am a bit disappointed in that.

Simon Stevens: I would have been happy to be here but the opportunity did not present itself.

Q48 Valerie Vaz: It did because I think you were in the diary for a long time and could have chosen to launch your document today even. But the headlines of the document seem to build on what our previous Chair Stephen Dorrell and also Andy Burnham have been talking about—integration in health care. That was the headline stuff, but I actually looked through the document and have major concerns about it because I think you have this blue-sky thinking, using somebody else’s money. Could you have a look at page 28?

Simon Stevens: Sure.

Valerie Vaz: Do you have it in front of you—chapter four? You say: “This ‘Forward View’ sets out a clear direction for the NHS – showing why change is needed and what it will look like.” Are you saying that the Health and Social Care Act should be repealed?

Simon Stevens: What I am actually saying is that it is not blue skies because if you look at pages 16 and 17 you can see where—in Cornwall, Rotherham, London, Airedale and in Kent—it is already happening. So this is the art of the possible. It is not some blue sky. It is actually what people across England are doing and saying they want.

Q49 Valerie Vaz: I will come on to that in a minute, but could you answer that particular question, why change is needed and what it will look like? Are you saying that the Health and Social Care Act should be repealed? Just yes or no.

Simon Stevens: We are saying that whether the Health and Social Care Act is repealed or not is not a matter for the NHS. It is a matter for Parliament, so that is your decision. But what we are saying as the NHS is that we, the national leadership of the NHS, will work together and in new ways so as to bring about the kind of changes that we think are required and for which, by the way, we detect quite a wide consensus across the country.

Q50 Valerie Vaz: But you are saying that something is not quite right and it needs to change. And the something that is not quite right is obviously the Health and Social Care Act, is it not?

Simon Stevens: No, I do not think that is what we are saying actually. I do not think we take a position on that very political question in this document.

Q51 Valerie Vaz: It is a political question because there is a lot of money being spent on the health service. But the words are there, and if you choose to interpret them in a different way we will leave it to the audience to judge that. But you wrote in the *Financial Times*—I think it was 15 July 2010—and you said, “This type of boldness may arise anyway as a result of the decision to extend competition law across the health sector and treat the NHS as a regulated utility.” Has your view changed or is that still your view?

Simon Stevens: No. The view that I was expressing there was that there is merit, I think, in having front-line clinicians, groups of GPs, strongly involved in the decisions about the way in which services develop rather than having those made purely by managers in health authorities, which is what went before. So I certainly was supportive of the idea that we should have stronger clinical leadership through the commissioning process. I also was and am, by definition because I am here, supportive of the idea that having a bit of daylight between the NHS and the day-to-day cut and thrust of Whitehall and due process will benefit the NHS itself and therefore the people that we serve. That is an argument that various people, including the King’s Fund, the BMA and others have advanced down the years. The truth is that it would not have been possible to have the NHS articulating without fear or favour the point of view that we have articulated in this Five Year Forward View were it not for the establishment of NHS England separate from the Department of Health or a Government Whitehall-controlled operation.

Q52 Valerie Vaz: Has your view changed or not from that?

Simon Stevens: I have just expressed my views.

Q53 Valerie Vaz: You have said something, but I am not clear whether your view has changed or not from that.

Simon Stevens: From which piece of—

Q54 Valerie Vaz: From what you wrote in 2010, being open to competition.

Simon Stevens: I am sure my views will continue to evolve, yes, and we are in a different place now in 2014 than we were. The point we are making here is that we need in many parts of the country much more integration. Anything that stands in the way of that obviously is something that we would not support. But we will collectively use the discretion and the judgment that Monitor, TDA and NHS England can bring to bear to ensure that those obstacles do not stand in the way of the changes that people want. If it turns out that there are issues with the way the rules are currently constructed, then we will say so and seek to get them changed.

Q55 Valerie Vaz: Great, and I am so pleased you said that because I wanted to raise something that came up before us at a previous Select Committee as to—I do not know how to use the word and whether or not it is—privatisation or outsourcing cancer services in Cannock and Staffordshire. The local people do not want it, some of the clinicians do not want it, but yet it is still going ahead. “File on 4” actually said that NHS England was not involved, but in fact we heard that they were being paid £250,000 for their advice.

Simon Stevens: Who was being paid?

Q56 Valerie Vaz: The commissioning support unit.

Simon Stevens: You mean the local NHS had chosen to use a CSU for something that was important, yes.

Q57 Valerie Vaz: Yes and they were paying them £250,000 to do that. You said that if you saw something that was going wrong—

Simon Stevens: The CSUs are there to support the CCGs.

Q58 Valerie Vaz: You said that if you saw something that was going wrong, as head of NHS England, you would try and put a stop to it—this outsourcing. Local people do not want it. Would you do that?

Simon Stevens: There clearly are very conflicting views on what is happening there in Staffordshire. Macmillan Cancer Support are heavily involved in trying to drive the changes that you say people do not want. There are historical problems with the fragmentation that has existed in cancer services for people in that part of country. So, as I understand it, even though NHS England is not driving this—it is indeed the local CCGs and others—what they are trying to do is produce much more integrated cancer services and have a long-term arrangement so that it is not just year by year, bit by bit. As I understand it, I do not believe that they are going to make final decisions on any of this until between July and September next year, so I am sure there is an opportunity to continue to influence that debate.

Q59 Valerie Vaz: Some of the contract is for 10 years, so could you say that you would put a stop to any contract, given that this is a kind of tricky period leading up to May 2015? Could you put a stop now to all contracts for 10 years—give your little edict out to the rest of the NHS—and say, “Please do not do this any more because you are tying up something that may look different in 10 years’ time”?

Simon Stevens: As I said, my understanding is that in the case that you have raised they are not making any decisions until next summer anyway; so I think that does answer the question that you have raised.

Q60 Valerie Vaz: Okay, that is excellent. I want to turn on now to TTIP. Could you say when your involvement stopped with UnitedHealth? Was that before you took the job or after you took the job? Were you still advising people on TTIP?

Simon Stevens: No. I took up post as NHS chief executive on 1 April and, as I previously told the Committee, I have had no involvement with my former employer since then and I am not going to.

Q61 Valerie Vaz: What is your view on TTIP, then?

Simon Stevens: The first thing to say is that, despite the many responsibilities that are placed on NHS England by the Government and Parliament, international trade negotiations is not one of them. We fully recognise that there are competing opinions on TTIP, not just among people in the health service but among Members from the same political party in this place as well. Anything that undermined the principle of a tax-funded health service available to all on the basis of need and not ability to pay we would fundamentally oppose.

Q62 Valerie Vaz: So you will fight for the NHS to stay out of TTIP, will you? Will you give us that assurance?

Simon Stevens: There is a premise to the question. If it did that, then we certainly would oppose it, but clearly, on the facts, there is a contested debate as to whether that is the case, and a number of people say that it is not.

Q63 Valerie Vaz: If it is, would you fight to make sure that the NHS does not go into TTIP—stays out of TTIP?

Simon Stevens: If it was going to be damaging to the NHS, absolutely, but many people say that that is not in fact what it would bring about.

Q64 Valerie Vaz: Okay. Whether it does or not, if it does, would you fight to keep the NHS?

Simon Stevens: I have already answered that.

Q65 Valerie Vaz: Yes or no.

Simon Stevens: Yes, if it did.

Valerie Vaz: Yes, you would. Thank you.

Simon Stevens: But I am not saying it necessarily does. For example, I have been passed a letter that the European Commission had written to your colleague John Healey for Labour in which, in relation to the investor state dispute settlement provisions, Commissioner Bercero says: “We can already state with confidence that any ISDS provisions in TTIP could have no impact on the UK’s sovereign right to make changes to the NHS.

I hope that this information clearly demonstrates that there is no reason to fear either for the NHS as it stands today, or for changes to the NHS in future, as a result of TTIP.”

That is just one piece of the evidence.

Q66 Valerie Vaz: Who wrote that letter to John Healey?

Simon Stevens: The European Commission, who are the negotiators.

Q67 Valerie Vaz: Who is it?

Simon Stevens: This is Ignacio Garcia Bercero.

Q68 Valerie Vaz: Thank you. So since you wrote or said, “The worldwide need for health care in ageing populations will lead to a demand for goods and services that can drive sales of American insurance, medical devices and record-keeping technology”, has your view changed?

Simon Stevens: I do not think I did say that, but I certainly do believe that—

Q69 Valerie Vaz: Did you not? Shall I send you the source?

Simon Stevens: You can, certainly.

Q70 Valerie Vaz: I apologise if you did not.

Simon Stevens: I certainly do think that great British companies—for example GlaxoSmithKline—if they come up with a new Ebola vaccine, and so on, should be able to make that available around the world without trade barriers. That would be a good thing. But the fundamental question for the NHS is: would we want any arrangement that stood in the way of the defining principles of the NHS? And my answer to that is clearly no.

Q71 Valerie Vaz: Good. Can I go back to something that you said on the “Today” programme—it is terrible, isn’t it? You mentioned, and you kept using this phrase over and over again, “the vast majority” of services would continue to be delivered by the NHS. What did you mean by that?

Simon Stevens: At the moment I think, as I said earlier to Mr Percy, the figure is 94%. So 94% sounds to me like the vast majority.

Q72 Valerie Vaz: That is a very wide discretion, is it not—“vast majority”? You say 94% now, so could it change?

Simon Stevens: As a matter of fact, both the last and the current Government have had in place in the health service an offer to patients in which patients themselves get to choose where, for certain conditions, they would get their treatment—not a bureaucrat, not a politician, but patients getting to make that choice on the grounds that a “like it or lump it” health service that says, “The only place you can go is the place we tell you,” is not a health service that most people probably want. More importantly, there is a big argument for the health service to win, I think, which is that it is possible to combine a collective, solidaristic needs-based principle for funding services with a degree of choice about where and how care is provided for patients. We lose something very important if we say that the price of having a health service is that patients get no say in their own care. So to the extent that some patients are choosing to go and have their hip replacement or their eye operation done in an NHS-funded facility but not at their local hospital, the question is: are you going to turn around and ban them from doing so? Parliament could do that. That is not the statutory framework that Parliament has, as we speak, established for the national service.

Q73 Valerie Vaz: That has not been the case: for a long time, people have chosen where to go, so I do not know why you keep raising the spectre, but just—

Simon Stevens: The reason I am raising the spectre is because it would be those choices that the patients make that will determine the answer to your question, not me or you.

Q74 Valerie Vaz: Okay, great, so I can accept from what you say that anything less than 94% is not the vast majority. You are assuming that less than 94% will not be privatised. Is that right?

Simon Stevens: I think that is to misunderstand what I have just said. What I have just said is that the choices that patients make are what will, at the margin, determine this, but my confident prediction is that the vast majority—and I think most people would understand what that is getting at—will continue to be provided by NHS organisations.

Q75 Valerie Vaz: So you do not think there will be much competition in the NHS, but I wonder if you could see a role for Monitor in the future. Do you see that they would have a role?

Simon Stevens: Yes. I can see a role for Monitor. Monitor provides an oversight role for hospitals and other providers. There are lots of different ways of potentially configuring the way in which the national NHS leadership works. Those are perfectly legitimate choices for the Government of the day to make, but changing for the sake of changing is something that I think the health service would not be enthusiastic about.

Q76 Valerie Vaz: I have just one last question. On page 38, you mention that “For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages.” Do you think that the NHS staff should get their 1%?

Simon Stevens: The 1% is a decision obviously for the Government and the Government have made that decision for 2014-15 and 2015-16. What we are saying is, looking out over the course of the next four or five years, is that kind of approach going to be repeatable year over year? For the reasons we give, we say we think it probably will not be.

Valerie Vaz: Thank you very much.

Q77 Rosie Cooper: I want to ask you about competition but before I do could I follow on from Valerie's comment? The Five Year Forward View uses the term "NHS leadership" quite frequently. By that, you cover a broad range of organisations—NHS England, Monitor, NHS Trust Development Authority, Care Quality Commission, Health Education England, NICE and Public Health England. If you are really saying that the NHS has to change so radically, is there not also a case for revisiting the complex leadership arrangements?

Simon Stevens: You could do—of course you could—but the truth is that each of those bodies is actually doing something a bit different. Public Health England has some specific responsibilities there on full display, given the Ebola crisis. You could call them all part of the same organisation and have the same headed notepaper, but would there still be a group of public health specialists working on Ebola? Yes, there would be. As to Health Education England, we have decisions to make as to how many nurses, doctors and therapists we train. Those are done both nationally and locally. You could call it what you like, but it is still a separate set of things that have to get done.

Q78 Rosie Cooper: Shouldn't efficiency costs, all those things that apply to everywhere else, apply to this?

Simon Stevens: And they have, in that there have been huge reductions in the running costs of the national part of the NHS. As to NHS England itself, our costs are going to be down by a third by the time we get to next April. We have a further 10% cost take-out occurring right now. It is worth remembering that the NHS has one of the lowest administrative costs of any industrialised health country—not just compared with the Americans, who are clearly outliers for all the reasons that we know, but even with the French or the Germans, I think the estimate is that Germany is probably spending about 5.2% of its health care spending on central administrations, as the OECD defines it, and France maybe 5.8%. We are under 3%, so we are very efficient when it comes to that kind of thing already.

Q79 Rosie Cooper: Fine. The Health and Social Care Bill made great pronouncements about reduction in management, which I do not necessarily agree with. Perhaps we should also be looking at the reduction in those NHS leaders as a grouping as they are. But to come to the question I really wanted to get to, competition is not mentioned at all—not by name—in your document. I wondered whether there has been an unannounced U-turn or whether that is the case. Listening to you today, you have said that competition would not be welcomed if it gets in the way of integration. Is that what you are saying?

Simon Stevens: Yes. Competition is just a tool, and to the extent that it advances the service change or the efficiency that we need to make then so be it. But to the extent it gets in the way of that, then, no, it cannot be allowed to be the tail that wags the dog.

Q80 Rosie Cooper: Okay. So, in the past, if a trust was in serious difficulty, the strategic health authority would take a strategic view, look at the situation and find a best fit. What would happen in that situation today?

Simon Stevens: In that situation today, the regional leaders of the NHS, particularly Monitor, TDA and NHS England, the so-called tripartite, would together work with the local organisations in the NHS to sort things out.

Q81 Rosie Cooper: Where would the question of being worried about competition tendering stand, so they could not just look at everything but would have to go out to tender? Is that a real view?

Simon Stevens: It was clearly an understandable concern that a lot of people had, but our sense is that, as people are, in practice, getting to make the decisions they need to make, that has turned out not to be the case to the same extent. If I can give you a couple of concrete examples, in the case of Oxfordshire CCG, which was one of the examples that was a sort of cause célèbre on this topic a year ago, I understand they have just decided that they will go with an identified provider, working together with Mind, without going through a large procurement process. In the case of Cambridgeshire and Peterborough CCG, another cause célèbre, I believe they have just decided to go with a consortium of local NHS providers. I think Monitor, if they were sitting here, would say that, all along. They have said there were three tests that have to be applied if you are contemplating a competitive procurement, or not doing so: one is, would the costs of doing the procurement outweigh the potential savings? The second is, is there only one feasible provider? The third is, have you done a detailed assessment, absent of a procurement process per se, to identify who will be the right person to deliver the services you are looking for? Any one of those three tests means that you do not have to jump through the hoops that people were worried about.

Q82 Rosie Cooper: What about The Priory—I have not actually seen it myself, but I was hoping to get to see it today in the *Health Service Journal*—where they say all mental health services should be tendered? They are going to push to make sure that all those services go out to tender.

Simon Stevens: They can make their pitch, but that is not their decision.

Q83 Rosie Cooper: You have been to, for example, Liverpool Community Health NHS Trust.

Simon Stevens: Yes.

Q84 Rosie Cooper: They need what I would consider to be some radical surgery and help to ensure that they provide better services for the people locally. I believe those solutions have not come forward because people are concerned about competition in the NHS and I would just seek your assurance that the right answer is not being held up because of fears of competition.

Simon Stevens: No. You have rightly raised this question with me in the past, including the Liverpool Community Trust, and I can come at that in two ways. One is that we are actually spending a not inconsiderable sum across the health service on improvement functions, some of those through things like the Leadership Academy, something called NHS IQ, and then we have strategic clinical networks that bring together specialists from different disciplines, cancer or heart disease. We have local clinical senates to bring together consultants and GPs, and so on, and academic health science networks as well. One of the things we say in here is that we have to take a hard look at how we are using that money to make sure that, collectively, it is more than the sum of its parts and is answering useful local needs, including sorting out community services in Liverpool, where that makes sense.

The second part of the answer would be that when you look at what I understand is the discussion now just about to be kicked off in Liverpool around rationalising cancer surgery, for example, it is obvious from that that the local providers and CCGs do not believe that there are impediments to having a more integrated sharing of services across individual institutions. Whether there will be support in the city for that obviously is another matter, but nobody is saying that there is a competition reason why that could not occur.

Rosie Cooper: Okay. I will come back to that, if I may, later on.

Chair: I know that David wants to move on to another question, but, Andrew, is yours a brief follow-up point?

Q85 Andrew George: Yes. In relation to the clearly stated objective of achieving the kind of integration that the Forward View articulates, and this is something which has been broadly welcomed, I have to say, of course what is happening to commissioners at the moment is that they tell us that they are—"enforced" is the wrong word—certainly encouraged with, potentially, threats, although I am not sure, to outsource a proportion of some of the specialties that they commission either through AQP or other methods. If you are to achieve the kind of integration that you are describing, how can you do that at the same time as commissioners are saying that they have no choice other than to identify four or five areas of delivery, which they have to put out for AQP?

Simon Stevens: Across the board, I do not think that is going to be the route that we are going to want to take, but there are some particular circumstances where, frankly, we do need to have extra support available. One would be the effort we are making on mental health services to improve access to psychological therapies—IAPTs, so called—and there we do need to get some additional providers into certain parts of the country rather than just have whoever happens to be the local mental health trust who in some cases are, and the polite word would be, struggling. So I think horses for courses is the approach here. It should not be a kind of blunderbuss approach, but, "Under some circumstances, does it make sense to ensure that patients have choices of different providers?" Yes.

Q86 Andrew George: But does that not mean for mental health services that that is bringing in more resources to commission additional services, or are you suggesting that you withdraw resources from current NHS providers and then go out to independent providers? In other words, are you going to centrally command this? At the moment, it seems to be that CCGs are able to identify those specialty areas rather than you commanding it from the centre.

Simon Stevens: Yes, that is absolutely right but, in particular cases, like trying to expand access for IAPT, we know there are some capacity bottlenecks in some parts of the system and that is why we want to try and get more choices.

Q87 Andrew George: More resources.

Simon Stevens: Yes, because we are putting more resources into—

Q88 Andrew George: More additional central resources to buy in extra services.

Simon Stevens: Exactly.

Andrew George: That is a different matter.

Chair: David has been waiting very patiently.

Q89 David Tredinnick: I want to ask you about new care models, and start with a general question. Then I would like to ask you about a couple of specific examples of new care structures in London and one in Nottingham, and see where we go from there. The Forward View discusses a number of new care models and ways of working. Do you consider that these new approaches will provide efficiency gains, and, if so, how have they been factored into your calculations?

Simon Stevens: Yes, thank you. We certainly do think that they will provide efficiency gains for more integrated care, particularly for frail older people. I do not know whether Bruce wants to talk a bit about some of that—then I or Paul can come back on some of the numbers around that—in terms of changing clinical practice and bringing together health and social care, primary care and secondary care for the folks we are talking about.

Professor Sir Bruce Keogh: We know that one of the big demands is particularly with older, frail patients. We also know that, if they get admitted to hospital, they tend to stay there for a while because people cannot easily get them out because of the support that is needed. So we are looking at a whole bunch of new ways of trying to deal with that with our urgent and emergency care review, with which you are familiar. There is a whole strand of work focusing specifically on mental health and specifically on frail and older people, and children. Our aim there is specifically to keep people out of hospital.

We have another area that we are showing quite a lot of interest in, which is the use of technology. There is technology now available that was not available two or three years ago—wearable devices and devices for monitoring people at home—which will provide, I

think, big opportunities over the course of the five years, opportunities which we probably cannot imagine yet, for keeping people out of hospital and monitoring them at home. There are some very specific models, which are outlined in the Five Year Forward View, which start to go some way towards breaking down the barriers between primary and hospital care in particular and between primary care and social care in particular in another direction. We are really keen to use those opportunities to make things as seamless as we possibly can for patients.

Q90 David Tredinnick: Thank you. There has been a huge focus, obviously because of the Health and Social Care Act, on the integration of health and social care, but there has not been so much focus on the integration of different services in health, such as those provided by acupuncturists, chiropractors and herbal practitioners, and I put it to you that with the health service now we really only have two legs on the stool: we have health and social care being integrated but not really enough has been done to integrate the other services when there are very good reasons for doing so.

For greater clarity, I want to read a couple of paragraphs here and refer to the Royal London Hospital for Integrated Medicine, which is but a mile away from here, which is part of, as you know, the University College London Hospitals NHS foundation trust. It happens to be the largest public-sector provider of integrated medicine, which is the integration, as I always understood it over the last 25-odd years in the House, we have been trying to work towards before social care came on the scene.

The Royal London Hospital for Integrated Medicine works within the normal NHS terms and conditions, “including that patients must be referred by their GP. All clinical staff are members of statutorily registered health professions with additional training and qualifications in [integrated medicine]. It has agreed 13 clinical care pathways at the moment, which use complementary medicine, based on recommendations from authority bodies such as NICE—bear with me for a minute, please—provided that the patients meet the criteria the commissioners fund automatically. Many are for conditions with which conventional medicine struggles, including chronic fatigue syndrome, chronic low back pain, chronic headache, knee pain, hay fever, non-organic insomnia, perennial allergic rhinitis, irritable bowel syndrome and weight loss.”

This integrated hospital, which is part of the health service, happens to have the highest level of patient satisfaction of any hospital in the entire United Kingdom. I would like to ask you, Mr Stevens, whether you have had a chance to look at this model yet and whether you plan to look at it, because it has a very long history—and I know the witnesses will be aware of it—and, if not, would you agree to go and have a look at it, please?

Simon Stevens: Yes, thank you. I am aware of its illustrious history. I also take your point, Mr Tredinnick, about the benefits that some parts of the spectrum of complementary therapies and integrated care have been shown to have, and acupuncture would fall into that category. I think there is more debate, obviously, about certain interventions at the other end of the spectrum, but at some point I would be delighted to visit. It just might not be very immediate.

Q91 David Tredinnick: I think it might be a good idea to do it. There is another organisation I would like to mention—Impact-integrated medicine partnership in Nottingham. Without going through the list of what they provide—it is quite similar to what I have just described—the results are, and I write in the margin here: “Two comprehensive evaluations of the service conducted in 2006 and 2010 have demonstrated the effectiveness of these inventive ways in treating a range of short and long-term conditions, particularly back pain, mental health conditions, musculoskeletal disorders, gynaecological complaints and chronic pain.” This is the key point: “Patients who have completed treatment subsequently visit their GP less often, report taking less medication and have less need for referral to secondary care, thus saving the national health service resources.”

Surely, part of your mission to reduce costs should be to look at these kind of services that are out there, which are working very well. They are not out in the long grass. They are in the national health service. Again, I would suggest that you might like to go to Nottingham, which is quite near where I represent—Bosworth, in the middle of Leicestershire.

Simon Stevens: I look forward to it.

Q92 David Tredinnick: Do you have anything to say about that sort of model? It is not something that you have majored in, in what you have said so far, is it?

Simon Stevens: Not so far, but what we say in the Forward View is that one of the things that the health service has to be better at is helping patients themselves, with supported health care, and we know that a number of the therapies and interventions that you are referring to and are provided in these two organisations do have high patient support.

Q93 David Tredinnick: Yes. They are actually increasing patient choice but reducing cost. They are reducing cost to the health service. Another example of this would be personal budgets. For various reasons I was involved in some of the early trials, and personal budgets show that patient satisfaction goes up and national health service costs go down, but also it releases care providers to go back to work in the community. With personal budgets, the patients very often choose some quite unusual therapies. One that sticks in my mind is piano therapy. Then you have tai chi and all kinds of yoga and things like that. These are not exactly very costly interventions and I sometimes think that there is pressure from the medical community to not have any inexpensive treatments because it suits some people to have expensive treatment.

Simon Stevens: I am sure Sir Bruce will want to respond that final slur, but in terms of your point about personal budgets I can reassure you that, yes, we do refer at the top of page 19 to the importance of personal budgets and integrated personal commissioning. I hope that that idea will find favour with you.

David Tredinnick: Thank you for that. There was no slur intended, Sir Bruce. But if I may continue, Chair—and I know you are being very generous—last week, we had the chief medical officer for England in front of us. In fact she was in front of Health in the afternoon and I was able to question her and in front of Science and Technology in the

morning, which I also sit on, so I also questioned her there. She has written a book “The Drugs Don’t Work”. I asked her about the BBC report that doctors are using antibiotics for prevention of colds by 40% more than they were a few years ago and she said she would be writing to GPs. If I have a cold or some kind of respiratory ailment, I would always go to my little homeopathic box and try and use that first. For colds, I find allium cepa, which is a tiny amount of onion, very effective, or gelsemium. We have in this country a faculty of homeopathy, doctors who are regulated by Act of Parliament, and in the last couple of weeks the Professional Standards Authority has agreed to oversee the regulation of the Society of Homeopaths. Why is it that, when homeopathy is used right the way across Europe and regulated and now it is properly regulated in the UK, we have such a tiny use? I put it to you that it is because there are a tiny number—a homeopathic number, if you will forgive the use of the phrase—one or two professors, who attack this—

Chair: David, can we summarise? Is there a bias against alternative medicine and why are we doing that because we have to—

David Tredinnick: I am sorry, Chair. I was listening with interest to my colleague Valerie Vaz and her line of questioning and this is the line of questioning that is important to me, so—

Q94 Chair: Yes. I was just wondering whether we could hear the response to that.

Simon Stevens: I do not know whether Bruce is better to—

Q95 David Tredinnick: I have finished my question. It is basically why are people in this country deprived of a properly regulated system of medicine that is available across the whole of Europe because one or two professors of medicine—probably with vested interests—are against it?

Professor Sir Bruce Keogh: There is quite a lot in all of that. The first point was about your integrated care budgets and access to people and you will see if you read the Five Year Forward View, for example, there is an example about singing for people with airways diseases. So we are entirely in favour of some alternatives. We are also in favour—and we think it is absolutely vital—of our NHS being evidence based. You have cited some evidence about how some treatments reduce costs and increase satisfaction. That evidence is really important, but it also needs to be supplemented with evidence about efficacy in terms of cure rates and what have you. So while you give an example of going to your homeopathy box in order to not go and visit the GP for your cold, others might equally visit a chemist and take aspirin, paracetamol or whatever. The message that I would like to impart is that we are open to any kind of evidence and we will look at it with an open mind.

Q96 David Tredinnick: Fine. I will finish on this, Chair, if I may, because I know you are anxious to move on. The flaw in this approach, Sir Bruce, is that nobody takes notice of patient experience any more. If you go to the three big homeopathic chemists in London, which have a huge throughput of people every day—I am not going to name them because I

would be accused of promoting them, but they are located not very far from here—you will find a huge number of people availing themselves of that service. All the doctors I have ever met at the faculty who have trained in homoeopathy will invariably try and use that before going on to powerful drugs, which might have very serious side-effects, which homeopathic medicine does not.

Professor Sir Bruce Keogh: We have tried to bring a structure to the way we assess the quality of services that we provide, and, of course, in the Act, there is a definition of quality, which is that any organisation or individual that seeks to provide high quality care should make sure that it is clinically effective and safe—and by that I mean does not add any unnecessary risk—and that it is as decent an experience as possible. So I think what that has done is start to fill in a gap—which you quite rightly outline—that has been in our NHS, around patient experience. We are attempting to fill that gap by giving that equal measure.

In terms of dissecting that down further, one of the things that we are keen to do is to make our NHS, as part of promoting evidence, focused on clinical and other outcomes. So we look at the NHS in five different areas. How can we prevent premature mortality? How can we look after people better who have long-term conditions and chronic illness? How can we look after people well who have short episodes of care from which they will recover—for example, a broken leg or cataract operation? How can we ensure that people have as good an experience as possible, which gets right to your point? Then, how can we make sure that people have safe care? For us, understanding the purpose of what we are trying to do and using evidence to drive changes forward is really important. So we are open to any kind of evidence.

Chair: Charlotte, we are going to move on to your question.

Q97 Charlotte Leslie: It is vaguely connected—funding transformation and innovation. First, on innovation—I am going to give a large macro-model, innovating in models of care, and then go to a more specific example—how will organisations be able to make innovations and test new models when their current financial situation, like that in many FTs and trusts, is so precarious? Will they not just take the money and feed it into delivering existing care, because they feel at crisis point?

Professor Sir Bruce Keogh: There are several things about that. You are right that some people are saying that whenever we come along with an innovation we are told, “Now is not the time because the money is not available,” but there is an alternative to that, which is gaining traction, and that is that the economics drive innovation in many industries and are starting to do so in ours.

There are two streams to this in my mind. The first is that we have a focus on quality, and you have heard from Mr Stevens how we have a focus on productivity and efficiency. There is a risk that, if we focus just on quality, we lose productivity. There is a risk that, if we focus just on productivity and efficiency, then quality drops off. The thing that links those two, and that needs to be foremost in our mind, is innovation. That is absolutely key, particularly when you are presented with the sort of challenge we are presented with at the moment. We have started to look at how we can get innovation out, and it is well known—and I am sure this Committee is aware—that generally, from getting hard-core evidence that something works in all health care systems around the world, it takes 15 to 17 years

for things to be taken up. We have an ambition to turn our NHS into the kind of go-to place for new things so that our patients get access to new and exciting treatments much more quickly.

Following on Ara Darzi's review, we instituted five academic health science centres, which were based on proper competition, and then we started to look at other parts of the world, such as Boston Partners, where hospitals and other providers formed a relationship with the universities. That seemed to be very effective. We have now looked at the country and have said, "Where do patient flows generally sit?" They seem to be nested in about 15 different areas. So we have defined now what we call academic health science networks. They are at a very early stage, but the idea is that we will bring round the table providers, commissioners, local government, industry—that is all sorts of industry. So, to take an example in your area, in your academic health science network there is a lot of aerospace industry and that brings IT and that sort of capacity—and also some pharmaceutical and med-tech industries together. We are keen to give those purpose; we are keen to see them as the test beds for innovation and to encourage them to roll out their innovations. It is early days yet, but we are seeing some very encouraging signs. We are also promoting local industry, and there are some examples in your area with a thing called the Small Business Research Initiative where we pump-prime small businesses to innovate in such a way that we can then subsequently put those innovations into the national health service. So we have taken a different approach. It will take a bit of time to bed in, but I think it is holding enormous promise.

Q98 Charlotte Leslie: I have a very brief question and perhaps you can give a brief answer. Any amount of innovation requires some risk and risk of failure. The public and politicians are not very good at acknowledging that inevitable risk of failure in innovation. Do you think we are at a place where people will acknowledge and accept that any innovation may have a risk of failure if it is to go and move things forward?

Professor Sir Bruce Keogh: I think the answer to that is yes, but it is all about how you talk to the patients. If you are honest, up front, and present the opportunities and the risks, it gives patients a choice. I have to say, in my own career, I have certainly found patients very supportive of innovations. When they are not supportive is when they do not know it is an innovation.

Q99 Charlotte Leslie: Is there anything politicians can do to support and not stifle innovation? Be honest.

Professor Sir Bruce Keogh: I think there is. There is something about helping us change the culture in the NHS, where people at the moment are feeling very risk averse and yet, in terms of some of the models of care and some of the innovations we would like to see, we are asking people to be a bit more adventurous. I think you could help enormously with that, yes.

Q100 Charlotte Leslie: If I may move on to a slightly more specific form of innovation, there is kind of the oak trees, which you talk about in terms of model delivery—

not of the acorns, but specific things—and sometimes they can make quite dramatic savings. I met with a couple of very experienced clinicians who had devised a new catheter which empties the bladder fully and then refills it, which is what the body naturally does, as opposed to having to drip out. The evidence that they got on what they had been able to do suggested that it would dramatically reduce the infection rates from indwelling urine catheters. But they have gone to the NHRA, which has presented them with enormous hurdles in order to be able to try this catheter on five very willing patients, surrounded by a community of very keen clinicians. It seems perverse that some very well meaning but probably quite risk-averse bureaucrats—because they have us politicians breathing down their necks—are stopping what, in common-sense land, would be a trial that needs to take place in order for that innovation to go on and perhaps save, as you will know, a lot of money on the infections caused by catheterisation. Is there anything we need to do to improve that? I am sort of suggesting there is.

Professor Sir Bruce Keogh: I think the answer is yes. I do not understand the details, but by all means drop me a line. But your academic health science network has a particular individual dedicated to dealing with these kinds of problems, whose name I have forgotten.

Q101 Charlotte Leslie: Perhaps you could write to the Committee in case any MPs have clinicians who are innovating in their area who are finding bureaucratic obstacles that are very well intentioned and then we might know how to help them through the system.

Professor Sir Bruce Keogh: Equally, if you come across good innovations that are just stalling because of something quite small—as it often is—that can be unravelled with the right people, drop me a line.

Q102 Charlotte Leslie: Moving on to how innovation will be funded, the Forward View talks about using property assets and FTs' accrued savings to help service transformation. How much money have you assessed might be available across the board from the property assets?

Simon Stevens: As I mentioned earlier, Monitor has a figure of up to £7.5 billion from surplus NHS land and property. Even if the answer is only half that number, that is still a pretty good start. Then, in terms of FT balance sheets, accrued savings, as I mentioned, £4 billion I think is the number that Monitor has.

Q103 Charlotte Leslie: We are notoriously bad at getting rid of assets, I think, under all Governments. How can we make sure that this is a kind of one-off box to raid? How can we make sure that those assets are used in the best possible way, for service transformation, and that they do not just get absorbed into the daily need to keep things going?

Simon Stevens: That is a question we are going to be putting a lot of energy into over the course of the next four or five months as we do these place-based reviews of how the health service might adapt to particular geographies. I am not going to give you a pat answer because there are some real trade-offs here. The health service wants to make sure that, where it does have assets to dispose of, it is getting the best bang for the buck, and,

on the other hand, does so in a smart way that drives the kind of change we want and not just the asset value that is realised.

Q104 Charlotte Leslie: I have one final question and then we all have to run because there is a Division bell. I cannot stop without saying this. If your predecessor was sitting in your seat, I would probably have said something about NHS Property Services because I have had significant concerns over how they were run and set up and the appointment of chairs. Can you reassure me that the problems with the NHS Property Services are behind us and then I will not have to be asking any more questions?

Simon Stevens: NHS Property Services is an agency of the Department of Health, not with NHS England, but I can assure you that we are certainly going to be having, hopefully, a constructive straight-up conversation with NHS Property Services about how we can unleash some of the assets and the opportunity that their portfolio represents to drive some of the changes we need here.

Chair: Thank you. On that thought, we will disappear for a few minutes for a Division, so apologies.

Sitting suspended for a Division in the House.

On resuming—

Q105 Chair: We are quorate, so we will continue. I am sorry about the gap. I want to ask one final question on the issue of the pump-priming money—the transformation money. Do you think additional money will be needed? You have talked about the £7.5 billion from surplus property and £4 million from accrued FT savings, but presumably the £7.5 billion from surplus property would take some time to come on stream and there is a real urgency to start some of these processes and we will need some double-running money. Do you think that is achievable? Have you been in discussions about whether that is likely to be forthcoming?

Simon Stevens: Obviously we cannot speak for the Department of Health or the Government, but the point that we do make is that the sooner we get started on some of these transformations, the more likely we are to see the increasing rates of efficiency later in the next Parliament. So even if we begin at the 2% efficiency rate annually, if we can make some of these upfront investments to kick-start change, then that makes it more likely we will drive the efficiency rate up to 3% towards the back end. Some of the pump-priming, as it were, we can do from our own resources deployed through what CCGs have collectively—

Q106 Chair: As you said, the £4 million and what have you.

Simon Stevens: Yes.

Q107 Chair: How much do you think that you would make a case for additional funding? If you were speaking to the Government and saying, “This is what we need,” or that you were trying to get political parties to set out in their manifestos, what kind of sums would you say you would like to see forthcoming to help you specifically with this task of pump-priming money?

Simon Stevens: Yes, thank you. We are not going to hazard a figure until we have done the detailed work across the country with our local partners in health and social care in different geographies around the country to be able to see what the A-to-B journey looks like and then be able to put that together into a national picture. But we do obviously have a sense from some geographies of where they have come from and where they need to get to, but we cannot at the moment say, “This is what the national answer needs to be.”

Q108 Chair: Some of this is assumed to be coming from the better care fund. A lot of people think they will be accessing the better care fund. It seems to have been spent many times over. Can you say how much of the better care fund is likely to be going into projects such as this?

Simon Stevens: I think we are going to be making announcements on the better care fund quite shortly in terms of the results of the local assurance process that has been going on between the NHS and local government. So, obviously, we will need to wait until that is finally wrapped up to be able to answer fully the question that you raise. The good news is that, across the country, the £3.8 billion that was being proposed for a pooled funding between social services and the NHS is going to be quite a bit higher than that as a result of voluntary decisions that councils and the NHS have made. When you look at how that is being used, it is a mixture of social care services, out-of-hospital health services and other things at the boundary between the two. I do not think we want to overstate what one year’s worth of pooled investment will bring, but it is the beginning of a process that is highly relevant to some of the models that we are talking about here.

Q109 Chair: Thank you. When are we likely to see those two reports, both the one on the better care fund and the longer-term overview of all the different projects and pump-priming-type issues that you referred to?

Simon Stevens: On the better care fund—just checking the date here on my watch—I think we should have something for you later this week. On the other issue, as I said to Ms Cooper earlier, spring time-early summer.

Chair: Thank you. Before we move on to Rosie’s question, Andrew, did you have one final point you wanted to make?

Andrew Percy: Mine are around integration, so I do not know whether you want to do that now.

Chair: We are within this group, so before we move on, if you are happy, as we have a lot to get through.

Q110 Andrew Percy: I have two quick questions—or they will be now.

Simon Stevens: That is a clue to our answers as well, I suspect.

Q111 Andrew Percy: I like in chapter three, I think it is, under the “New care models” that you highlight “viable smaller hospitals”. The first sentence says, “Some commentators have argued that smaller district general hospitals should be merged and/or closed.”

When you came to us last time, I was relieved to hear your commitment to smaller district generals and also to community hospitals. Can you outline very quickly, looking forward 10 years to when you are Sir Simon Stevens, inevitably, and you are still running NHS England, what will be happening in my local community hospital at Goole, which is not a district general but a small community hospital? We talk about integration all the time.

I am sorry to ask a longer question now, but I have a particular issue at the moment with the minor injuries unit and some problems with doctor cover, but trying to get the GPs, the hospital trust and the CCGs round the table, along with the ambulance service, to integrate everything—because we have advanced paramedics in the town but we have out-of-hours GPs operating next to the MIU, but they do not see MIU, and all the rest of it—is nigh on impossible. I would like to roll forward 10 years and ask about urgent care. But with regard to my local small community hospital, in particular, what will be happening in there? The problem we have, as we know on integration, is that as soon as you get everyone together everyone agrees, but it is other people’s cash they want access to. What will be happening? What is the vision?

Simon Stevens: I will let Bruce have a first crack at that, given that he is leading the urgent and emergency care review, which, as you say, is highly relevant to your hospital.

Professor Sir Bruce Keogh: I think you are familiar with the details of the urgent and emergency care review, so just to take the vision a little bit further, we are really keen that we get treatments as close to people’s homes as we possibly can. What is specialist one year will be routine in five or 10 years’ time, so the description that you are painting of having dialysis and other things really close to home is absolutely realistic and I do not think we yet know what other opportunities will prevail. We know that changes, for example, in super-conducting technology will mean hand-held MRI scanners in the foreseeable future. There will be massive changes. One of the things we do not want to do is lock in concrete the concept that certain things have to be done always in some central place. There will always be novel, new and complex things that need to be done in centres of expertise, but a measure of the success of those centres of expertise is how they can simplify whatever those processes are and roll them out to people closer to home.

Q112 Andrew Percy: I must pursue this. That is talking about moving, whether it is to someone’s GP surgery or in the home itself, but I still do not get what the vision is around viable small hospitals. Actually, while we have been here I have had a constituent e-mail me who attended Goole today to have a blood sample taken from a young baby and they could not take it at that hospital and instead had to drive 35 miles to Scunthorpe, which seems a bit crazy. I sat down with my trust chief executive last Friday to discuss local services and all of

the talk was about how services will have to move from the exit 1 site, or rather exit 2 sites, as they are at the moment, or 3 in some cases, and be merged on to 1. I cannot understand how that fits with what we are reading in here in terms of chapter three, which is, as I have said, what the future will look like. There is the talk about viable small hospitals, which I absolutely support and my constituents would absolutely support, but what will be happening in these viable smaller hospitals, given that at the moment people are talking about centralising services at one location in my trust—and that is repeated around the country—and services in many ways seem to be going away from hospitals? They are not going away from hospitals into the community; they are going away from one hospital site to, in my constituency or my area, hospitals that are, in some circumstances, 60 miles away. So it looks great, but can you explain what is the road map to get to that and what will be happening in my hospital in 10 years' time?

Professor Sir Bruce Keogh: There is not an easy and immediate answer to that, but one of the reasons that we have the structures we have at the moment is to help local CCGs, local councils and other interested parties come together in a way that will help to resolve some of those particular problems. What prevails in one community does not necessarily prevail in another, and the demands are different. We are saying in this document that we acknowledge the need for local hospitals. We also recognise that their purpose will need to change over time and that that purpose should be determined locally by the local community.

Simon Stevens: Maybe I can supplement what Bruce has rightly said with a couple of other thoughts. One is that, as we say in here, I think our view overall is that maybe the relative reimbursement rates for smaller versus larger hospitals is a bit out of whack, and that is partly because of the way in which we are reimbursing emergency services as against planned surgical services and specialised services versus tariff services. So NHS England and Monitor are looking at how we make sure we have a level playing field between our efficient reimbursement for different sizes of hospital. That is point 1.

Point 2: in terms of the cost pressures that are building inside some of our smaller hospitals, as we previously talked about last time I was here, some of that was driven by the medical staffing models, perfectly legitimately in some cases and in others leading to some adverse consequences. The Royal College of Physicians has produced this future hospital project which has the idea of, in effect, going back to the general physician, the hospitalist that might actually more feasibly provide more of the overnight and out-of-hours services so that you do not have to have every single specialty with a gazillion different specialists under the sun to keep an acute provider open. If you combine that with what we are saying about the possibility of more integration between GPs at scale and local hospitals, you begin to get some different medical staffing models which will not in every case mean that change is not going to be required but does put some new options on the table to sustain the viability of some of these providers.

The third point is that, as you know, Sir David Dalton from Salford Royal Infirmary has been doing a piece of work looking at how hospitals can generate efficiencies by linking up with other hospitals but not necessarily merging organisationally with their next door neighbours, and David will be reporting fairly soon—I think over the next four, six or eight weeks, or something like that. One of the ideas in there will be to find new ways that

smaller hospitals can link up with other smaller hospitals around the country and get some of those efficiencies. It is not a complete answer and there are going to continue to be changes, I am absolutely sure, in some hospitals but those are some of the new options we are trying to put on the table to deal with the issues that you raise.

Q113 Chair: There is sometimes a mismatch, isn't there, between what local people want and what the health providers and commissioners want? Local people want to have beds in their community hospitals and that is a tension, I think. Do you recognise that?

Simon Stevens: Absolutely. Let us be clear. There is also an affordability issue. In some places, clearly, it is not just about clinical models but also about affordability and those are very difficult trade-offs that people have to make. My hope is that, where those trade-offs are being made, people can, wherever possible, think creatively about ways of doing more with the assets that currently exist, including community hospitals, with the big move of chemotherapy into local settings as against having to travel to the further site. I am sure there is more than meets the eye to the incident that you report, Mr Percy, but the idea of having to go 30 miles, or whatever, to get your bloods tested or x-rays sounds strange, to say the least.

So, if anything, for all the reasons that Bruce says, the push of technology and diffusion—as a result of digitalisation and miniaturisation—is towards more things being done in local, more community-based, settings, including smaller hospitals than is the pull factor the other way. There are ins and outs, and I absolutely am not saying that there never will be closures, service changes, departments shifting and all the rest of it. There will be, there has been through history and that will no doubt continue, but I do think that that needs to be in the context now of some new options and some proper challenge where that makes clinical sense and works with what the people want.

Q114 Andrew Percy: I hoped you were going to say more diagnostics, palliative care, end-of-life care suites and step-up-step-down and all the rest of it. I hoped that is what you were going to say.

Simon Stevens: Yes, which I think Bruce was referring to.

Q115 Andrew Percy: Good—accepting that people may have to travel further, potentially, for their planned care perhaps. But just on emergency care—and I think we are due to look at this again anyway, aren't we?—following our report from last year, we are building up to winter again. When are we going to see just a complete remodelling of the commissioning of urgent care so that ambulatory services, out-of-hours GPs and A and E and minor injury services are all commissioned together? I am still having the problems I have raised with you previously in my own area, where we have these fantastic ambulance services, and we are really using them, and there is a proper community paramedicine model. There is not really any incentive to move towards that at the moment because they are still very much responding to the massive pressure at A and E and all the rest of it. We talk about this all the time, but when are we actually just going to—I hate to say “throw everything up in the air” because nobody likes a reorganisation and I have learned that those are not very

popular—radically alter the way in which we commission our emergency care services? We have had a summer crisis and we are going to have another winter crisis, inevitably. We do not seem to be making any great progress on changing the whole way in which everything is commissioned and brought together.

Professor Sir Bruce Keogh: I think we are making progress, but what we are trying to do in the way that we are developing the urgent and emergency care review is to build it in public. We have a number of things that we are looking at, and we are trying to get to a place where, when it happens, it does not feel like some kind of big bang; it feels like the normal thing to do. We are working in particular on some new approaches to funding, which are out to consultation at the moment. One of the things, for example, in terms of commissioning, that is clear to us is that at the moment in many of these facilities you just pay for the footfall and they have fixed costs. We know that the fixed costs for an A and E are of the order of 90%: we know you have to have booths, a reception, x-ray facilities and so on and so forth. We know that the fixed costs in an ambulance service are closer to 50% than 90%, and we know in an urgent care centre that the fixed costs are less than that—I think somewhere round about 30%. What we are looking at is trying to get to a payment system which enables us to pay for the fixed costs so that the place can exist. Then we will pay a bit according to the activity and then add on a quality premium, if I can use that term, to try and promote increases in quality. We are also encouraging on top of that commissioners to look at the holistic service. You are quite right that the CCGs commission the urgent care centres, the A and Es, the ambulance service and so forth, and many of them are looking at trying to do this in a holistic fashion.

Q116 Andrew Percy: Have you looked—a final question—at any of the community paramedicine models that have been emerging in the US and Canada?

Professor Sir Bruce Keogh: I have not, but I am sure the team have.

Chair: Are we all done? Rosie.

Q117 Rosie Cooper: Public health. The Five Year Forward View calls for a radical upgrade in the prevention in public health. What is the basis for the confidence that you have that this is really going to happen when you look at the pressures on funding in local government, distribution of responsibility for public health prevention across a number of different agencies and the variability in the capability and the grip of health and wellbeing boards, as was evident in the first round of the better care plans? How confident are you that you can really drive, if you like, what underpins your Five Year Forward View.

Simon Stevens: Yes. There is nothing inevitable about it. What we are signalling here is that we are going to put our shoulder to the wheel, recognising that many other players also have to play their part. We make the somewhat controversial statement that, looking back, in a way we have had a lost decade since Derek Wanless produced his report 12 years ago and argued for a set of changes which have not all come about. In the case of smoking, 18% or 19% of people are still smoking. Half of the class inequality in life expectancy in this country is explained by different smoking rates across the population. If you look at alcohol, there are heavy pressures in many hospitals from binge drinking on a Friday night. If you look at obesity, there is this huge issue with the way in which we are supporting our kids, particularly at primary school age and beyond. We have the figure in

here that one in 10 children are obese when they start primary school and one in five are obese when they leave primary school. So something is clearly going wrong there. We are not saying that the national health service can do it all by itself but that the H in NHS does matter, and we are going to work with others, as well as advocating for things that are not in our direct control, to try and make more progress over the course of the next decade than we have seen over the last decade.

Q118 Rosie Cooper: You have answered partly what Barbara is going to say. I was asking you what confidence you had that you can deliver it—almost, how much more effective can you be than in the 12 years since Wanless?

Simon Stevens: One way of coming at it is if you ask what have been the big improvements in health, potential years of life lost and the gains that we have made. We have benefited over the course of the last 10 years or so from some of the earlier changes that took place—the decline in smoking rates and reduced cardiovascular disease—and that meant that we did see significant gains in the reductions in early deaths. They might be slowing, given that we have had those gains and we have not yet got new sets of gains coming in behind them. So there is an urgency there, but, on the other hand, we also can see it in things like diabetes rates. If a substantial proportion of type 2 diabetes is preventable and if we have 3 million people with diabetes now—and Diabetes UK say that we are spending £9 billion a year on that—if we do not get serious about obesity through a whole range of interventions, including food and how we support our kids and a combination of all of the instruments available to Government on obesity, in the same way they have been brought to bear on smoking, then we know what the future looks like it. The future looks like lots more diabetes.

Q119 David Tredinnick: If I can get personal—

Simon Stevens: Personal about me or about you?

Q120 David Tredinnick: Me about you, although it is in a press release. It says: “The NHS chief executive lost three stone while working in the United States, when his employer had tax breaks for employees who met healthy living targets, including weightloss.” I can empathise with you as somebody who, knowing this Committee was going to look at weight loss, actually managed to lose only half a stone since last December, but through some degree of discipline. I note in here that you are recommending financial incentives not only to companies. You are suggesting that there will have to be financial incentives in the NHS and I think you are saying that for people who reduce weight there should be—did I read here—shopping vouchers? Is that right? Do you want to elaborate on that?

Simon Stevens: Just in the more populist version, yes.

Q121 David Tredinnick: Can you elaborate a little bit on that and then I will pass back to you, Chair?

Simon Stevens: Yes, certainly, thank you. The prequel to the story is that I also put on three stone while in the US and then managed subsequently to take it off. So the obesogenic environment that I was surrounded by—not in any sense denying my own personal responsibility here—is part of the story. So, yes, there was a series of nudges and supports to get me back in shape, but I do not want to individualise this because it is not just about individuals and it is certainly not about stigmatising. It is about providing a series of supports and changes in the broader environment as well. But, yes, we do specifically say that one of the blind spots that we probably have had in this country is that, because we have the advantage of a tax-funded health service and our employers are not on the hook for health care costs in the way that they are in France, Germany or other parts of Europe, we have tended to neglect workplace health as a site for helping people to stay healthy. So, is there a case for testing some of these models that have been tried in other settings? Yes, there is. Is there a case for the NHS getting its own act together pretty quickly? Most certainly. The good news is there are hospitals, other parts of the NHS, that are now testing precisely some of these models, so this is not anything that is inconceivable for the NHS. Sheffield hospitals and employers across the health service in Yorkshire are beginning to try these models. We had a very thorough report from Dame Carol Black on what we should be doing in this area and NICE has taken a look at the use of evidence-based workplace health improvement tools and so on. Is it the whole answer? No. Should it be part of the answer? We believe so.

Chair: Thank you. Barbara.

Q122 Barbara Keeley: It is not as if nothing has been happening here. That is the good news, I think. I am one of two Members of this Committee who worked on an all-party inquiry into physical inactivity and we heard from clinicians, the British Heart Foundation, Diabetes UK and cancer charities of the benefits of exercise and physical activity. I have to say that my colleague will probably join me in saying that not much happened after our wonderful report was produced, and that is just what happens. You do wonderful work and hear from all the right people, but it is a question of barriers. Obviously, we start from the poor position on obesity and lack of physical activity that you acknowledge in your report, and I have to say that I speak from the position that Salford might have a wonderful hospital in Salford Royal, but we have some of the worst inactivity levels in the country. So it is a real concern. I have looked—and many of us have looked—at barriers and I think that the things you have signalled are good, but you have to tackle the barriers. I want to put forward what I see as three prime barriers and see what your thoughts on these are.

Activity and exercise has costs that many people just cannot afford. If you are talking about the NHS being in a leadership position, you have some low-paid staff that will not be able to afford gym membership. It is all right to tell people to join a gym, but, to be honest, that is expensive and in the current environment, where you have not paid the 1% pay rise to nurses and other staff, it probably rankles a bit with them that you are being reported as saying they should join a gym, because all exercise programmes tend to have costs in them. So one is, if the NHS has a leadership role, how is everyone going to afford it, not just people at your level, because I am sure you can?

As Rosie Cooper has already touched on, activity levels are really being hit by cut-backs in local government. There is a report today that parks and leisure centres are under

threat as the ageing population swallows all council budgets. The LGA are saying that spending on what are considered non-essential services like parks and leisure facilities have been cut by 43%. That is very serious and will continue over the next few years—the Barnet graph of doom where councils have no money to spend on leisure centres, and certainly my council has stopped free swimming for young people.

The third barrier—and perhaps this is really pertinent—is that people who take exercise, particularly if they are not used to it, are overweight or older, will injure themselves. To be absolutely frank, the experience that most people, including me, report is that the NHS is hopeless at helping people who have injured themselves at sport. So if you get hip problems, knee problems and foot problems, your average GP, A and E consultant or back specialist will tell you to stop. “You have hurt your foot. Stop running. You are doing this. Do not do it.” We heard in the inquiry that people, across the NHS, are still advocating rest is best for patients, when it is not. The cancer charities, the heart charities and the diabetes charities say that it is not.

It seems to me that those are really quite substantial barriers that are going to get in the way, as much as I really do applaud this and I am sure my colleagues will as well. The question is, how are you going to tackle those barriers?

Simon Stevens: Yes. I think those are absolutely fair points. One of the things that NHS employers are making progress on with this—and there is some, so we have something to build on—is your point about low-paid staff, and you did not say it, which also relates to staff working at night. Do they have access to healthy food and do people get the rest breaks they need in order to be able to get a meal even when they are at work? All of these are the means to the end that we want to see. The TUC has a health and work initiative, and that is one of the things that we are looking at in the NHS more broadly. Nothing you have said is in any way contested. We get the fact that those are the kinds of thing we are going to have to deal with in order to make progress here, but, equally, I think the reason why magazines like *Nursing Times* and *Nursing Standard* have come out in favour of some of these kinds of approaches is that, ultimately, people do get it. It is right to support the health of the people who work for us and it is right that the NHS plays its part for the national burden of improvement that we all want to see.

Q123 Barbara Keeley: With sports injuries, how are we going to get GPs to not say, “Stop doing it”—

Simon Stevens: I will defer to the cardiac surgeon on my right here.

Q124 Barbara Keeley:—which is what they do—“Stop running. Stop exercising.” That is what they say. If you hurt yourself they say, “Stop doing it.”

Professor Sir Bruce Keogh: Yes, I understand the logic to that. I think that change is going to have to come about by perception. There is a huge change in perception, I think, about exercise. Heart attacks used to be treated by telling people to lie down, as you alluded to. I think people are starting to recognise the benefits of exercise, with particular respect to cardiovascular disease, but there is also emerging evidence in cancer that exercise may be as beneficial as some additional therapies which are given to cancer

people. The bit I think that I grapple with, and Mr Stevens alluded to it earlier, is how we bring the same level to bear on this that we brought on smoking. Many of the issues that you raise pertained, in a slightly different form, to smoking years ago, and I imagine we have quite a lot of thinking to do as a society, as NHS England and Public Health England, to try and address the barriers that you raise. I will be very interested to read your report.

Q125 Chair: A lot of issues of course require action at national level. Mr Stevens, what advice are you giving the Government about what changes need to happen at national policy level to enable some of the changes you want to see?

Simon Stevens: Yes. In a piece of joined-up endeavour—accidents will happen—the day after we published the Five Year Forward View, Public Health England published their game plan, their strategy for what needs to change and obviously obesity is a key thing that they put front and centre. It is a combination of the things that we, Public Health England and independent experts are going to be saying. The Academy of Medical Royal Colleges did a very comprehensive report on obesity, I think last year now, under the chairmanship of Terence Stephenson. So there is a combination of advice and advocacy which is coming to bear, but we do also—

Q126 Chair: To be specific, you are in a position of enormous influence. What advice are you personally giving the Government about what changes they need to be making at national policy level in order to make this happen—the kind of changes that you refer to—because there is a cost if it does not happen, as you set out?

Simon Stevens: Yes, there is. I am only partly going to answer that question today because for some of the changes that we want to see we want to marshal the forces of a coalition of people who will be able to bring the best evidence to bear and then we will go and advocate for that.

Q127 Chair: So you will be advocating strongly for action in these areas.

Simon Stevens: Absolutely. That is why we are straying wide in this Forward View. I know this is not the usual territory, in a sense, for the direct leadership of the national health service or NHS England to be in, but we firmly believe that, unless we change the conversation and the action on these sorts of topics, then the country is going to experience far worse health and well-being than would otherwise be available to us, and, what is more, it is going to crowd out the NHS's ability to do the good things that we could be doing by having to deal with a lot of preventable illness that could otherwise have been, by definition, avoided.

There is just one other thing I was going to say, which is that you rightly say that a lot of this requires national action. Part of the argument we are making here is that, compared with many other countries, one of the unusual things about our very unitary system of government is that local physical leadership, local authorities, actually tend to have less ability to influence some of these matters than do local jurisdictions in some other countries. So, at a time when the country is having a debate, post the Scottish referendum, about what devolution might look like, it would be good, in my personal opinion anyway,

if we were also to look at the role that mayors and local authorities could have on some of these health-related issues, to give them the tools to make an impact where that is what their people want them to do.

Chair: I know Charlotte wants to make a point and then Rosie, but they have to be brief points because we have to move on.

Q128 Charlotte Leslie: I have a brief boast, and this really a message to older people about getting active. My mum recently won the world triathlon championships in her age group and spent the weekend winning the British swimming championships.

Simon Stevens: Congratulations.

Q129 Charlotte Leslie: The point is that she could not swim when she was 40 and she wants to spend a lot of her time encouraging older people—it is probably not going to be winning international competitions—to walk the dog, walk up the stairs or whatever it is in terms of doing that, and I think we should have much more focus in what we are doing on enabling older people to get active because every little helps. But, again, it is sometimes frustrating when we talk about obesity in isolation because often these things are both a symptom and a cause of mental health problems. People who are obese are possibly depressed because they are obese and feel they cannot lose weight. But when you are depressed, what do you do? You go to the fridge and eat a lot of stuff you know you should not eat. I wish we could have a slightly more joined-up perception of what is cause and effect in obesity, and a sense of empowerment, I would suggest, is often a very good way of tackling that.

One of the things that we discussed in the physical activity commission was GPs prescribing pedometers to give people a sense of achievement, in a very small way, against what they did last week, which is not joining a gym. It's just saying, "I walked however many steps more this week than another week."

I have a final thing. I would value your thoughts on something that my dad, as a retired orthopaedic surgeon, used to go bonkers about, which is a trend for the easy option of mobility scooters, post-operations. He would talk about people coming out of a hip operation, finding it slightly difficult to walk and hopping straight on a mobility scooter, which may be very good in terms of giving people access socially—it has massive mental health benefits, you could argue—but in terms of building up the muscle structure around the hip, when what is needed is walking, is fairly disastrous.

To go back to a very personal level, athletes who have operations even at 70 and get straight back into exercise have a remarkable recovery rate. Are these things that you would be looking at, and have you done any work on use of mobility scooters, for example, and GPs prescribing pedometers?

Simon Stevens: My personal answer to the last part of your question is, no, I cannot confess to having done detailed work—or indeed lack of detailed work—on the impact that mobility scooters are having on obesity rates. Bruce, I am sure, will want to pick that up. The underlying point, though, I think, is that what we are talking about in terms of

tackling obesity is not impossible in that the Public Health England strategy just reminds us that, if we had the same obesity rates now that we had in 1993, then we would prevent 5 million cases of illness each year, which is the figure they have, I think, and we would be saving more than £1 billion in health service costs. It is just kind of where we have come from and we have forgotten along the way. So this is doable. Bruce, I do not know if you want to add to the reablement mobility point.

Professor Sir Bruce Keogh: There is probably not much that I can say in the time that is available except that a lot of this can be addressed by proper preparation for the operation. The time that people spend in hospital following hip replacement has come right down and a substantial proportion of them are done with a single overnight stay. We have learned from that that teaching people how to mobilise before their operation helps them to do it afterwards. When you are trying to teach people to mobilise when they are already in pain, it is a lot more tricky. I can certainly pick this up with the British Orthopaedic Association. If there is a trend in that direction, I will do that.

Chair: Thank you. Can I make a plea for a very short question because we are very behind?

Q130 Rosie Cooper: It is the overarching view, from what I am hearing—and I do not know if you have seen Alan Maynard’s tweet from yesterday, which I thought was really interesting and it said, “NHS Steven’s ‘plan’=let a thousand flowers bloom. Fine! But who will manage & learn from the incipient perturbations/‘innovations’?” —that it really does sound great, but how are you going to make it happen?

Simon Stevens: Yes. I have great respect for Alan, who always cuts to the chase on these matters, except on this occasion I think he might not have fully read the report because we explicitly say that we do not want a thousand flowers blooming but nor does one size fit all. Horses for courses is what we want.

Rosie Cooper: Okay. Let us see which race we are in.

Chair: It is definitely in the report; I remember reading it. We are moving on next to David.

Q131 David Tredinnick: This is integration and health and social care. We have covered a lot of this ground so I want to ask if you are in favour of a single budget for health and social care.

Simon Stevens: It depends, and I will tell you some of the things it depends on. Start with the patient or the user of services. For many of our service users or patients, what is health and what is social care is a distinction without a difference, and the way we have organised services based on the historic deal that was done in 1948 no longer makes sense. So, from the patient’s point of view, we have to increasingly try and dissolve those distinctions. However, we should also not kid ourselves that just combining two pressurised funding streams into one by itself will mean we have well-funded, well-functioning services.

As I think I said on my first day in this job on 1 April, putting together two leaky buckets will not make a watertight funding solution for health and social care in this country. The test I think we would want to apply to any proposal to do that would be to ensure that both sides of the funding equation were properly resourced rather than getting into some kind of robbing Peter to pay Paul situation. That would be the headlines of the answer. There are some specifics in that for particular services, particular patient groups. Yes, absolutely this will make sense, and the better care fund, as we have discussed earlier, is headed in that direction with more pooling than was asked for nationally. The proposal that we are making available to local authorities and to CCGs from next April called “integrated personal commissioning” allows you to blend your health service funding and your social care funding at the level of the individual for the first time, which is potentially a radical person-based way of getting this joining up as against just merging two big budget categories between departments of local government or the NHS.

Q132 David Tredinnick: On this personal budget issue, I put it to you that it is inevitable that patients are going to ask for a wider range of services. As a last question, I put it to you that, with regard to the model that I presented earlier on, of the third leg on the stool being what used to be called other complementary services—acupuncture, osteopathy, chiropractic and homeopathy, if you like—you have actually come forward with a third leg of your own for this health and social care stool, and that is the sort of “wellness agenda”, as I think it is called in America. Even in the House here, we now have mindfulness courses which are run by a colleague for people who are perhaps feeling under pressure.

Is not part of what you have to do to target specific areas, such as the massive use of antidepressants, and look at ways that people can help themselves there and deal with the issue of polymorbidity and polypharmacy, where some people are on six or seven drugs? I think north of the border in some cities some of the elderly patients are on six drugs—over 50% are. Can you just tackle the wellness issue and how we reduce this drugs demand?

Simon Stevens: Bruce, off you go.

Professor Sir Bruce Keogh: I will have the first go. The issue that you are addressing here is a complex one because it boils down to what a GP, a hospital specialist or some other prescriber believes is the right thing for an individual. One of the things that GPs are having to grapple with now is that they are no longer dealing with single diseases. They are dealing with people with lots of different conditions. That is where their skill comes in in addressing a polypharmacy issue. But I think—and this is almost an issue for the private consulting room, where GPs are in consultation with their patients—it is quite difficult for us in NHS England to tell people what to prescribe and when to prescribe it. Sally Davies will have raised this in particular warnings about things like antibiotics and antimicrobial resistance and so forth, but we have asked NICE to develop a quality standard on how we deal with multiple diseases in the elderly population. That will probably go some way towards dealing with the issue that you raise.

Chair: Barbara, you have a question on carers as well as integration.

Q133 Barbara Keeley: I have a couple of points to make first. In a 38-page document, there is only a paragraph and a few lines on England's 5.5 million carers and I think that does not give the right message. It would be pertinent in something as forward-looking as this to have given them more recognition. It seems like very little attention to me. The document says that the care that 5.5 million unpaid carers give is critical to the very sustainability of the NHS itself; you would not think that from seeing this little paragraph nestling there, and I do not think "Engaging communities" is the right place to put it. I regard carers as expert partners in care and I think it would do to give them that sort of priority.

You can tell I feel strongly about this. I have campaigned on carers' issues since 2005 and before I was an MP. I have repeatedly brought forward legislation on the identification of carers, but I have to say that the Department of Health has always worked against it. The civil servants have always said, "No, Minister, you do not want to do this or approve this." It is interesting that you now come, in this document, to saying that you are going to find new ways of supporting carers, and one of those will be to work with voluntary organisations and GP practices to identify carers and provide them with support. I first suggested this about 10 or 11 years ago and I have raised it repeatedly in legislation here. So we have moved somewhat, but that is not new—actually, from your time in Downing Street, Mr Stevens; it was probably around then, when we produced the first carers' strategy. As long as the NHS will not take on this responsibility—and it is the civil servants that have argued with Ministers over the years against the NHS having a duty to identify carers—I think we are going to miss giving carers the help and support they need. Incidentally, and I think you do recognise this, missing that will put a greater burden on the health of those millions of people and reduce their ability to care.

So I think this shirking, running away from this as a duty, is part of the problem and I am pleased that you feel like moving towards identifying and supporting carers, but a voluntary approach just is not going to work. I was at a meeting last week and someone from NHS England came and regaled all of us who have spent years dealing with this issue with some examples of carers being treated poorly as if this was news to all of us who have actually spent years talking about this in debates and trying to help carers. It is a massive issue. You say it is important for the sustainability of the NHS, and it is, but tinkering around with it and putting it as a low priority in your document will not help. I would like to have seen this much higher.

Simon Stevens: It is a massive issue and your leadership on this is hugely welcome. I do not think it is a small point, and this is obviously a very short document. There are lots of things we have not said in here, but one of the things we definitely did want to say, particularly to focus minds inside the health service, was about not the invisible but under-appreciated army of support that carers provide and in particular—yes, the 5.5 million or 5.4 million—the 1.4 million people in England who are providing full-time care, 50 hours a week or more, unpaid. There is no pat answer as to how we actually do something different and you are more experienced certainly than I ever will be on this topic.

Q134 Barbara Keeley: I have lots of pat answers and will send them to you. There are lots of ways of doing this, which have been suggested for years.

Simon Stevens: Exactly. We have been in good conversation with Carers UK and the Carers Trust on some viable steps that can be taken, given that moving to a complete package of support in the way that, in an ideal world, we would is just not doable tomorrow or the day after. But are there things that we can do to identify—and we specifically call out here—older carers who themselves, when they have a health crisis, generate a health crisis for the person they are looking after, and what is it we could do to provide more support there? That was one of the priorities identified by some of the carers’ organisations themselves. So we want to do what we can in a concrete way, recognising the years of frustration that you describe.

Barbara Keeley: But, if I could just add, and I know we have to move on, this voluntary approach is not going to work. I have said here in debates, but this will serve as an example, that we have at least 22,000 carers in Salford—at least that number—and a wonderful voluntary approach to identifying carers through their GPs. GPs referred 300 carers to the carers’ centre—300 in a pool of 22,000. That is the scale. If GPs had to identify carers, particularly those that you talk about—

Q135 Chair: Barbara, I think that is making a statement. You have made the point that you would like to see compulsory identification of carers.

Simon Stevens: Yes. The referral from the GPs is one route to it, but what the carers’ organisations have told us is that that should not be the only way in which the NHS actually more meaningfully engages in local care—

Q136 Barbara Keeley: No, but it is one of the main ones.

Simon Stevens: It could be, but it could also bottleneck. So “both” and “and all the above” is what we are trying to figure out nationally, recognising there are lots of different local approaches that have been taken or need to be taken as well.

Q137 Chair: Before we move off the issue of integration of health and social care, can I come back to some of the financial aspects of this? One of the biggest challenges for integrating health and social care is the funding gap in social care as well. How much do your estimations of the future funding gap take on board the implications for underfunding of social care?

Simon Stevens: We have not made an assessment as to what the next Government will decide to do on adult social care funding over the course of the next Parliament. If it is dramatically different from what we have right now, then obviously that will feed into higher demand pressures on the national health service, but we assume that will be for the next spending review.

Q138 Chair: We have talked about the assumptions made in terms of flat funding, real terms funding, but these figures take no account of what happens in social care. It is just assuming—

Simon Stevens: Obviously, we have had a pull-back in social care funding over the last several years. Those have shown up in higher demands on the national health service, so we are assuming that rate of increase in demand continues at, broadly speaking, its current pace, but we are not—

Q139 Chair: In line with background inflation; that is what your assumption is.

Simon Stevens: No—in line with the demand pressures which have shown up over the last several years as social care funding has itself been under pressure. But we are not assuming that there is going to be an even more severe downturn than the pressures that we have seen growing in social care over the last several years. Is that fair, Paul?

Paul Baumann: Essentially, we have extrapolated the experience of the last few years in terms of the growth of particular areas of activity, which will themselves have been influenced by the fiscal environment of social care. So we have projected the past forward for a number of years.

Q140 Chair: But there have been cuts in social care funding. In other words, are you expecting a time line of continuing constraint?

Simon Stevens: To the extent that those cuts give rise to higher demand pressures, then we are assuming that, incrementally, those carry on in subsequent years more and more.

Q141 Chair: Could you perhaps write in some detail to the Committee about the assumptions that you have made around all those funding pressures?

Simon Stevens: Yes.

Q142 Chair: That would be helpful. Then, over to Andrew.

Simon Stevens: Chair, I have one little comment to add. Obviously, with the better care fund one of the advantages of that next year is that £900 million or so will transfer from the health service to support social care in a way that was not available this year. One of the conditions attached to the approval of local better care fund plans is that social care services, not necessarily money, but social care services, have to be preserved.

Chair: Thank you.

Q143 Andrew George: In fact, this is not on the area of integrated care, as I think we have covered the single budget issue, but on to chapter three and the new models of care. Can I say in advance that, when I leave after your answers, it is not that I am storming out in protest at what you have just said—it is just that I have to go?

Obviously, we are aware in recent years that there have been pioneers, pathways, pilots and anything beginning with “p”—purloinings or whatever the next “p” word is going to be—and in chapter three you have described different models of establishing improved access to care and better outcomes. To what extent will you use the levers of money or sanctions? If the future is going to look something like this or there are some further pioneers which will come along no doubt in the forthcoming years, how can you ensure that this is delivered? To what extent will you be able to direct or induce these changes?

Simon Stevens: Yes, that is a very subtle and important question. The reality is that across most of the country, because the pressures are there in the health service, people know that doing more of the same is increasingly difficult. So people are looking for new ways in which care can evolve and there is an enormous consensus around the kind of models that are set out here. I think we are going with the grain of the change that people want to bring about. The question is not whether people are motivated to do it. The question is the wherewithal, the enablers, getting rid of some of the barriers that stand in the way. So, yes, some of that will be flexibilities in the way some of the national payment rules or regulatory systems are brought to bear in a particular geography, but really what we are envisaging is a shared dialogue between the national NHS bodies and the players in different parts of the country about what their future looks like. They had a go at elements of this earlier in the year with some draft five-year looks themselves, which got us some but by no means all of the way towards sustainable solutions. There is a hunger across the health service for this kind of conversation. I do not think in any sense we are going to be having to do anything other than go with the grain of what people themselves, for the most part, want to do.

Q144 Andrew George: So you will not be holding back any funds in order to provide financial inducements. That lever will not be used.

Simon Stevens: We have to ask the question, where we need to kick-start service change, service transformation: is there a case for freeing up some of the cash from day-to-day operations in order to lever in some of these new models and deal with the double running costs? That is certainly something that we will be looking at. I do not know whether Paul wants to add anything.

Paul Baumann: Perhaps I can give a concrete example of that. Every year, we have a degree of what we call draw-down to bring forward previous years’ surpluses and the investing of those. We have a cash limit to draw down every year. Part of the question we are currently addressing is how we prioritise which CCG gets priority access to that draw-down amount. It seems to me that this sort of thing is very much part of the way in which we are going to make that prioritisation.

Q145 Andrew George: So if, for example, one health economy wants to invest in primary care in order to ultimately reduce the budgets in the acute sector which cannot discharge into the primary care setting, for example, which is a common problem, then you are saying that those health economies might be able to come to you and say, “Can we have future years’ funding rolled up so that we can make that investment and achieve the savings in future years?” Is that—

Paul Baumann: My example was more on previous years' surpluses. So this is a CCG that has a surplus which it is bringing forward and being enabled to invest that in the sorts of things you were just talking about.

Q146 Andrew George: You also say that some parts of the country will be able to continue commissioning and providing high quality and affordable health services, as they are now. Who is the arbiter of what is high quality and affordable? Who will be making that kind of judgment? Is this something which NHS England will be sitting as judge and jury on?

Simon Stevens: We will be part of the jury panel. But some of the other jurors will be the Care Quality Commission when it comes to the standards of care being provided, and Monitor and TDA in respect of the financial viability of the provided configuration that exists in a particular geography. So, yes, those will be the principal participants nationally.

Q147 Andrew George: Some models involve primary care services being brought in and provided by acute services, and sometimes there are attempts to integrate the two. In terms of ensuring that you do not end up with a system where primary care is purely a gateway into the acute sector, how are you going to manage that in those circumstances?

Simon Stevens: I think it is going to look different in different parts of the country and I will just give you two concrete examples.

If you are Northumberland, then I think it is quite likely that we are going to see more dissolving of the boundaries between the GPs and Northumbria Healthcare trust, which is providing the community hospitals and the acute hospital service in Ashington.

If you are Birmingham—I say this without having spoken to any of the NHS players in Birmingham, so this is just me free associating, but nevertheless it is a city I know a bit about having been born there; so here is my version of what Birmingham might look like in five years' time—I suspect we will see perhaps two large groupings of GPs across Birmingham. One already exists—they are called Vitality—and there is another one that is coming together. They might be, as we talk about with the multispeciality community providers model, taking on more of the community nursing, perhaps employing some physicians, geriatricians, psychiatrists and so on. In addition to those two, there will be some GPs in the city who will choose to remain unaffiliated as smaller practices under the current model and then we will probably say to at least one of the large hospitals in the city, perhaps University Hospitals Birmingham if they want to do it, that it would be reasonable for them to start providing general medical services within the area that is currently overseen by Birmingham CrossCity CCG where we know there is a big retirement bulge of GPs coming up. There are a whole load of pressures in primary care there and they will be doing a more soup-to-nuts integrated service. So, in Birmingham, I do not think there is going to be a single answer. I think there will be three or four different configurations just as there are now. It is just that the new three and four will have more of an integration focus than the current fragmentation has across Birmingham. But, as I say, I say that without having, as yet, discussed that with the people of Birmingham.

Q148 Andrew George: That is very interesting. I am sure that all of the Birmingham media will have been noting everything you were just saying about it. In your chapter three, you particularly highlight models, pioneers and so on across the UK. Are there any health systems in other countries with a similar arrangement with regard to public health services for which useful models can be brought into the UK? Are there templates which can be used?

Simon Stevens: Templates, no, but parts of examples, yes. In other parts of Europe, generally speaking, the very rigid distinction that exists between GPs versus hospital specialists is more blurry, and a historian of the national health service, Roy Porter, said that the original deal when the NHS was set up in 1948 was that the consultants got the hospitals and the GPs got the patients. The point of this Forward View is that that probably is no longer a good basis on which to organise our health services. Other parts of Europe do that and other places have tried giving hospitals more incentives around the total health of their patients rather than just the payment-by-results, tariff-type system to try and change and align incentives there. Scandinavian countries often have more sharing of back offices between smaller hospitals to keep them viable. So there are lots of examples of pieces of this, but there is no place about which we would say, “That is what it should be.” The NHS is what we have, it is what we want and we can evolve to a better place, learning from ourselves and from others as we do.

Q149 Andrew George: Can I finally just ask—and this is straying forward, if I may, into work force planning and the consequences for that—in terms of the future as you see it? If you are looking forward to the future over the next five years, we know that over the last 20 years those who are paid least well within the NHS are being asked to do more and more in terms of their capability and the procedures which they are being asked to perform under the guidance of professional clinicians. But in terms of the work force we will be needing in five years’ time, what will this mean in terms of consultants, GPs and registered nurses going forward? Is the present complement adequate going forward, are we going to have to see increases or do you envisage a decrease in any of those professions?

Professor Sir Bruce Keogh: As Stephen mentioned earlier, Health Education England have a kind of 15-year strategy for trying to address the work force. What is clear is that a significant part of expenditure in any health care system relates to its staff. I do not think we necessarily harness the expertise of our staff at different levels. We do not maximise the capability of different groups to do new tasks. There is quite a lot that we can do in terms of ensuring that people are operating to their maximum capacity, particularly, if you like, in the less professional parts of our work force and additionally in the hierarchy of the work force. I think that by doing that you end up with a work force which is happier, with people who feel more fulfilled and you can reduce costs, or in fact open up the opportunities for more of the work force. As to happier staff, we know—and I think this Committee has heard from David Guest in the past on this—that there is a statistical association between engaged staff and better clinical outcomes. That probably does not answer the kind of numbers question. But the other thing that is going to happen over the course of that time is that we are going to see massive shifts in the way that things are done.

If you take vascular surgery and go back 15 years, it was done by surgeons. Now the surgeons do half of their work without picking up a scalpel. They do it through other techniques. We are going to see new types of consultants emerging. One of the things,

again, that Mr Stevens has alluded to is the concept of the generalist or the hospitalist, and we will be looking at all of this in conjunction with other colleagues.

Chair: Virendra, you wanted to move on to the issue of mental health.

Q150 Mr Sharma: Thank you very much. Mental health is a major concern that everybody is now talking about. You also have set up your five-year ambitions on mental health. You specially relate achievement of those ambitions to provision of new funding. That is what you relate to. Why do you make that link for this service alone but not for others?

Simon Stevens: We do not just make it for this service. We make it for cancer services, for services for frail older people, the improvements we want to see for children services, all of them, because what people working in mental health tell us is that mental health services have been the poor relation when it has come to investment by the NHS and about 13% of the NHS budget is spent on mental health, as you know, compared with perhaps about 26% of the illness or the disability that we are facing as a nation. We are out of balance there. We are, as you see and we have mentioned earlier, trying to make a concrete step to change that by introducing some of the same sorts of quality standards and access standards into mental health that has drawn money into some of the physical health services over the course of the last 20 to 25 years, but there is a lot more we want to do over and above what is here. We need to make progress on child and adolescent services, on the eating disorder services and crisis care, which has seen huge improvements in the course of the last 18 months or so. There are big improvements in the number of people at times of mental health crisis ending up in a police cell as against an NHS facility. We have a lot to do in mental health and we are very ambitious to do it. That is what the users of the mental health services, the stakeholders, want us to do as well.

Mr Sharma: Thank you.

Q151 Barbara Keeley: I want to ask a question which goes back to some earlier answers you have given. We had a very good debate here recently on pancreatic cancer but we heard a number of examples where patients—proved in the end to have pancreatic cancer—were shuffled about. The worst case we heard of was 17 different referrals from a GP to different specialists. Clearly, something different has to happen for that type of cancer, and I know that the support charities tear their hair out about what that might be. Is that something, as you look at these new structures, you think you will be able to take into account? Is there some good news there for the pancreatic cancer patient, their families and those who work on research, because I think that is one of the most profound problems they have?

Professor Sir Bruce Keogh: Pancreatic cancer is a dreadful condition and one of the particularly difficult things about it is that the diagnosis is often not easy to make and first someone has to think about it. I do not want to give a quick and easy answer to that, but I am quite happy to go away and think about what we can do.

Q152 Barbara Keeley: It just seemed to come down so much to the fact that people had to keep going back to their GP and there was not the cross-referral—if only you could have sent them, with a difficult diagnosis, to somewhere to have a series of tests trying to find out what was wrong with them. But, more specifically than anything else, if you are looking at structures, that seemed to be a condition which our NHS does not fit with.

Professor Sir Bruce Keogh: Yes.

Barbara Keeley: We can leave it there.

Q153 Chair: Can I ask a question following on from Virendra's point about mental health? Obviously parity of esteem is there in the mandate to the NHS and part of that is going to be the economic issue about funding. Who will be held to account if we do not deliver parity of esteem for mental health?

Simon Stevens: We will, among others, but no doubt we will be directly here to be held to account.

Q154 Chair: What will that look like? When we talk about holding people to account, what will happen if we do not make progress on parity of esteem and we still have the same issues that we are talking about now with mental health services in five years' time?

Simon Stevens: We are getting a lot more transparent about what has been happening inside mental health services. To some extent, it has been a bit of a closed world relative to some of the managerial efforts that have been made in other parts of the health service and, frankly, to the attention that Governments of different complexions down the years—where they have put their stimuli for the health service. Fortunately, I think that is changing dramatically, and even within the last several weeks the focus has now been placed on this, the five-year ambition for mental health that we published together with the Department of Health a fortnight or three weeks ago. Mental health is the only set of services where the NHS has staked itself out for the next five years despite not knowing what the funding environment will look like through 2020. So I think people—

Q155 Chair: So you are confident that we will not be having the same discussions in five years' time about mental health.

Simon Stevens: I may live to regret this, but yes.

Q156 Chair: Thank you. Would you consider making, for example—and you talked about it—children in police cells a “never event” in the NHS just as we would have a “never event” for wrong-site surgery, again an issue that has been going on for some time now?

Simon Stevens: Yes. I do not want to just, off the cuff, say yes specifically to that now, but I think that sort of thinking is absolutely right.

Q157 Chair: Just on a final point, how much independence did you have about the drafting of your Five Year Forward View? Were you able to do that completely independent of Government?

Simon Stevens: Yes, this is our report, the “our” in this case being the national health service, so we had control over the contents and we stand by the propositions that we have advanced.

Q158 Chair: One of the points about the Health and Social Care Act was to give you much greater independence and say, and yet we have seen proposals like a £55 payment for diagnosing dementia. Is that something that was a political initiative or was that something that came from NHS England?

Simon Stevens: That came from NHS England. We hold ourselves fully transparent.

Q159 Chair: I just wondered. So that was something that came—

Simon Stevens: We had been set a goal to increase the dementia diagnosis rate from 50% to 66% in the mandate for which we are accountable. How do we do that, given the levers available? We have obviously been resourcing GPs, hospitals and community services to try and increase the diagnosis rate, as the Alzheimer’s Society and others are encouraging us to do, so there is strong patient group support for this. This was made available in order to recognise some of the extra costs associated with care planning, with getting the diagnoses done.

Chair: Thank you for clarifying that. I do not know whether any other members of the Committee have follow-up questions. Thank you. That was a marathon session and we really appreciate your attendance, thank you.