Public Accounts Committee

Oral evidence: Financial sustainability (NHS bodies), HC 736

Wednesday 19 November 2014

Ordered by the House of Commons to be published on 19 November 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon, David Burrowes, Meg Hillier, Mr Stewart Jackson, Anne McGuire, Austin Mitchell, Stephen Phillips, John Pugh

Sir Amyas Morse, Comptroller and Auditor General, Gabrielle Cohen, Assistant Auditor General, Sue Higgins, Director, National Audit Office, Robert White, Director, National Audit Office, and Richard Brown, Treasury Officer of Accounts, were in attendance.

Witnesses: Andy Hardy, Chief Executive, University Hospitals, Coventry and Warwickshire NHS Trust, Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust, Dr Peter Green, Chief Clinical Officer, Medway CCG, and Rob Larkman, Interim Officer, Barnet CCG, gave evidence.

Q1 Chair: Mr Larkman, you are interim chief executive, are you?

Rob Larkman: I am interim chief officer at Barnet CCG, as well as being substantive chief officer at Brent, Harrow and Hillingdon CCGs.

Q2 Chair: Why are you interim at Barnet?

Rob Larkman: I am interim at Barnet following the departure of its chief officer three or four months ago. Pending a review there, I am leading on looking at options for their future management arrangements.

Q3 Chair: How long was he in post for?

Rob Larkman: The previous chief officer. Since the inception of the CCG, which would be since April 2013.

Q4 Chair: So he only survived how long?

Rob Larkman: A year and a half or thereabouts, or a bit less, yes.

Q5 Chair: We do not like people coming and going in this Committee.

Welcome to you all. Sorry, but we were just trying to work it out. I have to warn you that, as is the way of things here in Parliament, we are likely to be called for a vote quite shortly, but we thought it was better to start and get on with it, because these things are never time-precise. We will adjourn for 10 minutes at that point.

Let me start with a general question to you all. The Report that you will have seen presents us with a worsening position over time, and we have had letters from both Monitor and the Trust Development Authority, suggesting that things look pretty gloomy into the future. You are the guys who have to deliver at the front line.

I will start with you, Mr Hardy. You are here, I think, because you do well in some of these things. Can you talk to us a little bit about the challenges you face? What is doable and not doable and what do you worry about, going forward, given where we are at this point?

Andy Hardy: I should just say that I am also here as a representative of the Healthcare Financial Management Association, as I am the president this year.

First, in terms of the Report, it is an accurate reflection of the pressures that we face in the NHS. Clearly, there are huge challenges ahead. We have had four years of relatively flat cash in terms of no growth—

Q6 Chair: We know all that. It is really much more about knowing what the impact is on you and what are the challenges for the future. We come to the NHS pretty regularly in this Committee.

Andy Hardy: There is particular pressure, obviously, in terms of increased activity. I think all acutes, as you will see in the figures in front of you, are starting to struggle, to different degrees. One of the main drivers behind that is undoubtedly, I believe, the differential tariff, because if you look at the increase in activity it has been predominantly on the emergency side.

Q7 Chair: So you think that it is a broke system?

Andy Hardy: I would not say it is a broke system; I think it is how you approach that.

Locally, in Coventry, one of the key things that we have done is to agree with our commissioners—we re-based the baseline for that on the outturn for 2013-14, rather than on the 2008-09 baseline, on which there have only been marginal payments since, so that has made a big difference.

Q8 Chair: The purpose of the tariff was to reduce A and E.

Andy Hardy: In terms of the marginal tariff.

Q9 Chair: The 30%.

Andy Hardy: I think that was a stated belief, but it clearly has not happened, because in my own organisation I am seeing a 5.7% increase year on year, and I have seen—

Q10 Chair: Say that again.

Andy Hardy: 5.7% this year; 15.5% over the last four years. So if that was the reason, that has not been successful, but as I say it is how you approach that. We approached it as a system issue. We have worked with our commissioners to re-base, so we are not seeing the financial challenges that some other organisations are having with that 30%. That has been a major driver of some of the challenges.

Q11 Mr Stewart Jackson: In a sense you have answered the question I was going to ask. It is a catalyst and a mechanism for improving relationships between the different providers in the local health care economy. I suppose the question is, how do you share that good practice? On one hand, there is a point to be made, which is that that 30% marginal tariff is unfair because it penalises A and E and lets off the hook all the other providers, including the Clinical Commissioning Group, public health and the local authorities. But you are saying it has worked for you. How can an imperative be put into the system, so it works across the whole NHS?

Andy Hardy: I agree with you that it could be seen as being punitive towards acute, because 30%—steps in increase in activity just does not cover the cost. But one of the things that members of the HFMA have highlighted is that one of the effects of the changes in architecture of the NHS has been to ask, who takes on that system leadership role? Actually, one of the clear things that we have got to do is work together, because none of us can afford to just stand back and wait for someone else to take a lead. The HFMA has done a lot on that.

So we look locally, to see what are the biggest challenges facing us. Urgent care, not unlike lots of other places in the country, is a major challenge facing us in Coventry, and clearly one of the pragmatic ways to move forward was to rebase. But of course the challenge there is that you also need some head space and some room financially to be able to make the changes you need to do to make things going forward. Of course, one of the theories of 30% is not just to drive an activity, but with the 70% to ask: what would you do with that money to prevent people needing to go to A and E, or to have people move out of hospital into more appropriate settings more quickly?

We have not seen that happen quick enough, so an approach we have taken in Coventry was, "You have got to get round the same table," because at the end of the day within health economies I do not see any point in having one part that is overspending and another place in surplus; you have to make the best use of the money across the system, and I mean both nationally in the system but most importantly locally in the system.

Q12 Chair: What is the position on your own health trust? Are you in deficit, or are you—?

Andy Hardy: We are currently forecast to break even this year.

Q13 Chair: And is your CCG in deficit or in surplus?

Andy Hardy: A small surplus.

Q14 Mr Jackson: You mention urgent care. Obviously, some health care economies, including my own in Peterborough, have a model where they have an acute district hospital with an urgent care centre, but there is some duplication there. Would you say that the urgent care centre, where it exists, should be under the same governance as the acute district hospital, so that there is proper collaboration there?

Andy Hardy: I think there are examples of both working well. There is clear evidence that where you have co-location of urgent care centres with a major acute hospital, you see efficiencies being generated. And certainly then if you look in terms of achievement of the important 5% target as a barometer of flow through the whole health economy and not just about the emergency department—never talk about the ED—there is evidence that having them co-located works. They do not need to be run by the same organisation, but I think there is lots of merit in their being run by the same organisation.

Q15 Mr Jackson: What is your temporary staffing level? The report identifies that it has increased to 9.7%—

Andy Hardy: Yes. In terms of the proportion of my total pay bill, this year on temporary staff it is about 9.8%, so very consistent with the report. And I have seen about a 34% increase year on year.

Q16 Mr Jackson: And in terms of emergency medicine—this is perhaps a question for all our witnesses here—do you discern any difficulty in recruiting and retaining staff in that particular area, given that that is the pressure area?

Andy Hardy: There is clearly a national challenge in terms of recruitment of staff, within both the emergency department and acute medical jobs. They are incredibly stressful jobs; it is relentless. There are different ways you can address that. For example, we are looking at joint posts between sub-specialties and acute medicine, to make those posts attractive. But as I said, they are relentless jobs, so you need to think about how can people work in them long term, and what you can do for the employees.

Sitting suspended for Divisions in the House.

On resuming—

Chair: Apologies for that. It is really distracting, but that is how we have to operate. Anne, do you remember what you were about to come in on?

Q17 Mrs McGuire: This is a well used trick of the Chair by the way.

You mentioned that there was an issue with strategic management, and you identified that the organisations involved in the delivery of the service need to work together. Do you have any ideas of how that will happen? It has always been a criticism of the—to use a neutral word—reform of the NHS that you actually lost that layer of strategic management, both in terms of commissioning and financial management.

Andy Hardy: What I was trying to say was that, with the change in architecture following the recent reforms, there was no clear organisation or layer of organisation put in place to do system leadership. What is really important is that we get together and lead our own systems. We have seen a big difference in that. The five-year forward view was recently signed by senior leaders from both the regulators and NHS England, which is really important. So I am just now seeing over recent weeks NHS England area teams, TDA representatives, CCGs and ourselves all getting in a room. We have to do that and move on. Although those layers have been removed, it is our role as accountable officers for our independent organisations to get together and lead the systems in our local health economies. It is great to see that we are getting a steer at a national level as well.

Q18 Chair: I am quite interested. You say that there was no system leadership. Let me ask a question of Matthew Hopkins, who, of course, I know. My local hospital has run a deficit probably since I have been the MP, so well over 20 years. If you are in trouble, who do you go to? Who is your boss with whom you would discuss that?

Matthew Hopkins: So the line that we have is into the trust development authority, but I pick up Andy's point that the most important thing is for us to recognise that a hospital is not island. It is important to have a good relationship with our GPs and clinical commissioning groups and also with our local authorities. I have noticed in the six or seven months that I have been in north-east London that the relationships with local partners are actually quite strong.

Q19 Chair: So why are we in such a mess?

Matthew Hopkins: The issues that we face, as you rightly point out, are long-standing, but there is a real sense that the local leaders need to stop looking upwards and actually start leading their local health economies for the people they serve.

Q20 John Pugh: What if it doesn't happen? I wrote down an expression that Mr Hardy used: "best use of money across the system". If that is not happening, who is accountable? There is a range of people who might want to do that or be involved in it, but if it doesn't happen, whose heads roll?

Matthew Hopkins: That is an important question. Our CCG colleagues see themselves as having accountability for commissioning good quality services for the people they serve.

Q21 John Pugh: So they are responsible for the best use of money across the system. Would they say that?

Matthew Hopkins: Exactly. The benefit that we have locally is that each of the chief executive leaders of the trusts, commissioning groups and local authorities meet regularly to discuss the nitty-gritty of how we will make best use of the resources that are provided to deliver care in what is, as Andy pointed out, a system where there is growing demand. I see that as a really important part of my leadership role, and my staff—all 6,000 of them—expect me to be doing that and having those conversations with other local leaders. That is an important part of it.

Q22 John Pugh: If commissioners and providers do not share the same view about the way forward, what happens then?

Matthew Hopkins: Inevitably, there will be times when elements of the five-year forward plan are not necessarily completely and totally aligned. I am sure that that is the case across the country. However, the only way that you are really going to resolve that is by putting patients first and understanding our own pressures and agendas while recognising that we are paid by taxpayers to do a good a job on their behalf for our local people. We therefore need to take that really seriously. That is a conversation I have on a weekly basis with my local authority colleagues, my community services colleagues, my mental health colleagues and my commissioning colleagues, and indeed with my staff.

Q23 Mr Jackson: Can I press you on that? I am not sure that that necessarily adds to our stock of knowledge. This Report is about effective resource allocation cumulatively across the NHS. I think that what Mr Pugh was getting at, and what the pertinent question is, is that previously you had clinical frameworks and strategic health authorities, and more often than not they did work, although, in my local case, they did not, but that was atypical; and what comes out of the Report is a feeling among all sorts of players and stakeholders where you have got different—I hate to use the term, but it is a generic term—operating centres each looking at their own deficits and surpluses, that there is not an overall long-term plan. You mentioned the five-year plans, but what the Report has also found is that they are subject to flexibility—let us put it in a charitable way—and review, because they are overly optimistic. Again, who is looking after the whole of the financial planning process for the whole of the NHS in England, not just the trusts and CCGs?

Matthew Hopkins: My experience locally—this is set out also in the five-year forward view that NHS England recently published—is of the need for the TDA, Monitor and NHS England to work collectively together, along with the Care Quality Commission, to make sure that there is a consistent message going out to commissioners and to providers about the way in which people would expect the local leadership to work, but where there are areas that cannot be resolved locally, the tripartite panels of NHS England, Monitor and TDA are able to facilitate those local resolutions and move forward. I have had experience of that relatively recently, with conversations about urgent care, and there has been a consistent line from all of those three partners.

Q24 Mrs McGuire: Mr Larkman, I noticed that when John Pugh said something, your body language gave a slightly more nuanced interpretation of Mr Hopkins' response. I wonder whether you would like the opportunity to translate your body language into something that we can all understand.

Rob Larkman: I will do my best. I am not entirely sure what my body was trying to say, but certainly I see CCGs as important system leaders, and I think CCGs increasingly see themselves as

that. We in CCGs need to take ownership of the transformational change that needs to happen across the areas we are responsible for. CCGs, as commissioners of services working across a range of providers, need to be driven by their understanding of population needs. We know that the population and its needs are changing—the population is growing older and people are living longer with long-term conditions—and we need to change the way in which services provide care to populations. That means addressing long-term conditions in a different way to prevent people pitching up unnecessarily at A and E departments and being admitted unnecessarily.

Q25 Chair: So CCGs are system leaders. Andy Hardy and Matthew Hopkins, do you agree with that?

Andy Hardy: We have all got a role as system leaders in our own systems.

John Pugh: You are all system leaders.

Andy Hardy: We cannot sit back and wait for other people to lead.

Chair: I want to say something to Mr Larkman.

Mr Jackson: Dr Green is bursting to get in.

Q26 Chair: We looked at Barnet CCG when we were looking at out-of-hours services. I was concerned about that—it was one of the pilot areas that we looked at—and if the CCG was a system leader, we had to make sure there was not a conflict of interest. Eight members of Barnet CCG are shareholders in Barndoc Ltd, and one of them, Dr Jonathan Lubin, is the chair of Barndoc Ltd. Another is employed by Barndoc to provide out-of-hours services. Is it sensible to have system leaders where there is that sort of conflict of interest?

Rob Larkman: One of the things we are constantly focused on is governance in clinical commissioning groups. It is really important to have GPs in the driving seat when we are commissioning services for local people. What GPs who are conflicted in that way do not do is take part in a decision about—

Q27 Chair: Eight of them. Eight in Barnet. How many people have you got in the CCG?

Rob Larkman: I looked at this just this morning. I think it is five members of the governing body who have shares.

Q28 Chair: It was eight.

Rob Larkman: Yes, that may have changed.

Q29 Chair: It was eight when you took the decision to give Barndoc the contract.

Rob Larkman: The CCG has never awarded a contract to Barndoc. It was the predecessor PCT that awarded the contract to Barndoc. Going forward, any decision to award contracts to Barndoc or any other provider organisation will not—

Q30 Chair: They did not extend the contract or anything like that? They haven't reviewed it in their lifetime?

Rob Larkman: We are reviewing the contract now and we expect to re-procure that contract in the next 12 months. Any decision made about that will not involve conflicted GPs.

Chair: Five GPs.

Q31 Mr Burrowes: I am MP for Enfield and that case obviously includes issues for Enfield and the perception of conflict. It is not just a case of dealing with older decisions. Barnet, Enfield and Haringey have had to deal with a reconfiguration that has had an impact on primary care, emergency care and out-of-hours services and contracts. GPs have wanted to tender for new contracts and provision, and all of that is impacted by seeing the decision makers or those expressing an interest. Don't you agree?

Rob Larkman: What is important is that we have extremely rigorous processes that manage those conflicts of interest. Conflicts of interests are not inherently bad, as long as they are properly managed and declared.

Q32 Chair: How many members of your CCG have a conflict of interest? You can't have that many. How big is the CCG?

Rob Larkman: In Barnet?

Q33 Chair: No, the whole lot. The CCG has Barnet, Enfield and Haringey. When we looked at this there were eight in Barnet, and I heard that was reduced to five. There were five in Enfield and Haringey, though I don't remember how they split up. There were 13 GPs on that joint CCG with an interest in Barndoc.

Rob Larkman: Yes, none of whom would have been involved in the decision to award the contract and none of whom will be involved in any decision that involves potentially awarding a further contract to Barndoc.

Q34 Chair: How many people? There is such a large number of people. How many people are you left with?

Rob Larkman: The remainder of that will have clinical input to the governing bodies: the secondary care doctor member, the nurse member, the lay members, the executive members. What we have done in north-west London is bring in GP input from outside of the CCG when we have a sensitive decision to make. That is a similar governance mechanism to that we are now putting in place in Barnet.

Q35 Stephen Phillips: When you say that obviously none of the people involved in Barndoc would be involved in re-procuring the contract, how many of those who will be involved in the decisions when the contract is re-procured are partners or in a practice with GPs who are linked with Barndoc?

Rob Larkman: That is a good question. If they are partners of a practice that has shareholdings in Barndoc, they would not be part of the decision to award a contract.

Q36 Chair: How many GPs have you got on your CCG?

Rob Larkman: About 70 practices.

Q37 Chair: How many GPs have you got on the CCG?

Rob Larkman: On the governing body?

Q38 Chair: Yes.

Rob Larkman: Eight.

Q39 Chair: Eight. So when I first got the information, all of them had an interest and you have now reduced that to five.

Rob Larkman: Yes. Before my time, I think a number of GPs relinquished their shareholdings.

Q40 Mr Burrowes: This is not just about the time it comes to retender contracts. We know that CCGs have an ongoing duty and responsibility for primary care and out-of-hours services. If my constituents or others have a concern, as some do, about the provision and extent of out-of-hours services, at the moment nothing is changing. It hasn't changed since that tender and it is not changing now. The question is that your review and ongoing duties, and those with interests, are affected by that decision. It is not just a case of removing yourself from one decision of tender.

Rob Larkman: Nor would we.

Q41 Mr Burrowes: It is an ongoing duty that appears to be conflicted.

Rob Larkman: Indeed.

Dr Green: Could I come in at that point as both a GP and a commissioner? This is very difficult, because the view generally seems to be that involving clinicians more in the commissioning process seems to be a good thing. To work in an out-of-hours organisation, you have to be trained as a GP. There would be an argument to say that GPs who know the local area best are potentially the best people to be required in that out-of-hours service. You then need to get around the conflict

issue, which is why it is really important that the governance arrangements are very clear and that who makes the decisions and how they are made is very transparent and clearly articulated.

Q42 Stephen Phillips: Are you not simply illustrating a case for out-of-hours services being run by GP practices in the way that they used to be because that would not give rise to this conflict of interest?

Dr Green: One change that came in when GPs were allowed to opt out of the out-of-hours provision was to move the responsibility back to the GP with whom the patient was registered. When I started practising, I was responsible for my patients 24/7, irrespective of who actually provided the care. When the co-operative movement took off, there was a change to the regulations that meant that, provided I had made suitable arrangements for a competent and fully qualified person to provide that care, if they made an error, they were responsible for it. When the changes came back in, in the contract changes, the responsibility went back to the registered GP, which meant that I could be responsible for someone else's error in front of the GMC and potentially lose my licence.

Q43 Stephen Phillips: But only if you had procured someone to deliver the services who was wholly incompetent to do so. You cannot be held responsible for the negligent clinical decision of another doctor in circumstances where you just happen to be the GP with whom the patient is registered. The GMC is not going to go down that road, is it?

Dr Green: The regulations were changed backwards.

Q44 Stephen Phillips: You still haven't really answered my question: don't these conflicts of interest simply illustrate that it is much better for out-of-hours care to be provided in the way that used to happen, rather than for them to be contracted out to the same GPs who then make more money out of the out-of-hours services?

Dr Green: There is an argument for that. In our area, in 1989, we set up one of the first out-of-hours co-operatives in the south-east. There was a lot of talk among local GPs about whether we could keep the co-operative going after the introduction of the changes at that time. Considerations about who was ultimately responsible and who would be in front of the GMC, irrespective of the decision that the GMC may make, were a factor in the decision to allow that to move out of it. I think that GPs taking back control of out-of-hours services may, in certain circumstances, be advantageous, but that there would still be the same conflicts, because there would still be a payment for providing the service.

Q45 Mr Bacon: Would this be more effective: as you said, there is a strong argument for saying that local GPs are in the best position with the local knowledge to provide out-of-hours services, so is there not a strong argument for saying, "Let's just have a service. Let's have it 24/7, and if you are a body taking a contract, that is what you contract for."? Why not stop calling it "out-of-hours" and just call it the local service? You get rid of this extra layer of contracts, you have the people who, in your own view, are the best to provide the service, and you save money. What's not to like?

Dr Green: I do not commission in-hours care; that is commissioned directly through NHS England, although I do commission out-of-hours care.

Q46 Mr Bacon: Sorry, I was speaking to you in your capacity as a GP rather than as a representative of a CCG.

Dr Green: There is an argument to be made. To come back to Stewart Jackson's earlier point, this is about the use of resources. The five-year future plan talks about this. As a CCG, we are required to build up plans on our joint strategic needs assessment based on the needs of the population. The funding that the system currently gets comes through CCGs for acute mental health community services, through NHS England for specialist and primary care, and through Public Health England for public health. The funding formulae for those different elements are not all the same, which makes movement of money between them slightly more difficult than it could be. If you had a single funding formula based on the needs of the population, it would be much easier for all the system leaders to come together and decide where we want to spend that money for the best gain.

The Report also discusses demand. Demand and health need are not necessarily the same thing. Health economists talk about supply, demand and need. Do all patients need to be seen within four hours for a cold, which is what happens when they turn up at A and E? We know that 45% of the people who turn up at our A and E are aged between 15 and 44. I know that 44% of the people with an illness who would expect to require the services of an emergency department are not within that age range, so part of that is convenience.

Q47 Chair: So what are you going to do? Everybody always says that to us. Are you going to stop me going to A and E? Are you going to charge me for turning up at A and E?

Dr Green: No, but it comes back to the earlier points. If we know people are going to the site where A and E is, we need to put a primary care service there to meet that need. It is not about duplication, but about skill mix. The skill mix of a primary care physician is different from the skill mix of a physician trained in the emergency department.

Chair: Can you keep answers tight, because there are four of you and we have a big group afterwards?

Q48 Mr Jackson: Isn't the issue about money, though? My understanding is that the tariff is based on the cumulative unit price for the clinical health outcomes. We have talked about the marginal rate—30%—on the 2008-09 baseline. That is subject to some discussion, but one of the things that came out of the Report was that there is not a level playing field between acute district hospitals, which are seeing lots of throughput and are volume driven, and their disadvantages as against specialist hospital trusts, for example, children's hospitals or Moorfields eye hospital, which are centres of excellence but are seeing fewer people. I would be interested in your view on how you overcome that, because that seems to be a very important issue that is not really being addressed.

Dr Green: There are difficulties in the tariff. The five-year forward plan clearly stated that the larger hospitals were making about 5% and the smaller hospitals were making a very small or negative amount on that. Equally, this Report itemises, in paragraphs 2.5, 2.12 and 3.4, the

limitations in terms of the reporting on costs, income and support. You have the numbers at the top, but there is a bit on the side where you do not really know what is happening. From that, I think it is very difficult to know that the tariff is truly reflective of the need.

Rob Larkman: There are anomalies in the way the PBR tariffs work, that's for certain, but perhaps more significant than that are the anomalies in the basic allocation formulae that underpin what CCGs are able to spend. If I look across the eight CCGs in north-west London, there is a disparity in terms of distance from their fair shares target of between £100 million for one CCG in inner north-west London through to £25 million below target for CCGs in outer north-west London. That makes it very difficult for CCGs that are way under their capitation targets to invest in primary care and out-of-hospital services and to work with social care partners to create new models of care.

I just wanted to mention that the way we have gone about solving that problem in north-west London is by collaborating across those eight CCGs and agreeing a way in which we can introduce a financial strategy that creates equity of access to an investment pool across the eight CCGs in north-west London. For the first time in their history, Harrow and Hillingdon CCGs, for example, are now posting a balanced budget and are able to invest in primary care and out-of-hospital services. That is the sort of model that I am trying to get to in north central London as well.

Q49 Mr Bacon: Is not the obvious corollary of that simply to merge the eight CCGs into one?

Rob Larkman: That is an interesting governance discussion. The merger is not on the cards at the moment.

Q50 Chair: Just say to me when you have eight, you can do the investment in primary and keep your hospitals solvent.

Rob Larkman: Absolutely, so over the last two or three years, we have developed our collaborative strategy, which is all about investing in out-of-hospital services and supporting our acute providers—

Q51 Chair: Are any of your hospitals in deficit?

Rob Larkman: Some of them are, some of them aren't.

Q52 Chair: So they are not solvent.

Rob Larkman: But they have a plan into solvency. Once we have implemented our strategy across north-west London and have made the necessary investments, we anticipate that we will have a solvent health system across north-west London.

Mr Jackson: I have a potentially very simple question. Dr Bennett from Monitor is here and will give us evidence later. As I understand it, Monitor is going to produce a consultation document later this week on funding and payments to trusts. What would be the No. 1 issue that you would need to be addressed by Monitor, as a majority are obviously foundation trusts, that would make life easier for you in terms of reducing deficits and increasing services?

Andy Hardy: As we talked about earlier, I think the No. 1 issue that challenges the provider side is the marginal tariff for emergency. I think there is general agreement that the tariff itself needs to change. It was a policy tool, which brought about exactly what it was intended to: it brought out more activity, it helped drive down waiting lists. It is now time to move away from that and think about how we can develop pathways of care, seeing whole-year tariffs, et cetera. That is the kind of thing that I am sure we will see, that joint work between NHS England and Monitor. That is what we will be looking to do.

Matthew Hopkins: I agree with that. The one thing that we are keen to see is a degree of stability, so that we can be assured of the income that we can expect to have across a good period into the future and have some degree of certainty in relation to that, because that allows us to plan more for the long term, but as Andy rightly says, there is some nuance in relation to the way in which the tariff works. Particularly I would be keen to see the introduction of as much best practice tariff opportunity as possible, because that, in and of itself, will drive organisations to really focus on quality as a way of also helping to deliver optimum tariff performance, and therefore improve the income position.

Q53 Chair: Just to be helpful, Mr Hopkins, what are you currently thinking the deficit will be at the end of this year?

Matthew Hopkins: Our plan for the year is a £38 million deficit this year, which is broadly stable from last year.

Q54 Chair: It won't be down from last year, so stability keeps you at a deficit of £38 million.

Matthew Hopkins: This year was very much a year of stabilising the organisation—bringing in a new leadership team, really focusing on—

Chair: I would say it's about my 10th leadership team, but never mind.

Matthew Hopkins: Well…. The priority for us is then to plot a course, as I said, with our partners, across the next five years to see how together we can start to bring that deficit down.

Q55 Mr Bacon: Did you say the £38 million was in the current financial year?

Matthew Hopkins: This financial year.

Q56 Mr Bacon: What was the deficit in the last financial year?

Matthew Hopkins: The deficit was £37.1 million.

Q57 Mr Bacon: And the year before that?

Matthew Hopkins: I have the figures in front of me. The year before that was £39 million.

Q58 Mr Bacon: So it is pretty consistent. Over the last 10 years, what is the total deficit?

Matthew Hopkins: In cumulative terms?

Mr Bacon: Yes.

Matthew Hopkins: Well over £200 million.

Mr Bacon: Way over £200 million.

Matthew Hopkins: Yes.

Q59 Mr Bacon: How do you get the money?

Matthew Hopkins: Well, the agreement with organisations, particularly in relation to organisations overseen by the TDA, is that we agree cash support where that is required to enable us to maintain payment to suppliers and to—

Q60 Mr Bacon: This is the public dividend capital, or whatever it is.

Matthew Hopkins: Yes.

Q61 Mr Bacon: Is all of your deficit funded by public dividend capital?

Matthew Hopkins: Not all of it, because we have certain reserves on the balance sheet, but a large proportion.

Q62 Mr Bacon: Is some of it local? Because one thing that the Report says is that the centre doesn't keep track of local support—whatever that means.

Matthew Hopkins: I think local support would be support agreed with CCGs on an in-year basis. We have our contract for the year with some exceptions, particularly funding of our referral-to-treatment target work, but that would not be considered a local arrangement.

Q63 Stephen Phillips: On the local funding point, how much are you getting from your CCGs simply by way of cash transfer to keep your deficit down?

Matthew Hopkins: We are not receiving any transfer of that nature.

Stephen Phillips: No, I am asking the whole panel. Have you come across situations where NHS England has pressurised CCGs into providing hospital trusts with finance to keep their deficits down?

All witnesses *indicated dissent.*

Q64 Chair: What proportion of your staff are now agency staff?

Matthew Hopkins: We have a 12% vacancy rate, and it varies across the organisation. For example, in our emergency department we have 50% of the number of A and E consultants that we need, so we are supplementing those posts with temporary staff to the extent that we can. Our expected expenditure this year will be broadly the same as last year, but it was a significant increase during last year's financial period.

Q65 Chair: What is it this year on agency staff?

Matthew Hopkins: We are spending about £1.5 million a month on temporary staff.

Q66 Mr Bacon: How much of that is for A and E to top up that gap you are talking about?

Matthew Hopkins: There are particular areas where there are national pressures in relation to shortage specialties, so another area would be in our intensive care units, where we struggle to find the right number of senior nurses—specialist nurses. So it is not just in our A and E departments; there are some specialist areas that many NHS trusts are struggling with.

Q67 Chair: It would be helpful for the Committee to know that half of the consultants are agency staff. What about the registrar level and what about the nursing level?

Matthew Hopkins: It is not necessarily half. Half of the posts are vacant and we look to secure the rest through temporary workers.

Q68 Mr Bacon: Some of the other 50 you make up with agency staff but you don't get all the way to 100. Is that what you are saying?

Matthew Hopkins: Yes

Q69 Mr Bacon: So how far do you get with the other 50?

Matthew Hopkins: Well it varies on a week-by-week basis.

Q70 Mr Bacon: Yes, but roughly. Is it 20? 48?

Matthew Hopkins: Roughly we are able to secure probably half of the extra.

Q71 Mr Bacon: So you get from nought to 75, of which 50 are permanent and the other 25% are agency staff and you are 25% short.

Matthew Hopkins: Exactly.

Q72 Mr Bacon: And how much are you paying for those 25 compared with the 50?

Matthew Hopkins: The rates for temporary doctors are very competitive.

Q73 Mr Bacon: Sorry, does that mean good or bad? High or low?

Matthew Hopkins: High. So in some cases we are paying two and a half times what we would pay—

Q74 Mr Bacon: Give me a number. How much would you pay to get a standard—if there is such a thing—well qualified A and E consultant in on a day-rate as a locum? What would you pay for one day?

Matthew Hopkins: Well, we could pay £110 an hour.

Q75 Mr Bacon: Gosh, that is almost more than lawyers get. Sorry, Mr Phillips, I just couldn't resist that. That is just one day and they would do how long a shift? Eight hours? Ten hours?

Matthew Hopkins: Depending on their availability—

Mr Bacon: How many hours might they do?

Matthew Hopkins: It could be a 10-hour shift.

Q76 Mr Bacon: Could it be a 12-hour or 16-hour shift?

Matthew Hopkins: I was about to say that the best practice and requirement for emergency standards in London is that we have a consultant on the shop floor for 16 hours a day. So it could be.

Q77 Mr Bacon: So if you are a consultant you could get £1,760 in one day for turning up very early in the morning and staying quite late in the evening?

Matthew Hopkins: That is what the market is dictating.

Q78 Mr Bacon: Whereas what would be the salary cost for that one day for a staff person?

Matthew Hopkins: An A and E consultant earns as a basic starter around £75,000 a year.

Q79 Chair: I haven't got the figure here but you have an enormous number of people you are paying over £1,000 a day to.

Matthew Hopkins: And many of those will be—

Chair: Across the hospital. I cannot remember how many. I cannot put my hand on the figure but a huge number are being paid over £1,000 a day.

Q80Meg Hillier: I want to ask about your A and E figures. As I understand it, year on year from October last year to October this year, A and E attendance rate went up 20% at King George's and 7% at Queen's, but the A and E unit at King George's is still under threat of closure. Is this a pressure about the costs? Everyone is under pressure on A and E, access to GPs and so on. Is it to do with the growing population in that area? What is your plan to deal with that? Will the A and E close?

Matthew Hopkins: The picture in October is quite interesting. The year up until the middle of September was broadly in line with what we would expect to have seen and planned to see with our CCGs, which was a plan for a broadly 4% increase across both of our A and E departments. We found in October—you have the figures in front of you—a significant spike in the number of attenders. When I talked to our A and E staff at King George's, they could not say that there was a particular case mix change. There wasn't really a problem with people coming in with chest problems or young children coming in with similar respiratory illnesses; it was broadly across the board. We are working with our commissioners to work through exactly what the data tells us about whether that spike is a step change in activity that will continue, or is just a spike and it will settle down again. We have seen in the first two weeks of November a similar level of attenders, but not of the same order that we saw during October.

Q81 Meg Hillier: But the A and E still has this threat of closure over it, hasn't it? Yet the population is growing in the area. What is the situation there?

Matthew Hopkins: The situation goes back to a number of years ago when there was a public consultation on service reconfiguration across outer north-east London. That concluded that the ability to consolidate urgent care services at Queen's was the right solution, the one that the commissioners wanted to move forward with. That would require a different type of urgent care provision at King George's.

What I have been focusing on in my first few months in the organisation is trying to stabilise things and to make sure that the patients who are coming through our A and Es on both sites today are being as well looked after as possible in the most timely fashion. We're struggling to make sure that people are treated within the four-hour standard, but we absolutely have to get that right before we can countenance progressing a significant change. That's really the focus and what we have agreed with the CCGs and also with NHS partners—that we need to see a much stronger quality and performance picture before we progress with those changes. That was the agreement, actually, from the Secretary of State—that that was what needed to happen prior to the changes coming into being.

Q82 Meg Hillier: Chair, can I just follow that up? This is quite an important issue. It was quite some time ago that that closure was mooted. The population in that area is growing now, it's much younger, it's perhaps more reflective of my own constituency now. Does that mean that there will be some reconsideration of this, because there has to be a value-for-money-element in it as well? If you have people who need care, there has to be the provision there; otherwise, that demand is going to bump into the system in some other place, which will not be good value.

Matthew Hopkins: Once we have been able to make the changes to improve the way in which our emergency patients experience care in our hospitals, we will need to put together a business case that determines the scale of the increase in the Queen's A and E that will be inevitable—the extra critical care beds that we will need and so on. But I think it's important to remember, going back to the A and E consultant figures, that if I had one A and E, I would have enough A and E doctors. The fact that I have two A and Es means that I am splitting my staff across two sites. In a situation where we have a national shortage of A and E consultants, the proposition of maintaining strong, high-quality services across two sites will require a significant growth in the A and E consultant numbers, whereas for a single A and E, you need 10 consultants on a rota and 18 registrars on a rota to safely staff that department.

Q83 Chair: I have found the figure now. Last year, you spent on A and E agency staff £7.1 million, with 217 shifts paid at rates of at least £1,000 each. You know I am concerned about this as the local MP. We look at that; we look at the fact that you've had years and years of a deficit; we look at the demand, which Meg has referred to; we look at the way in which you're forced to use agency staff and the cost of that. You are on this downward spiral. We look at some of the quality indicators, such as the fact that almost 50% of people waiting for elective surgery are waiting longer than they should be—I cannot remember how many people are waiting over a year to be seen, but it is a large number. Given what is happening to NHS funding and given all our understanding of what is happening to the deficit more nationally, how are you going to get yourself out of this? What needs to happen?

Matthew Hopkins: A number of things that relate to system-wide funding, which has been talked about already. There does need to be recognition of the message that's set out in the five-year forward view, which talks about—

Q84 Chair: More money.

Matthew Hopkins: Which talks about more money coming into the system. The third area is the fact that there are certain things in my organisation that we are not yet doing. Let's talk about the first one, which relates to the point about the target allocation for our CCGs. In north-east London, Barking and Dagenham and Redbridge are some way off the target allocation that would be required. If the three CCGs were brought to target over the period of time, that would be £25 million of extra funding in the system.

Q85 Chair: So more money and a bigger slice of the cake, at somebody else's expense.

Matthew Hopkins: If the CCGs were at target allocation, there would be £25 million more to spend on health care in outer north-east London. That is the first area. On the second area, as is pointed out in the five-year forward view, there are opportunities to improve efficiencies within the NHS, but an expectation of getting to 4% efficiencies year on year is unrealistic. We are at 2% this year. Many organisations are delivering at 2%. We can do more to become more efficient, but it is not the only solution.

The third area I want to reflect on is the success I had in south-west London in turning round an organisation in deficit while improving quality. In my experience it is possible to improve quality while addressing a financial deficit. The things that we focused on were first and foremost about

making sure that all of our staff understood that quality comes first, but the other side of that coin is a focus on value for money and making sure that we are gripping the issues in relation to funding. Simple things such as being paid for the work that we do might sound over-simplistic, but there are examples in my organisation where we are delivering patient care and, through our own inadequate and inefficient systems, not billing the commissioners for it. Those things are fixable, but it ultimately requires the staff body, from our clinical teams through to our administrative teams, to take an interest in both sides of the coin—not just the quality, but also the finances. If we can emulate some of the things that I have led in south-west London, I think that that will make a dent in that £38 million, but it will require the first two points that I have made to actually resolve it.

Q86 Mrs McGuire: I am sure the CCGs in your area will be thrilled to know that more bills will be coming down the line, which, as you have just identified, you were perhaps not so efficient in delivering to them.

I want to go back to the issue of the pressure on A and E and the shortages of staff there. If I was sitting at the moment as a consultant in London—given the figures you have just given us—why would I apply for a permanent post as an A and E consultant when, in one day's shift, I could earn probably three times what I would get as a permanent member of staff? I am just asking you to clarify whether that is the real position out there, because that is certainly what the figures seem to determine. As a follow-up, it would help the Committee if you could identify how many of those locum consultants are effectively permanent locums.

Andy Hardy: There is evidence that some doctors and nurses and other professionals are making the choice to become professional temporary staff, but that is not across the whole of the country. London is a special case in terms of pay rates. If I look at my own A and E, we are fully staffed at the consultant level. In our major trauma centre, we have got 16 consultants, and our junior doctor rota is also compliant. But there are other specialties where we have to rely on agency staff, and some of those are permanent agency staff. That is what they do for a career.

Q87 Mrs McGuire: Whatever happened to Dr Finlay?

Andy Hardy: That is important, because most doctors are in it to be doctors. They contribute to the hospitals that they work in, and it is not all about money.

Matthew Hopkins: My experience in my last organisation was that we were able to capitalise on the relationship with the major trauma centre and put some joint appointments together, which created interesting work both in terms of district general hospital type work and also the more interesting trauma work. My organisation that I am currently leading could do better in terms of developing those relationships. It is the case, though, that we need to construct attractive jobs that are fulfilling. We also need to make sure that the organisation is one that staff want to work in for the reputation and the value that they get for their wider careers.

Q88 Mrs McGuire: But there is obviously a cohort of people who do want to work for you, but they want to work for you—to quote Mr Hardy—as professional locums.

Matthew Hopkins: And as Andy said, there are staff—not just doctors, but nurses and others—who are making that choice.

Q89 Chair: That is shocking. I wonder whether any of you knows how much it costs the taxpayer to train an A and E consultant.

Andy Hardy: In excess of £400,000.

Q90 Chair: They might owe a little bit back to the state, rather than feeling that they have to become professional locums, at massive further expense. Over £400,000.

Matthew Hopkins: Can I just point out that some of the locums are substantive appointees elsewhere and are doing extra work on top? So it is not just the picture of professional locums.

Q91 Stephen Phillips: Following on from the question that Mrs McGuire asked about why consultants would work for NHS when they could work for themselves and make a lot more money. I wondered whether Mr Larkman and Dr Green, wearing their CCG hats, could say if they think GPs are generally taking advantage in an entrepreneurial way of the new regime to make money.

Dr Green: No. If you look at things such as the quality and outcome framework you see that most practices will exceed the upper threshold for performance. They do not stop when they get to the 70% or 80%. All the work they do above that threshold is unpaid, and yet they do it for the sake of their patients.

Q92 Stephen Phillips: Is, for example, the Barndoc company to which the Chair referred, a not-for-profit company?

Rob Larkman: Barndoc is a not-for-profit so it has never paid a dividend to its shareholders.

Q93 Mr Bacon: Dr Green, why do people bother to have QOF optimisation software then, if they are just going to do it for love anyway?

Dr Green: The optimisation software is really valuable. The success of QOF is partly down to the financial incentives, but it is actually because it is easier to deliver care for those areas, because the optimisation software gives you the prompts and reminders for providing care. When you see the patient, you can do call lists for calling patients in.

We use exactly the same approach in our CCG for a range of other clinical issues. We know the smoking status of 92% of the adult population: 18% of those smoke. We have done a bit of work around familial hypercholesterolaemia recently. We can find all the people at risk and get them in to screen them. It works because we have made it easier for GPs to do the job they want to do, which is to look after the patients. It is not because we paid them to do it.

The optimisation software is really good. In my view, we should systematically embed that across the whole of primary care. What we need to do to decrease demand on A and E is to keep people healthier. That is the primary thing we need to do. If you don't have a stroke, you would never think of going to A and E. If you have a stroke, you must go to A and E.

Q94 Mr Bacon: I have been to A and E and I've never had a stroke.

Dr Green: No, but in that particular clinical scenario. If I can prevent people from having strokes and reduce the number having strokes by better managing the atrial fibrillation, blood pressure and lifestyle, fewer people will have a stroke and fewer will go to A and E. As well as managing the hospital side of this equation, we must decrease the need and work to keep people healthier. The primary care database, because we have the records there for 99% plus of the population in the UK, is a perfect place to drill down and utilise the information to find people at risk, to provide care to them and look after them far better.

At the moment I think we are still in primary care providing a reactive service. We wait for people to become unwell and they come to see us. We need to turn that into a proactive service where we predominantly try to keep people healthy, stop them getting unwell, diagnose them early and, if they do become unwell, look after them better, by using that sort of software to make the job easier to do.

Q95 Mr Bacon: What if you reversed the burden of payment? I am not sure if this is true because it is anecdotal but I have been told that in Japan you pay your doctor all the time and you stop paying when you get ill. If we reversed the system of payment so that you paid your doctor only when you were healthy and stopped paying when you were ill, don't you think that would be more effective?

Rob Larkman: I think that is an interesting concept. We need to do more to incentivise people to stay healthy.

Chair: Let's leave that hanging in the air.

Examination of Witnesses

Witnesses: **Richard Douglas**, Director General of Finance and NHS, Department of Health, **Simon Stevens**, Chief Executive, NHS England, **Dr David Bennett**, Chief Executive, Monitor and **David Flory CBE**, Chief Executive, NHS Trust Development Authority, gave evidence.

Q96 Chair: Sorry that we are late; we had to vote twice, but I hope that that has now stopped.

Before we get into it, I want to ask about Colchester because it is so topical. Is Colchester a foundation trust?

Dr Bennett: It is.

Q97 Chair: Right. This is fairly general, but it is interesting: Clifford Mann, the president of the College of Emergency Medicine, on whose training we apparently spent £400,000, said that the situation at Colchester "highlights almost better than any other story I've heard recently the chronic

underfunding that is endemic in emergency care, throughout the UK but particularly in England", so he blames the tariff system. He also said "I can guarantee that if"—the Government—"doesn't spend money on staff and beds, then we'll see more Colchesters up and down the country". Is he wrong?

Dr Bennett: I certainly don't think that he's completely right.

Q98 Chair: I asked whether he is wrong.

Dr Bennett: He is partly wrong, for sure. The problem at Colchester was a specific issue with a very high level of demand in their accident and emergency department, as a result of which they did something that often happens. You will find that several trusts each day will declare that there is an incident to alert everyone in the trust and the health economy that they need special efforts to deal with that particular spike. In this case, it coincided with the CQC inspection, which is why it got a lot of media attention.

Q99 Chair: Honestly, I don't want to interrupt you, but I do understand that there are issues with the quality of care in that hospital. What I was trying to get at, because it is pertinent to this hearing, is Dr Mann's assertion—this is why I asked, "Is he wrong?"—that the situation at Colchester highlighted how endemic chronic underfunding was the cause and that if we do not get more money in it will happen more often.

It was interesting to listen to my friend at Barking, Havering and Redbridge NHS Trust, because basically 90% of what he said was more money—it was either a bigger cake, a bigger slice of the cake, or getting paid properly, which is another way of having a bigger slice of the cake. He basically talked about more money. Dr Mann has said that if the Government do not spend more money, we will get more Colchesters. He is making the case that money is at the heart of some of the quality issues and certainly at the heart of the crisis.

Dr Bennett: This partly brings us back to the marginal tariffs—the split tariffs. We have looked at this. First, some people say it has not had an impact on reducing admissions, but, actually, it looks as if it has—you can see an effect. That is not to say that admissions have not continued to rise, but, almost certainly, they would have gone up faster had there not been the split tariff.

Q100 Chair: Is there evidence of that?

Dr Bennett: Yes. We have looked at that.

Secondly, there isn't a correlation between the overall financial performance of trusts and the extent to which they are reliant on the accident and emergency income.

Q101 Chair: Must be.

Dr Bennett: No. There are some trusts for which it is an issue, but across the spectrum there is not a strong correlation. But we have accepted that there have been issues about making sure the baseline is right, because there have been changes which have not always been reflected, and we

have asked that that is reflected in the future. We have said that we need much greater transparency around how the 70% that is kept back is spent to reduce attendances and potential admissions. We are looking, in the longer term, as NHS England has come up with a redesign of the whole urgent and emergency care pathway, at realigning the payment system to that. But in the shorter term, for next year, in the tariff we are just finalising now, we are also looking again at whether there are further changes we can make.

Q102 Mr Jackson: Obviously, you have looked at the Report. Paragraph 2.7 on page 32 refers to a survey by the Foundation Trust Network of 26 of its member trusts. The network comes to a figure of £3.2 million. I may have misunderstood what you said, Dr Bennett, but when you say "review", are you going to start again on that baseline 2008-09 figure?

Dr Bennett: That's the longer-term goal: to completely restart.

Q103 Mr Jackson: What's the time scale for that?

Dr Bennett: I think that'll likely—

Q104 Chair: Which of you makes the decision on the tariff?

Simon Stevens: It's a shared decision, and we're completely aligned on this.

Q105 Chair: Whose decision is it? All four of you?

Simon Stevens: No. It's a shared decision between NHS England and Monitor—

Dr Bennett: Between the two of us.

Simon Stevens: And we are completely aligned. What David said is absolutely right. In precisely the way he said, we are going to make some changes for next year to deal with aspects of the marginal tariff in the context of a broader set of changes we want to make to the payment system. At the moment, we believe that smaller hospitals are probably not getting their costs covered at an efficient level of production relative to larger hospitals, so we want to rebalance various aspects of the tariff, including emergency admissions, specialised commissioning and other things. This is a package; these things can't just be seen in isolation. When you look at the financial performance of larger hospitals compared to smaller hospitals, they are doing a lot better for a variety of reasons we can talk about. So there is an adjustment we need to make for next year, which we will do, and then—

Q106 Mr Jackson: Can I just interrupt you? If you look at page 17 and the EBITDA margins, things are going a bit pear-shaped.

Simon Stevens: Yes, but the interesting thing about the EBITDA margins is that if you split them out, the larger hospitals—with over £400 million revenues—had EBITDA margins of 5%.

Smaller hospitals had -0.4%. That is why we think that, in aggregate, they payment system is not properly helping those small and medium-sized providers.

Q107 Mr Jackson: No doubt we can talk about that in more detail a little later. However, page 32 says that the document Monitor is praying in aid for this review dates back to December 2013, so we are already a year on. If you go back to figure 4, everything is going rather south. The moral of the story is that you need to do this review pretty quickly, because what comes out of the Report is that these issues are having quite a significant impact now. Cumulatively, the deficits are only going to get bigger. I suppose my question is, why is there no alacrity and no imperative to get this done more quickly?

Simon Stevens: There is, and we were about to tell you what the other things were. We have said we are going to make adjustments, in the way David described, for next year. But, in addition to that, we have also made an offer to any part of the NHS that wants to come to us and say, "Here's how we would like to amend the way the emergency payment system works for next year. We will work with you on what that looks like, but it needs to be a shared agreement"—

Q108 Chair: Who's "we"?

Simon Stevens: The local CCGs and the hospitals.

Q109 Chair: Will they come to you, Simon, or to you, David?

Simon Stevens: To both of us. As we do that, we will put it in the context of a broader set of changes we want. Rather than trying to increase the amount we pay for each click of the turnstile, people actually want to completely change the way in which we pay for all care, so that it is easier to redesign, do the stuff you were hearing about from the GPs, get the upstream support for people at home so they do not end up going to the A and E department in the first place.

Q110 Mr Jackson: That is all tickety-boo—

Simon Stevens: Well, it is three timelines. It is now, it is next year and it is the year after.

Mr Jackson: Okay, but let me give you this scenario. The CCGs are in surplus. There is a sort of asymmetrical relationship there. They are in surplus, or a lot of them are, and everything is going swimmingly for them. They don't have a vested interest. Okay, they can have a nice cup of tea and talk to the chief executive of their hospital trust, who is struggling. The point is these guys are struggling with numbers with A and E. They are being financially penalised by this system. I know it was put in place to be an incentive and a catalyst to drive down admissions, but I guess what I am asking is: what is the strategic body doing to force the health care economy in those areas to work together to help those acute district hospitals? They are under pressure because of demographic changes with older people, immigration and organic housing growth in some areas. In other words, those hospitals are not getting the help from the other key stakeholders in their area. What are you going to do about that?

Simon Stevens: You entirely accurately describe the pressures in Peterborough with population growth and the extra admissions in the hospital. We are doing several things. We are putting in extra money, as you heard in the last session, to support Peterborough, particularly given some of the infrastructure costs that you have in your hospital. We are working with the local CCGs and the providers on changing the way the payments system will work, beginning next year. In addition we are putting extra money in this winter. So each of the providers that you have heard about, including Barking, Havering and Redbridge, are getting extra cash this winter.

Q111 Mr Jackson: I am putting winter resilience moneys aside, because that is non-recurring. This is recurring financial structures and governance, which is what I am getting at. I suppose I am taking the side of the poor benighted chief executives of hospital trusts, who are struggling every single week to meet their four-hour targets; specialist trusts, which I mentioned earlier, have an easier time. I am just trying to weigh up how we can make the job easier for them. The public see the pressures at A and E for instance.

Simon Stevens: You are quite right. We have 1.3 million more A and E attendances than we had back in 2010. We have a strategic choice as the NHS: do we just continue to assume that that is in some way God-given and that we will continue therefore to put more and more of the money at the margin into A and E and emergency attendances? Or do we do what most people around the health service think we should do, which is beef up primary care, community health services and get the connections right with social services, so that if people don't need to go to A and E, they don't find themselves there because everything else has been hard to locate or has been scaled back? At the moment we are out of balance and we are just reinforcing a model of care which we think we need to change.

Q112 Chair: Mr Stevens, at present—and we had a very helpful letter from Dr Bennett on this—you have a growing number of trusts that are in deficit. Are they in deficit because they are under-resourced, or because they are badly managed?

Mr Bacon: Or because the CCGs are in surplus?

Simon Stevens: On that point we know that the answer is no; that is not the reason, as per the NAO finding. On page 34 the Report says, "The surplus or deficit of the clinical commissioning group that gives a trust the largest funding does not explain the size of the trust's surplus or deficit…detailed analysis found no causal link, however, between the financial health of providers and that of their clinical commissioning groups."

Stephen Phillips: Mr Bacon was making a different point. If the CCGs are in surplus, there is no reason why the trust should be in deficit if the money was shared.

Simon Stevens: We have to be clear about our terms here. The CCG surplus is, as it were, a historical stock of savings that in fact are being drawn down and used year by year. So CCGs as a whole are going to be about break even on their plan for this year. Of the 211, 19 are projecting financial pressures, but in the round, plus or minus £20 million, CCGs are going to be about break even. They are not running a surplus on the resources we are allocating them.

Q113 Chair: So why are they in deficit? Are they badly managed or under-resourced?

Simon Stevens: In many cases, the health service in that particular area is out of balance.

Q114 Mrs McGuire: What does that mean?

Chair: Under-resourced?

Simon Stevens: It means that we might be spending more in one type of service than another. It might mean that we have high fixed costs in some places. It might mean that you have different rates of emergency admissions in different parts of the country that are not just explainable by the number of older people or other demographics of the area. There is something going on with how those community and primary care services work that puts pressure on hospitals.

We have seen the NAO helpfully document for the Committee that there has been a 124% increase in the number of emergency admissions that stay for less than 48 hours over the course of the last 14 years. Only 7% of that 124% increase was explained by the ageing of the population. That tells us that there is something else about the way that community and primary care services are out of balance. We know that, because we can see that the number of GPs has only gone up by about 0.5% a year—far lower than the growth in the population, the ageing of the population and so on. We have to get primary care right as well.

Chair: That still has not answered the question.

Q115 Mr Jackson: Can I ask you two quick questions? I will not dwell on Peterborough, not least because Dr Bennett's specialist subject on "Mastermind" could be the finances of Peterborough and Stamford NHS Hospitals Foundation Trust. There was a practice where primary care trusts were fining acute hospital trusts for things like bedsores and poor food. Does that not happen any more? Do you have an official position on that?

Simon Stevens: Yes. There is something called the NHS standard contract, which lays those things out. One consequence of sending a very clear signal on those points, as well as huge clinical leadership across the NHS, is that there has been a fantastic reduction in the number of bedsores and hospital-acquired infections across the NHS over the last several years. Is the financial signal the only reason for that? No, of course not. Changed clinical practices and the increase in the number of nurses on wards will have helped as well—but it is all part of the mix. We are being encouraged by the ombudsman to contemplate setting financial incentives for sepsis and other things that we want in the way of quality improvement, to try to link more of the income that provider organisations get to quality, not just the number of people who are being treated.

Q116 Mr Jackson: One last point before we move on—what comes out of the Report quite clearly is that so much is about good relations between key people, which is a bit intangible and difficult for the Government to legislate on. One ramification of that is that there seems to be a problem with what CCGs are intending to commission, in terms of their plan, and the income that trusts expect to get. That gap remains through the years. How will you get over that? It skews the planning, ensuring that it is inaccurate. How do you improve the planning process?

Simon Stevens: That is a really powerful question that the three of us—David Flory, David Bennett and myself—are spending a lot of time on so that we get it right for next year. It is

absolutely true that this year, as new organisations, CCGs set a level of ambition for what they thought they could do for changing demand. That has been different from what has actually occurred. We have a gathering on the better care fund coming up soon, and the planning for that fund puts this issue into quite stark relief.

There has been better local planning between councils, CCGs and providers than there was last year or probably at any point in history, and that has forced people to have these kinds of conversation about what they will and will not do. There is a difficult judgment for us to make nationally. Where we see a level of ambition that is admirable but that we think might be at the stretching end of the spectrum, do we step in and say, "Actually, no. We want you to dial back your level of ambition because we don't think it's going to happen in practice," or do we say, "Okay. We'll back you in your local judgments. Go for it," while recognising that that might not be what actually comes about as the year proceeds? That is the nuanced judgment that we have to make.

Q117 Chair: I will go to John Pugh, but I am really frustrated because I do not feel that I had an answer to my question.

Simon Stevens: In terms of whether it is money or competence—that bifurcation?

Q118 Chair: You said it might be competence in primary care.

Simon Stevens: No. Look, I don't want to be anything other than supportive of people in difficult situations around the NHS. Generally speaking, people are working incredibly hard and doing incredibly well under the circumstances. Is it the case, however, that in some individual hospitals, you sometimes see a lack of operational sophistication and even, on occasion, clinical leadership, and that in turn shows up as poorer A and E performance than you might otherwise have? Yes, that is the case in a small number of institutions. But we have teams of people who go into help those providers raise their game, including the emergency care support team, and when that happens we see improvement. We are ensuring that people get that kind of focused support, particularly over this coming winter period.

Chair: I look forward to that improvement. I am just trying to find your letter, Dr Bennett.

Q119 Stephen Phillips: While the Chair finds the letter, let us turn back to Colchester. It has had three chief executives in the past two years, hasn't it?

Dr Bennett: Yes.

Q120 Stephen Phillips: And it lost its director of nursing recently.

Dr Bennett: It has had an interim chief executive.

Q121 Stephen Phillips: So is Colchester incompetence or lack of money?

Dr Bennett: There were some quite serious failings in Colchester, as a result of which the leadership of the time has moved on. We have yet to get stabilised, long-term leadership in there, which is what we are working hard on, but that was the fundamental issue.

Q122 Stephen Phillips: The fundamental issue was the incompetence on the part of the leadership team, correct?

Dr Bennett: It was the way the trust was being managed.

Q123 Stephen Phillips: When you say that the incompetent leadership has now moved on, have they moved on to other positions within the NHS?

Dr Bennett: Not to my knowledge, no.

Q124 Chair: Can I just ask one thing? If we talk about competence, what I was going to lead to was that you have a growing number of trusts that are now in deficit. In fact, your very helpful figures 2014-15 suggest that 81 out of—remind me—a hundred and…

Dr Bennett: 147.

Q125 Chair: So over half are now projecting a deficit this year.

Dr Bennett: Yes. Well, that was for Q2, so for halfway through the year.

Q126 Chair: Presumably they are mainly acute trusts?

Dr Bennett: They are almost entirely acute trusts.

Q127 Chair: So out of the acute trust cohort, what percentage is, in quarter 2 of 2014-15, reporting a deficit?

Dr Bennett: I think it is something like 80%.

Q128 Chair: So 80% of foundation trusts in Q2 of 2014-15, when the money is getting tight, are currently projecting a deficit. Is that incompetence or lack of resources?

Dr Bennett: First, I think the other point that Simon was trying to make is that there is a third issue: neither incompetence nor lack of resources, but how the system collectively is working. That can sometimes be about relationships, but it is also about, historically, how different parts of it have worked and how well it has worked together. As Simon says, one of the things that we focused a lot of attention on at NHS England, TDA and Monitor over recent months in particular, is trying to get the systems to work better. For example, you can have a foundation trust that is struggling because it is seeing high levels of attendances or even admissions, which, if we can get the whole system

working better, can be reduced. That is neither incompetence nor lack of resources; it is just getting the system to work better.

Q129 Chair: And the system has got worse, has it?

Dr Bennett: I think what is true to say is that of course the system is being squeezed. We have effectively seen a 4% productivity ask for every year for four years now. As the system gets squeezed, things that are working less well than they should be, start to show up more.

Q130 Chair: Does this new deal that you talked to Stewart about—in effect, putting more money in for A and E admissions—mean that we are going to have fewer foundation trusts in deficit next year?

Dr Bennett: It will make a difference.

Q131 Chair: Fewer?

Dr Bennett: Oh yes, absolutely.

Q132 Chair: And is it the same with you, Mr Flory?

David Flory: Yes.

Q133 John Pugh: We are all much taxed by the issue of systems. The system as a whole is solvent, but for pieces within it—the acute trusts in particular—many of them are not solvent and the position is worsening. We can see the explanations for that and we have heard some of them. They are all to do with A and E costs, but also, as you have mentioned, Mr Stevens, the fact that small hospitals are not adequately rewarded on the tariff, so the more work they do the more money they seem to lose. One of the stark conclusions here is the lack of relationship between good financial outcomes and good clinical outcomes. Is there any disagreement on the panel as to that—that actually we do have a situation where the two are not aligned?

Dr Bennett: Are you asking whether—

John Pugh: I am referring to sections 2.20 and 2.21. Clearly it appears that those organisations that have good clinical outcomes are not necessarily in a rosy financial situation, and vice versa.

Dr Bennett: Well managed organisations tend to have good outcomes, and their finances are in better shape as well.

Q134 John Pugh: So you are contesting the fact that financial outcomes and clinical outcomes are not neatly aligned? That is what the Report says.

Simon Stevens: There is pretty strong evidence both here and internationally that if you improve quality for some things, you can reduce cost; and so the discussion we were having with Mr Jackson about bedsores, for example, or hospital-acquired infections—when you have a bedsore, that adds a number of days of extra stay in hospital, and that ends up costing you more. So I think we believe that one of the good consequences that will flow from the big increase that there has been in ward nursing levels in recent times is that we will begin to see further improvement on some of these sorts of quality metrics.

I think the particular analysis you are referring to in the NAO Report was doing a correlation across a range of measures—

Q135 John Pugh: There was "little evidence of statistically significant relationships with the other clinical performance variables".

Simon Stevens: Yes, by the subset of measures of what constitutes quality in a clinical setting

Dr Bennett: In the previous sentence it says there are weak correlations between some measures of quality and—

John Pugh: But will you accept that something is going systematically wrong if we do not pick up a good correlation, given that we have got an internal market? The whole theory of internal market is that good financial outcomes should correlate with good clinical outcomes.

Dr Bennett: No, I think what that tells you is there are so many other things going on it is difficult to correlate the two things.

Q136 John Pugh: Can we talk, very briefly, about the other things going on? I empathise with Mr Jackson's acute trust chief executive, who was trying to cope with these difficult budgets that need to be managed successfully. I drew up a list of the things that could affect his financial management, all of which appeared to be beyond his control. He does not know whether, for example, he will get a bung at the end of the year, from NHS England, to balance the books.

Simon Stevens: He won't.

Chair: He does—every year.

John Pugh: There is quite a bit of evidence that he does. He does not know whether local commissioners will be funded at or below target—

Simon Stevens: He does, because we set 15 or 16 allocations last year.

Q137 John Pugh: Okay, but he had not done hitherto. He does not set the tariff. He does not know whether new targets will come from the Department of Health, NHS England, or wherever; and he does not know—and this is a big imponderable—whether the Treasury will pour more money in from time to time, or intends to.

Simon Stevens: That, I agree, is one of the great unknowns.

Q138 John Pugh: Yes, so in terms of actually managing as a player in the market, he has got a whole pile of completely uncontrollable variables he cannot deal with.

Simon Stevens: Except that he has got a several hundred million pound organisation, of which he is the chief executive, and 65% of his cost structure, if he is representative, will be his own staffing patterns. The variation in terms of clinical process and efficiency within organisations can be quite striking. As Mrs Hodge was talking about the Barking and Havering situation, I took the opportunity to look at their numbers as you were talking. I will just let the facts speak; if you look at their emergency length of stay for people over 75 years, it is 9.9 days, I think, compared with around eight or nine across the rest of London. If you look at the proportion of people who, with an emergency spell, are staying more than 15 days, that is in the 8% range. So there are lots of variations that are actually in the control of —*[Interruption.]* To say that one just washes one's hands of it, really—

Q139 John Pugh: No, I am saying that there are a significant number of known unknowns, which make it unlikely, on the face of it, that the system as we have it will guarantee an efficient service, seamlessly delivered locally. I just think there are sufficient imponderables there, and you yourself have referred to some of them. The solution that most people come up with when they talk about their local context is that the guys who have to deliver this efficient, seamless and local service all meet at some point on the health and wellbeing boards. They agree a plan that will take them, by one magic step, forward five years to the seamless, efficient service that everybody dreams of and aspires to get. However, the health and wellbeing board has no executive power, has it?

Simon Stevens: The health and wellbeing board is a forum where sovereign bodies come together to make decisions. It has certain responsibilities laid out in the—

Q140 John Pugh: But it does not necessarily give you local, strategic leadership of a kind that can enforce a decision once made.

Simon Stevens: Well, we have assigned health and wellbeing boards the ability to have a significant influence. More broadly, we have set up these things called systems resilience groups. There are wonderful names for all this stuff. They used to be called urgent care—anyway, we know what we are talking about, which is the right people in each area coming together to have the conversation about how to ensure that their local services are properly co-ordinated and integrated. Talking to a number of those groups, they tell us that relationships have come on an enormous distance in the course of the past three, six or nine months. Let us be clear: in some places, they historically have very poor relationships; it has been an arm-wrestle.

I have been pleasantly surprised when I have had folks in, and the chief executive of the council has come alongside the CCG and the acute trust chief executive, and we have had that conversation. I had it with the folks from Barking and Havering. The chief executive of Havering council came, participated in the conversation, and described what needed to happen in the local area. That filled me with hope.

Q141 John Pugh: What is their relationship with the regional branch of NHS England, and how does it compare with the previous relationship between the strategic health authorities and the PCTs?

Simon Stevens: Obviously, it is different. Prior to the creation of foundation trusts, all the wiring joined up at a health authority or a regional health authority level, as you know. That is taking us back a decade, because once foundation trusts were created, their accountability was independent of that regional tier, for good reason. The three organisations—TDA, Monitor, and NHS England—are, through our regional folks, increasingly ensuring that there is a shared point of view about what needs to happen in each geography. Indeed, the five-year forward view explicitly commits us to advancing that form of joint working, so that people have a coherent and unified perspective on what needs to change in different parts of the country.

Chair: Okay. Anne.

Q142 Mrs McGuire: I know that you heard our interesting conversation earlier about the use of temporary staff. The NAO, in paragraph 2.19, pointed out that we are nearly at 10%. It says that "9.7% of staff costs were for non-permanent staff", which is an increase. I would imagine that that would increase again next year. Have you any strategy for working with the trusts to try to reduce the impact on their costs of the hiring of temporary staff?

Dr Bennett: Yes. Some trusts are much better at managing this than others. It does, of course, in part depend on what is going on among the work force in their area, but even in similar areas some trusts are much better than others. A very simple thing is acknowledging that you will never recruit as many people as you think you are going to, so try to recruit more than you think you need. It sounds simple but some trusts do it well and others do it badly. One thing that we are doing is ensuring that those simple lessons are well understood across all trusts. We are taking a look at whether there are any initiatives that we can take centrally to help to drive down some of the costs of agencies. The Department has been taking a lead on coming up with a toolkit that we can share with providers.

Q143 Chair: How much was spent in 2013-14 on agency staff across the piece?

Richard Douglas: Across the piece in 2013-14, it was £2.6 billion, which was up from about £2.1 billion in the previous year. That has grown exponentially in the past couple of years.

Q144 Mrs McGuire: Could you give us a flavour of what in this toolbox will drive down the costs?

Richard Douglas: We have got a mix of things.

Mrs McGuire: It is a mixed toolbox.

Richard Douglas: It is a mixed toolbox—most toolboxes have a number of tools in them. There is work that has been done before by NHS employers on what the high-impact actions would be, which are about how you manage the work force and how you roster. Some of that is pretty

basic stuff, but it has not always happened in the same way everywhere. On top of that, we are looking at what further work we can do.

There are three issues for us on this. One is the management of staff now. The second is predicting volume and ensuring that you have the right people to meet the volume of need, which was one of David's comments. The third is a price issue. The other thing that we want to focus on is whether there is anything we can do to drive down price, so that even if you end up with a higher volume, some of the issues of price can be addressed.

Q145 Chair: How?

Richard Douglas: We have got a number of framework contracts with agencies that try to deliver the best price possible by getting decent volumes. There are some agencies that won't take part in that framework, and there is a question for us about how we address those agencies.

Q146 Chair: You could insist that, when students become—

Richard Douglas: Well, then you look back and think: are there bigger policy questions about overall employment?

Q147 Chair: How much does it cost? Were they right about it being £400,000?

Richard Douglas: It sounds about right. The other thing that we may need to think about is that whole area of terms and conditions and training, but none of those have an impact on the very short term.

Q148 Mrs McGuire: We always talk about the internal market within the NHS, but effectively you are also operating in an external market, because if you have a shortage of particular consultants or doctors or nurses or whatever, you have to go out there into the market. I am interested in how you will interfere in what is a competitive market to drive down prices.

Richard Douglas: We are the main buyer. We have tended to operate very much at a local level. At the end of the day, there are other people who buy from the agency nursing market, but the bulk of it is us. What we are trying to get into is: how can we use that clout, particularly when the volume side is going, to get better prices?

Q149 Mrs McGuire: What links do you have with the major universities who are producing medical students for the provision of medical staff—we will deal with doctors, but I will use that generic term—in terms of numbers? We are forever hearing that more doctors are being churned out—I do not mean that in a nasty sense—than ever before, so if there are more of them, where are they all going? Is it just that the pressure on A and E has become greater because there is difficulty in trying to see a GP at certain times? Mr Stevens is eager to answer that question—his enthusiasm is overwhelming.

Simon Stevens: Absolutely. Where are they going? They are coming to work in the national health service. The fact is that we have—

Q150 Mrs McGuire: We have already heard that some hospitals are operating with quite a significant deficit in consultants.

Simon Stevens: Sure, but we have got 160,000 more clinical staff working in the NHS than we had back in 2000, when we began on the big catch-up spend to try to improve the quality of and access to services.

Mrs McGuire: I remember it well.

Simon Stevens: The answer is: we are employing them. What is more, we have more now than four or five years ago; there are 13,500 more clinical staff working in the NHS. So, in some cases, would we like more? Have we got gaps in particular specialist areas? Sure we have, but the truth is that the NHS work force is growing as the needs and funding for the service have grown.

Q151 Mrs McGuire: Does that mean that we have to have a conversation about how much it can grow?

Simon Stevens: That is the conversation we were attempting to initiate with this five-year forward view: what will the next five years look like; what will be the shape of services; and how do we get the balance right between investments in hospital medicine versus GPs, nursing versus social care and all those kinds of judgments?

Q152 Mr Bacon: I realise that you cannot do this overnight and that you have 160,000 more clinical staff, but you have not got 160,000 more A and E consultants. You wouldn't need that many, but there is a current, and apparently chronic, shortage. What are you doing now to ensure that in five, six or seven years' time you don't have that shortage, specifically in that one domain?

Simon Stevens: The number of training places in emergency medicine has increased quite substantially. I am sure that the folk involved would like there to be more. There is an issue about ensuring that we fill the places that are there and, more profoundly, there is an issue about redesigning the way acute medicine works and the interface with general practice.

Q153 Mr Bacon: What about the status of A and E consultants, as opposed to other kinds of consultants? I have heard it said that they do not appear to have the same status. It is noticeable that you have the Royal College of Radiologists and the Royal College of Paediatrics, but it is the College of Emergency Medicine, not the Royal College. Nobody seems to have thought that they need a royal charter like the others do. What are you doing about the status of A and E consultants, about paying them more than other kinds of consultants, and about making them feel wanted?

Simon Stevens: They obviously are a crucial part of the team in any major hospital, and their numbers are going to expand. If Bruce Keogh or Keith Willett were here talking to you about the urgent and emergency care redesign that we are embarked on, they would make the point that it is certainly the front door, but it is also the connection between the A and E and the acute medicine

taking place in the rest of the hospital that often explains why patients sometimes wait too long in A and E departments. That piece is crucially important. It is actually a broader conversation about acute medicine in the round, and the Royal College of Physicians is actively engaged in that.

Q154 Mrs McGuire: Is that also because there is an issue at general practice level? People are now going to A and E because of difficulty in accessing general practice appointments or even, alternatively, just because of a change in attitude as to whether your first port of call is an A and E department as opposed to your general practitioner. You just cut out the middleman and go straight to A and E.

Simon Stevens: I think that is part of the explanation. That is why the conversation we began about A and E payment is not completely black and white. If we just keep putting what extra investment we have into yet bigger, more expansive A and E departments, rather than investing it in primary care, we are just going to perpetuate that very dynamic that you rightly describe. There are some choices for us there.

We must also not forget pharmacists, who are a hugely important part. People with coughs, colds, aches and pains, particularly over this coming winter, should certainly think about whether the pharmacist can help. Pharmacists train for only one year less than a doctor. There are 11,500 pharmacies around the country. The NHS winter campaign will remind people that the pharmacy is often a very good first port of call, compared even with the GP surgery or the A and E department.

Q155 Mrs McGuire: Even opticians are often the first port of call, and are where someone finds out if they have glaucoma, high blood pressure or other medical issues.

Simon Stevens: That is right. We would certainly encourage people to go, over the winter period, to www.nhs.uk/asap, where they will get good-quality medical advice on which would be the right port of call.

Chair: Right, Amyas and then Stewart.

Sir Amyas Morse: I just want to ensure that I understood what the form of intervention next year will be, and what resources would be involved. I fully understand that there are possibilities of achieving efficiencies, and you quite rightly want to pursue those. You will be going forth and talking to trusts and telling them how they can be more efficient. Will you go forth telling them how they can be more efficient and helping them with funding in any way? Or is the prediction that you will arrest the trend towards negative financial performance based on giving them more advice on how to be more efficient? Is there something more substantial involved in the intervention than that? I was not quite clear.

Simon Stevens: There certainly will be funding. There is obviously next year's commissioning round. People will be making agreements about the levels of activity that they are likely to have to undertake.

Sir Amyas Morse: Will it be real money or not?

Simon Stevens: It will be the money from the allocations that are available to CCGs to pay for these services, together with the specialised commissioning budget. I do not think any of us

would pretend that the financial pressures that exist there now are going to disappear overnight, or indeed next year. I am sure there are going to continue to be financial pressures in some of these stressed parts of the country.

Sir Amyas Morse: Do you expect that to be for the next two or three years, in fact?

Simon Stevens: If history is our judge, some of these have been multi-year problems. I think that what we are seeing is that we need a much more profound intervention in changing the way in which care is provided in some parts of the country. If you look at Staffordshire, parts of Cumbria or Medway, it is pretty obvious that, with the exam question as it has currently been set, people are not going to be able to provide the answer, so we will have to change the exam question, which is what we are trying to do through the forward view, with new care models, new sets of options and better forms of integration.

Sir Amyas Morse: That all sounds great, if I may say so, but I want to be sure that we are not indulging in any short-term optimism bias in what we expect to be achieved as a result of pointing out how people can do things efficiently. I take it that you are not indulging in that. You are being realistic. We have heard various predictions about how much by way of efficiencies can be realistically delivered by foundation trusts, and they do not sound like enormous numbers.

Simon Stevens: No, next year will be incredibly tough. Let us be absolutely clear about that. That is point one. Point two: those parts of the country that have deep financial pressures now are almost certain to continue to have deep financial pressures next year; there is no doubt about that. Our point of view is that just doing more of the same will not get us to where we need to get to. That is why we have got to make some quite profound changes to the way care is delivered, of the sort that we advocate in the forward view.

Q156 Chair: What I just do not get—we have heard this so much in the last four years—is that that means you have to spend money up front. All of us can take you to our local patches. You have to spend money, investing in GPs and facilities and all that, yet here we are, with the deficit growing and growing in the trust. You will not have the money to do the change unless somewhere—the Treasury—gives you more money to do it, not next year or the year after, but now. It is one of these massive investments up front to get the savings downstream, and nowhere do I see any indication that you are getting that. Nobody has said that you will get more than current inflation level expenditure. All the discussion that I hear is that it will go down, post-election.

Simon Stevens: Our shared point of view—others may want to come to this as well—is that there are still efficiency opportunities available, from the range of tools available to providers and CCGs.

Q157 Chair: Where? Where are you, Mr Douglas, going to find the money? Who is going to find the up-front money to transform community services?

Simon Stevens: If you look at the range of efficiency performance across providers in England, an independent econometric survey has shown that there is an opportunity of between 5% and 5.6% of efficiency—

Q158 Chair: I am sorry to keep interrupting, but the record so far—looking at both Mr Flory and Dr Bennett—is that they have not even managed to reach the 4% they were set.

Simon Stevens: Actually, the NHS has delivered between £18 billion and £20 billion of efficiencies over the course of this Parliament.

Q159 Chair: Hang on. Do not quote those figures. Both the trusts for which Dr Bennett and David Flory are responsible are delivering between 1% and 2%, and the main way in which savings have been delivered—let us be realistic; all I want is an honest conversation—has been through a salary freeze. That is the record after four or five years of real attempts by this Government and all of you guys to try to get money out of it.

Simon Stevens: About a third of the savings that have been achieved over this period have come from pay constraint. We stuck our neck out in the forward view and said that we do not believe that over the course of the next Parliament that is going to be an indefinitely repeatable strategy. You mentioned the 1% and 2% The conventional methods are, over time, going to have to be increasingly replaced by the broader system changes that will indeed require some pump-priming investment. That is the case we make.

Q160 Chair: Where will that come from?

Simon Stevens: Well, that will be for the next Government to decide. Our argument, quite explicitly, is that, absent that, it will be harder to get the 2% rising to 3% efficiency to sustain the kind of modern, compassionate health service that we believe the people of this country want.

Q161 Chair: So the only way forward is a massive injection of up-front cash for 2015-16.

Simon Stevens: That is not quite what I said. If you look out over the next five years, the composition of the efficiency opportunities is going to have to change over time. In order to kick-start that, yes, we will need some up-front investment, but if we do that, we think that the NHS can get perhaps two thirds of the way towards the kinds of efficiencies that will be required.

Q162 Mr Burrowes: In terms of clues as to where it could come from, last year Monitor discussed surplus assets. What is the current level of surplus assets in the NHS?

Dr Bennett: Surplus assets? I don't have a number for that.

Q163 Mr Burrowes: Last year you identified £7.5 billion of surplus assets across the NHS, and said that urgent work should be undertaken to examine the extent to which those assets were still available. Has that work been undertaken?

Richard Douglas: Most of that work is being done by the department. I would agree that when you look at what we need to do to create the headroom to pay for change and to invest in the

system, a large chunk of that may be around capital expenditure. I do not have the number with me, but we do have a lot of surplus assets and, even more importantly, potentially surplus assets if we reorganise some of them.

Q164 Mr Burrowes: Would you be able to give a figure?

Richard Douglas: I do not have the figure with me, but I can come back to the Committee on that.

Q165 Mr Burrowes: Will you do that?

Richard Douglas: It is an estimate of surplus assets. You tend to get assets that are declared surplus by the system—someone says, "We don't need this anymore"; you get underutilised space that you can look at and say, "It has not actually been declared surplus, but with a little bit of change we could make it surplus and sell it; and you get other situations where people really have not thought about whether they could move facilities or whatever.

Q166 Mr Burrowes: The report from Monitor was in 2013. Have you come up with a plan of how to release some of the surplus?

Richard Douglas: We are doing a mix of things. Some of that surplus estate got moved into property services, and we are currently going through a process of selling that. The other thing, which is one of the more fundamental changes that I think we may have to make to support the investment, is to look again at the capital regime that we operate in the NHS. We currently have a capital regime that basically allows people to borrow against their income; there is no strategic ownership of capital planning. We need to change that in order to release some of the resource for investment.

Q167 Mr Burrowes: In terms of implementing new working and trying to ensure that there are productivity savings, do you think that that requires more or less management?

Simon Stevens: Do you mean to ask whether we are over-managed or under-managed as a share of spending in the health service?

Mr Burrowes: Yes.

Simon Stevens: By international standards, the NHS is very lean in its management costs. On the OECD definition, we spend under 3%, compared with between 5.2% and 5.8% in France and Germany, and obviously way north of that on the other side of the Atlantic. Anyone who claims that too much is being spent on good management has not actually studied the international comparisons or the facts. We know that good quality management makes a huge difference to the performance of different parts of the health service. That is an argument that I would definitely agree with you on.

Q168 Mr Burrowes: What is your view? Do you think that there are too many or too few managers? There has obviously been a reduction over the course of this Parliament.

Simon Stevens: There has. There are now 21,000 fewer back-office administrative and managerial people than there were prior to the last set of health changes. This many come as a surprise to the Committee, but at NHS England we took 20% of costs out over the course of the past year, and we are taking another 10% out going into next year, so we will have cut the cost of running our part of the health service by more than 30% in two years. We are running pretty lean as well.

Q169 Mr Burrowes: So what is your view? In terms of being more efficient—more productive in savings—do you need more or fewer managers?

Simon Stevens: Obviously there is a legitimate concern that if managers just get to decide how many managers there should be, perhaps there will be more managers. Nevertheless, my personal view is that given that we have GP-led CCGs, it would be a good thing if the clinically led CCGs themselves were able to make that decision in the same way as they are able to make so many other decisions.

Q170 Mr Burrowes: But your personal view is—

Simon Stevens: My personal view is that, as long as the GPs are doing it, CCGs should be able to make that decision.

Q171 Mr Burrowes: Do you agree with the Health Foundation argument that we now have an undermanaged service, which makes it more difficult to implement and embed new ways of working in order to achieve ongoing productivity savings. Do you agree with their analysis of those data? They are looking comparatively across international data.

Simon Stevens: You can spend money on all kinds of administrative stuff and get absolutely no bang for the buck for the taxpayer at all. Have there rightly been opportunities to take costs out? Sure, there have. But does that mean that we will not need a significant leadership and management effort to bring about the kinds of service transformation that we need in the broad view? Yes, we will. We have to preserve and nourish that, rather than castigate or eliminate.

Q172 Mr Bacon: Before we leave this point about capital assets—you used the word "lean" in terms of managers. Do you think that the NHS is lean in the way that it uses its capital assets? You are shaking your head, Mr Douglas.

Richard Douglas: No, I don't actually.

Simon Stevens: The London Health Commission said that there was about £1.5 billion-worth of surplus assets available in London.

Q173 Mr Bacon: Is that just London?

Simon Stevens: That is just London. I think that they said you could fill Hyde park with all the unused buildings and premises. We have a huge opportunity there, which will create some of the fighting fund for the kinds of up-front investment that Mrs Hodge was talking about.

Q174 Mr Bacon: I do not want to spend long on this, but am I right that the NAO has a Report coming out on PropCo? CAG, does the NAO have a separate Report coming out on NHS PropCo?

Richard Douglas: I think that there is going to be one. From my end, I think that there will be.

Q175 Mr Bacon: We looked at NHS estates many years ago, and there was £23 billion of assets then. There seemed to be no appreciation at all of how they might be managed, when they might be added to or when they might be sold. There was nothing being done at all. My information on PropCo at the moment is that anyone out there with money on their balance sheet who would like to do something cannot get them to reply to an e-mail or get anyone to make a decision. Would getting that fixed help you to solve your other problems?

Simon Stevens: Definitely. In terms of the GP angle, one thing that we have to do better is GP premises investment. We talked about that last time. There is a huge unmet need for that—not necessarily just an extension of a clinic's existing front room, but doing things at scale with proper investment.

Q176 Mr Burrowes: The barrier to that is GPs.

Simon Stevens: No, the barrier to that has been constraints on the ability to liberate some of this investment to invest in those kinds of—

Q177 Mr Bacon: We are talking about money and the availability of money to do the things that you say you want to do. There are billions of pounds sitting there and it is not being used. You mentioned GPs; I did not. But it just so happens that I have a GP surgery in my constituency that has twice paid for planning permission to get something done and then NHS blockages further down the pipe meant that nothing happened. This is not just about GP surgeries; it is about other kinds of asset and much bigger assets. You have said, "Definitely." When?

Simon Stevens: Richard will provide you with the answer.

Richard Douglas: I will come in on the wider properties. Are we lean in our use of assets? No, we are not. Most people looking at our system would say that we invest a lot more in bricks and mortar than most, comparatively, and a lot less in equipment and IT, despite some of the conversations that we have had here. We have not always invested in the right properties. Yes, there is a lot to take out on the property side. PropCo is one element of this, and it is a small element relative to the rest.

The majority of estates sits with provider organisations. If we focus all our attention on PropCo, we potentially miss a big opportunity. PropCo takes a lot of stick from people. It is taking a

bit of time to get it up and running properly but, actually, it has done a lot more in terms of disposing of assets and reducing costs than all the constituent bodies that we brought together to make PropCo two years ago. It has a long way to go, but it is making progress.

Q178 Mr Jackson: I concur with what Mr Bacon says. The delay in the disposal of capital assets, which I saw in my own constituency, has an impact on clinical services and the structural debt for trusts. On money and finance, I refer you to page 36 of the Report, which is about providers' costs. There is quite a surprising finding in paragraph 2.12: "Trusts do not collect and record cost data consistently enough or in enough detail for systematic analysis." That is a reference to the Monitor report, "A guide to the Market Forces Factor", which was published in December 2013. It is quite astonishing, really. I am getting old, so I will have to switch on a light on my phone to see the report, because it has such small writing. It says that Monitor reported that "it is almost impossible to distinguish between avoidable and unavoidable components of expenditure." That is quite a surprising, not to say shocking, finding and I wonder, Mr Stevens or Dr Bennett, whether you want to comment on it, before I go on to my second question.

Dr Bennett: It is an issue, and so one of the things that we are right in the middle of doing as part of revamping the whole pricing system is to get a much more systematic, detailed and consistent approach to costing across the whole of the provider sector. In any case, we need that to do pricing properly, but it will then provide the individual providers, the commissioners and us with much better insight into what is going on. So, yes, it needs to be fixed.

Simon Stevens: I agree, although equally it is worth noting that what we will try to do with the way funding works in the health service is to move away from paying for each component of care and instead move towards paying for a year of care—capitation, if you want to use the jargon. David and I will publish a paper quite shortly on how to move that forward. So, yes, you need the underlying costs, but we don't just want to price each widget; there is an enormous administrative cost in doing that. The bigger question is, "What is the opportunity to reshape services—"?

Q179 Mr Jackson: Will the Better Care Fund allow you to do that in a more holistic way?

Simon Stevens: The Better Care Fund certainly will. Let me just express a sense of historical humility on this. I happened to be reading, as you do, the speeches of Aneurin Bevan the other day, and in a speech to the Nuffield Trust in about 1946 or 1947 he talked about the importance of hospitals getting costing systems in place for the start of the National Health Service. So, there we are.

Chair: He should have been tougher on the GPs.

Q180 Mr Jackson: That has caught almost a micro-issue; now, I will move to the macro-issue and our friend, private finance initiative. If you look at figure 17 on page 38, what is quite frightening is the impact of where surplus meets capital charges in PFI schemes. It does not look very healthy. On the positive side, the Report makes mention in paragraph 2.17 of a refinancing of a PFI. I know that that is not strictly your pay grade; it goes right up to the Treasury—

Simon Stevens: No, it is Richard's pay grade. We have got some senior people here today.

Q181 Mr Jackson: It may be above his. But how much serious long-term work is going into the refinancing, or alternative financing, of PFI, because the figures bandied around are an enormous amount of money? I think that in the NHS PFI schemes are £63 billion of encumbrance to the taxpayer. That will have a big impact on clinical services in the future for financial sustainability. What is your view on that?

Richard Douglas: The annual payments are about £1.8 billion. We have 77 providers with PFI schemes; around 31% of our providers. We have a number of them in financial difficulties and I think that, as the Report made clear, we have got four out of six with deficits in excess of £25 million on PFI schemes.

We also have a number of providers that have PFI schemes that are doing pretty well, so I think we have to be careful that we do not pitch this as being just a PFI problem. We have got 44 providers that have surpluses in excess of £5 million and 36% of those have PFI schemes. A PFI scheme does not, in and of itself, cause you financial problems. We have to be a little bit careful about how we present that as an issue.

Now, are there circumstances where we could think about buying out a PFI scheme? If we get propositions that are both affordable and value for money, we will look at them. The two that are referred to in the Report came to the Department—well, Northumbria came to the Department. We discussed it with them and worked on the value-for-money issues. However, I don't see there being lots of cases that are like Northumbria, if I look at this situation honestly. The characteristics of a scheme that potentially make it susceptible to a buy-out mean that it is not the majority of PFI schemes in the NHS at the moment. However, we are seriously looking at options about where this could work and what we could do more widely to look at reductions in the cost of PFI.

Q182 Mr Jackson: The reason I bring it up is obviously I understand it is not the experience of every trust; but obviously in this situation, where we are looking at long-term funding, we have got to look at areas where we can have some control. You cannot legislate to stop people getting old and falling over in winter. You cannot legislate, really, for population changes. You cannot legislate for the cost of drugs, generally speaking—and there are lots of other examples; but you can change or seek to change the long-term financing by refinancing, which is the challenge. How do you change the financial regime, where you have control?

Richard Douglas: There are two big issues for us—well, three big issues. One is the affordability—so how much would it cost to buy these schemes out? There are a lot of them. The capital cost is pretty high, in that you have to find the one-off finance to do it. The second is doing that in a way that gives value for money. On some of these it will be quite difficult to get to a value-for-money solution.

The other thing, on the flexibility point, which I think is important to remember: some of the inflexibility people complain about with PFIs is that it means their building is maintained; their equipment is replaced. They cannot save money by cutting back on maintenance and replacement. I am old enough to remember what happened in the 1990s when we faced financial problems, and a lot of people dealt with those by cutting back on essential maintenance, cutting back on equipment—which then led to the whole programme of replacing hospitals in the early 2000s; so I think we have got to be a bit careful.

Q183 Stephen Phillips: Looking at figure 17, there does seem to be a very close correlation between the trusts facing significant deficits and their capital charges. One of the things that you said, Mr Douglas, is that you are looking at various options. What are those options across the provider estate that you are looking at? Because PFI is very expensive. I quite understand that they have led to decent buildings, which are maintained, but the taxpayer is being asked to fund these at vast cost over a number of years. So what are the options you are looking at?

Richard Douglas: The options vary. There are some schemes where it may be possible to buy them out entirely. There may be some options—and again it depends on what the market is like at different times around refinancing. A chunk of the cost in a number of these is around soft facilities management services, where there are elements of that that you can renegotiate without unpicking the whole deal; and there is some from the hard facilities management. There is a whole range of options around that.

The fact that new hospitals, whether it is publicly financed or privately financed, tend to cost people more money in the facilities side of it, is not really a surprise. In some of these cases, as well as actually costing money in terms of facilities, they are helping to save money in terms of delivering the service, because they are better configured hospitals.

Q184 Stephen Phillips: By the same token what figure 17 indicates is that if you could eliminate significant PFI costs for the majority of trusts with significant deficits, the number of acute providers with significant deficits would also reduce significantly. So is this not an area which you and NHS England and, indeed, the Department, ought to be looking at in a great deal of detail?

Richard Douglas: It would. We are looking at a great deal of detail. What that reflects is that hospitals have to pay the costs of the facilities they are in; so I think there is a question—just eliminating the cost of having a building would not be appropriate. I think what we have got to do is: how can we reduce the cost of that building in a fair way to the whole system?

Q185 Stephen Phillips: Thank you. I just wanted to take Mr Stevens back to efficiency savings, if I may. I am not sure we got a clear answer, but in 2013-14 providers were required to deliver 4% efficiency savings: correct?

Simon Stevens: That was the tariff top line as it were, yes; but in net it was nearer to probably 2%, 2.5%.

Q186 Stephen Phillips: Was that achieved, or not?

Simon Stevens: Yes, 2%, 2.5% was achieved; so that is why in a forward view we assume that something net in the zone of 2 to 3 is feasible.

Q187 Chair: Explain net. I do not understand net.

Simon Stevens: When we say that overall we are looking for a 4% gross efficiency, for various reasons—so-called leakage—that tends to become about 2%.

Q188 Chair: I do not understand that.

Dr Bennett: Broadly speaking, for several years now we have set a 4% efficiency factor, which is in the tariff and focused therefore on the acute sector. The acutes have actually achieved we think about a 2% real efficiency improvement, but until very recently their finances stayed broadly in line, which suggested that they were finding other ways of closing that additional 2% gap. Some of that has come through demand growth generating extra revenue for them.

Q189 Stephen Phillips: That is unrelated to achieving the target of 4% savings, isn't it? Even if you have growth, you are still supposed to achieve a 4% saving.

Simon Stevens: Our expectation, net, is that it will be nearer to 2%. We say that in terms in the planning guidance and that is what we say in the forward view.

Q190 Stephen Phillips: Right, so you would say that 4% gross has been achieved for the 2013-14 year?

Chair: 4% savings.

Simon Stevens: The net has been, as David said, 2% or 2.5%, something like that.

Q191 Stephen Phillips: Let us be clear. I asked you about the 4% and you said, "Oh, 4% gross is 2.8% net."

Simon Stevens: 2% to 2.5% net, and that was achieved we think.

Q192 Stephen Phillips: That has been achieved, has it?

Simon Stevens: In 2013-14, yes.

Q193 Stephen Phillips: That was the target you were set as NHS England and Monitor, yes?

Dr Bennett: There is a difference here. In the system overall, roughly speaking, if you look at underlying cost drivers, demand growth and so on, the revenue to the system went up by around 4% less than the underlying drivers, so that was the overall 4% ask. For the 2% figure, there are various ways of doing that, including changing which bits of the system provide services and so on. The 2% figure is looking at individual providers and what they are able to achieve. We will have to acknowledge that the system will only be able to achieve the underlying efficiency improvement in the longer term.

Q194 Stephen Phillips: That leads me on to my next question. The NAO reports that it is anticipated that 4% will be required for the next four years on the part of each provider—that is in paragraph 11 of the Report. Is that achievable or not?

Simon Stevens: Not 4% net, no. In fact, when we publish jointly the tariff document for 2015-16 in the next few weeks, you will see that we have made a judgment about what 2015-16 will be both gross and net, but for the rest of the next Parliament, our proposition is that, net, it needs to be in the 2% zone, which is consistent with the levels of achievement delivered in the previous years. How we get to that 2% will need to change during the course of the next Parliament, from being unit improvement at individual institutions to broader system efficiencies as a result of the new care models that are being introduced.

Q195 Stephen Phillips: Right, so if I look at it in broad terms, what you are saying, or will be saying, is that 2% to 2.5% will be achieved across the system—that that is capable of being achieved—for the next Parliament?

Simon Stevens: That is right, with the caveats that we have put into—

Q196 Stephen Phillips: But not the 4%.

Dr Bennett: No. One of the things that has contributed to the 4% improvement in recent years has been wage freezes, and as you said very clearly, that is not sustainable. That is one of the reasons why we are not going to be able to sustain the 4% for the whole system.

Q197 Stephen Phillips: Which leads me to two more questions. Mr Stevens, you referred to an independent econometric study indicating that between 5% and 5.8% efficiency savings across the system, as I understood it, could be delivered in addition to those that have already been delivered.

Simon Stevens: Let me be precise about this. What it said is that there are two elements to the net efficiency that are achieved by providers. One is catch-up—that is, less efficient providers becoming more efficient relative to the best, and if you look at the spread across the 90th percentile, that was estimated at between 5% and 5.6% of spending through providers. In addition to that, each year it becomes possible to be more efficient as a result of changes in the way medicine is delivered, technology and so on, which in the jargon is called "moving the efficient frontier". That, looking back, has been estimated to give you another 1.2% to 1.3% a year.

The important distinction here is that the 5% to 5.6% is a one-off opportunity, and the 1.2% or 1.3% frontier shift is an annual opportunity. So what Monitor and NHS England have looked at together is how much of the 5% to 5.6% catch-up is it feasible to expect each year. We believe that 1% of that 5% could be delivered each year, and then in addition 1%-plus from frontier shift. That is why we believe that 2% net, based on that evidence, is not unreasonable, but as you get towards the back-end of the Parliament, the composition of that 2% net will have to change.

Sorry, I know that was an incredibly dense—

Q198 Stephen Phillips: No, it is very helpful.

At some point, the "moving the frontier" efficiency—the 1%—will become incapable of being delivered.

Dr Bennett: Not necessarily, if this is new technologies and new ways of doing things. The point that Simon is quite rightly making, though, is that the catch-up you can only do once, and then you are left with 1%, if you stick with the current ways of delivering care. That is why we are saying that, over the course of the five years, we have got to shift away from simply looking for people to deliver the care in the current way better, which in theory you could keep on doing that at least 1% a year for ever—

Q199 Stephen Phillips: I am sorry; I don't want to interrupt you, Dr Bennett, but we are a little bit pushed for time. So you would say, based upon past experience, in terms of moving the frontier forwards, new technologies and everything else, you can achieve efficiency savings on an ongoing basis of 1% each year?

Dr Bennett: In the long run, if you don't fundamentally redesign the way you're doing it, and that is what we need to do.

Q200 Stephen Phillips: With the catch-up element of the efficiency saving, at some point that comes to an end?

Simon Stevens: Yes. If you are doing 1% a year on that opportunity, you have got about five years in front of you.

Q201 Stephen Phillips: From which it follows, looking in the medium to long term, that the budget for the NHS as a whole, as a proportion of national wealth, will have to increase if we want to deliver the same standards of care in the future.

Simon Stevens: I think that statement is true, but I don't think it follows from the premises. The reason I think that statement is true is that, if you look in the post-war period for all industrialised countries, as countries have got richer they want to spend a higher proportion of their national income on health services, and it would be pretty hard to think you would suspend the laws of social choice and economic gravity and that that would not continue to be true over the long term, including in this country.

As to why I don't think that necessarily connects to the premises, we believe that there is quite a big opportunity—based on new medicines, new technology and new ways of delivering care—that will not only sustain the 1.2% to 1.3% frontier shift but could potentially improve it quite dramatically.

Q202 Stephen Phillips: Historically, those new technologies have always been more costly than what they have replaced, haven't they, which is why health inflation in the health sector runs ahead of inflation in general?

Simon Stevens: No. They have expanded the realm of things you can do, which is one of the reasons why health services expand, but actually a number of the technologies can themselves be cost-saving and certainly cost-effective. But one of the big opportunities in front of us, I think, is that the National Information Board last week published a series of road maps for what we need to do on bringing broader technology to bear in health services. Those benefits will be spill-over benefits over

and above all the benefits that we will get from personalised medicine and from new drugs. Think about what has happened: cardiovascular disease deaths in this country are down by over 40%, partly because of secondary prevention and the discovery of statins, which are incredibly cost-effective and may even be cost-saving. Smoking rates have helped as well. So there are some things that will actually do—

Q203 Stephen Phillips: Where I am trying to get this discussion to, and I promise the Chair that this will be my final question, is that, to take the party politics out of this, at some point as a country we will need to have a discussion among ourselves about whether or not we are prepared to plough a lot more money into the NHS in order to deliver the best care free at the point of need. Would you agree with that?

Simon Stevens: Yes, because we have said in the Forward View that the choice facing the country, at least for the next five years, is a choice between the constrained funding increases that of necessity there have had to be in these times of economic recession and austerity—so somewhere between what we have just had and what the health service has been used to during its post-war history, which has been real-terms increases of 3% to 4%. Our proposition is that somewhere at the mid-point between those two, given the other changes we want to bring about, is what would be viable over the course of the next five years.

Dr Bennett: That means that if we can do all that is possible to drive the technical efficiencies in the current ways we deliver care, make better use of technology and change the way that care is delivered—that includes more effective prevention, which can obviously have substantial savings upstream, and better integration of physical and mental care. If we can get all that right, we think that the residual ask is something like 1.5% in real terms each year, which will hopefully be less than GDP growth. That should not be driving up—

Chair: We hope.

Q204 Meg Hillier: I should declare, for the record, that I am an ambassador for Healthcare DENMARK. It is an unpaid honorary role, and I am one of four UK ambassadors. That brings me to the international comparisons on capital—Mr Stevens's specialist area.

Simon Stevens: I might be about to disappoint.

Q205 Meg Hillier: If the Department is not doing it, Mr Douglas, it should be. I still have some analysis to do but, on the face of it, in terms of capital build, the Danes are moving to 21 acute hospitals. Those seemed to be built for about 40% less than the typical NHS bill. That is a back-of-the-envelope calculation, and I have not done analysis of some of the clinical costs yet. But if that is true, it is staggering. It may be down to greenfield versus old Victorian buildings, but the question is: are you doing international comparisons? Who is doing it well and which countries should we be chasing? I do not think that we are leading.

Richard Douglas: On the capital costs—the hospital build cost—a well-known management consultancy recently gave me the same number for Denmark.

Meg Hillier: I wonder if that was my fellow commissioner.

Richard Douglas: The estates team at the Department of Health are looking at that to see whether it is true and whether there is something that we can replicate. If it is all greenfield sites, it is very different from doing something within a city. But we are looking at it on the back of that.

Q206 Meg Hillier: Just the Danes or anywhere else?

Richard Douglas: The Danes and the French are the two that we are looking at particularly, at the moment—the capital costs. We do a lot of work on international comparisons and always have done, around how care is delivered, relative costs and a number of other matters. As part of our efficiency work at the moment, Lord Patrick Carter is doing work on how we can create some headroom for trusts and help them to manage the efficiency challenge over the next few years. He is doing a lot of work on international comparisons and what we can learn from other countries.

Q207 Meg Hillier: I am glad that it is starting. Does anyone else have any comments? Mr Stevens, you have a history in this.

Simon Stevens: I have to declare an interest: I am a non-exec director of a charity called the Commonwealth Fund, which does a lot of international health comparisons. In terms of the challenge in front of us in England, I hope that we are not in a situation where we have to contemplate lots of hospital building expansion over the next five or 10 years. Some hospitals will need to be replaced because they are still in old premises or could be more efficient. But generally speaking, if we carry on doing what we have always done, one consequence of population growth and ageing—according to the Nuffield Trust—would be that we would need 17,000 more hospital beds by the end of the decade. That is the equivalent of 34 new 500-bed hospitals. We will have succeeded if we do not have to build a single one of those 34 new hospitals, because we have instead invested in services that are much more attuned to what the people on the receiving end of them would prefer.

Q208 Chair: We have four organisations in front of us this afternoon. David Flory has not contributed a lot. When are we expecting every trust to be a foundation trust?

David Flory: There are still 93 NHS trusts. The focus of our work, as the NHS Trust Development Authority, is assessing the clinical and financial sustainability of those organisations. We are now going through a process with the trusts, including those run by earlier witnesses Mr Hardy and Mr Hopkins, to review the timeline prospects of achieving foundation trusts in the current context and environment. Through that process, we are identifying those of the 93 that will not be able to make it.

Q209 Chair: Ninety-three will not make it?

David Flory: No.

Chair: Some within the 93.

Q210 Mr Bacon: How many are not going to be able to make it?

David Flory: We are still working through all of that. The plans for next year will give key information about the prospects of organisations demonstrating sustainability into the medium term. Now, my view is that the majority of the 93 will be able to produce plans and demonstrate their plans for the future, both clinical and financial, in order to get in front of Monitor to be assessed for authorisation.

Q211 Chair: By?

David Flory: There will be a number that we are pretty clear will be able to do that within two years, and a further number that we think will be able to within four years. There is a third group that we are still working on fitting into whichever of the two time scales they are in. Typically, the group for which we can't work out the answer yet is made up of organisations—some of which we have referenced today—that face significant financial challenge and need to recover that position before they can produce a viable plan going forward.

Chair: Disproportionately represented in this Committee.

David Flory: The time frame will definitely be at least four years.

Q212 Chair: The reason I asked the question is that you have four organisations. We have talked about management at the trust level, but there is also management cost at the centre.

Simon Stevens: But that is rapidly shrinking and is lower than it was when you had one organisation.

Chair: That is true across Government.

Simon Stevens: That's therefore a success across Government.

Mr Bacon: On that logic you should double the number of organisations. You aren't planning to do that, are you?

Q213 Chair: If you didn't have four—if you had fewer of you—the costings must decline.

Simon Stevens: I actually do not think so, because we are doing different things.

Chair: You're not. What we've had the whole afternoon is, "David and I are in the same place." What we see is duplication.

Q214 Mr Bacon: You are not really telling us that what Mr Flory does with his hospitals and what Dr Bennett does with his hospitals are fundamentally different things, are you?

Simon Stevens: I do not have a dog in that fight.

Q215 Mr Bacon: Look at the chart of bungs. You said there weren't going to be any bungs, Mr Stevens, but figure 22 describes 31 bungs.

Simon Stevens: Additional year-end bungs was the question, just to be precise.

Mr Bacon: Twenty-one of them are to Mr Flory's hospitals and 10 are to Dr Bennett's hospitals. Fundamentally, the two of them are engaged in the same activity, which is monitoring what the hospitals under their care are doing and intervening when they think it is required, with a slightly higher pressure of the foot on the gas for Mr Flory than for Dr Bennett.

Q216 Chair: How many people do you employ, Dr Bennett?

Dr Bennett: Doing what David Flory does in TDA, about 80.

Chair: No, how many entirely?

Dr Bennett: Entirely, 450.

Q217 Chair: And how many are there in your organisation, Mr Flory?

David Flory: There are 240.

Q218 Chair: And when you do these great and wonderful deals with Simon Stevens about everything—the world—you are doing the work within your organisation and it is being duplicated in NHS England?

Dr Bennett: Well, it's not being duplicated. We have joint but different responsibilities for pricing, for example, which is most of what we have talked about. If I can just illustrate the point on the stuff that David Flory and I do that is similar, if you put together looking after the foundation trusts, which is the bit where we have about 80, and looking after the non-foundation trusts, the first thing that someone would do is say, "You know what? We need one unit that looks after those that are better performers, on the whole—the foundation trusts—and another unit that looks after the other ones." Before you know it, you have recreated our bit and TDA's bit, but now you've got someone who has to be in charge of the two of them.

Q219 Chair: That might be true if it wasn't that, in terms of financial health, yours are declining faster than his, actually—ironically.

Dr Bennett: I am not sure that is strictly true, net of all various—

Q220 Chair: I don't want to go through all the stats because it is too late, but if you look at a lot of the stats in the Report about financial resilience and whether things are on your red card, they are declining. You gave us that very helpful note, which updated things, that looked at it going down. Let me ask the final thing on management. We now have how many CCGs?

Simon Stevens: There are 211.

Q221 Chair: And how many PCTs?

Simon Stevens: There are 152, which became 151, I think, just before—

Chair: And has anyone done a little exercise—

Q222 Mr Bacon: Hang on, it is 300-and-something that became 152.

Simon Stevens: No, prior to that it was 98, and so the—

Q223 Mr Bacon: When I was first elected, it was six in Norfolk, which went down to one. Now it is about five CCGs. I was meeting the chairman of my local medical committee, and I said, "How long is it going to be?" *[Interruption.]* I am helping you, in fact. Before I could finish my question, he said, "We've got a bet on that they're going to merge again." So it is just in and out, isn't it?

Simon Stevens: I've attempted to put a ban on CCG mergers, at least for the next year and probably beyond, because I believe that there are no right answers to what should be the number of CCGs or health authorities, or any of those people. There is a wrong answer, and that is to keep changing your mind, because everybody takes their eye off the ball while all that stuff is going on—so don't do it.

In fact, there is quite good evidence that the smaller CCGs actually have more GP engagement, and since GP clinical leadership was the magic ingredient that CCGs were supposed to create, doing things that diminish that destroys the point of CCGs in the first place.

Q224 Chair: The only thing I was interested in was the administrative cost of the CCGs, as compared to the administrative costs—

Simon Stevens: Much lower than PCTs.

Richard Douglas: We have taken £1.5 billion a year out of the administrative costs of the system.

Q225 Mr Bacon: £1.5 billion per year?

Richard Douglas: £1.5 billion a year. It is a recurring reduction from all the changes—

Q226 Mr Bacon: That is extraordinary. So, £15 billion over 10 years. What on earth were they spending it on?

Richard Douglas: Well, they're not any more. It's there—

Q227 Chair: This is £1.5 billion at the PCT/CCG level?

Richard Douglas: If you look at the overall cost of strategic health authorities, PCTs, the Department of Health, and every other bit of superstructure we had, it is £1.5 billion less.

Q228 Chair: I can see my members are anxious to leave me and I want to carry on.

Have you now got final figures on people who were made redundant in the reorganisation and were then re-employed?

Richard Douglas: I would have to come back to you on that. It is not—

Q229 Chair: The figure I have is 4,300 staff.

Richard Douglas: I would have to check up. I do not carry that number around in my head.

Q230 Mr Bacon: It is far too embarrassing to give it out right now. Write to us.

Richard Douglas: It is genuine; I don't carry it in my head.

Mr Bacon: There are people—you know this—who have been redundant four, five and six times, and then come back into the NHS.

Q231 Chair: And we have paid: the cost I have—I don't know where I got it from—is over £200 million in terms of redundancy payment, and then they come back in some guise or other.

Richard Douglas: Could I take both those two figures away and write to you?

Q232 Chair: The importance of mental health as an issue has been raised across the political spectrum. Correct me if I am wrong, but if you look at expenditure on mental health, half of CCGs spend less than 10% of their budget on mental health, although it is responsible for 23% of illnesses. A BBC survey found that 43 out of 51 mental health trusts—you will know this—had real-terms cuts of 2.36% in 2013-14, compared to 2012-13. Expenditure is going in one direction, political statements in another.

Simon Stevens: Not so. Expenditure in real terms is actually going up this year on mental health.

Q233 Chair: So the BBC is wrong, is it?

Simon Stevens: I would be happy to take a look at what they said, but the reason they might be wrong is because you cannot just look at expenditure on mental health trusts; you have to look at expenditure on mental health services delivered in primary and community services, and mental

health service spending arising from NHS England's own specialised services, because we have responsibilities for certain parts of the mental health spectrum as a whole. When you look at all of that combined, we are seeing a real-terms increase in mental health spending, based on the data we currently have for 2014-15.

For next year we are, for the first time in 25 years, going to introduce mental health access standards for psychological therapies, and for quick access for people having their first psychotic episode—or early intervention for psychosis—within two weeks. We are then committed to rolling out a broader range of access standards on mental health over the course of the next Parliament. So actually this is the one area that we have staked ourselves out on, in terms of the next Parliament, even ahead of knowing what the funding will be.

Q234 Chair: Okay, I hear that, but it just doesn't make sense to me; I'm sorry. One is an answer to a PQ—questions that Mr Douglas answered, and I am sure he consulted you—which is that half of CCGs spend less than 10% of their budget on mental health. So whether it is community based—

Simon Stevens: The point I was correcting was the claim that somehow mental health spending in real terms was falling this year. Based on the data we have, that is not the case.

Q235 Chair: Well. That was what mental health trusts said.

Simon Stevens: Yes. That is precisely my point. The mental health trusts are part of how mental health services are provided, but they are not the only part.

Q236 Chair: So are expecting them to go into deficit, Dr Bennett? Their performance—

Simon Stevens: Mental health trusts have some of the highest EBITDA margins of any provider trusts.

Dr Bennett: Their financial performance is among the strongest. As long as they are getting enough revenues for their share of the services that they are providing, they will be all right.

David Flory: It is significant that the majority of mental health foundation trusts have had stronger plans clinically and financially to demonstrate future—

Q237 Chair: I do not understand how they do it if they have less money and you are giving them more to do. It does not make common sense.

Simon Stevens: The broader point is that we want to expand the share of investment into mental health services in the round, but we have some opportunities to change the way that we are spending. We are spending too much on medium-secure psychiatric services. If that money were invested locally, it would prevent people from needing some of those services. We have certainly seen that in children and adolescent mental health services, where CAMHS tier 4 is expanding because reductions are being made in CAMHS tiers 2 and 3. That is one reason that we want, from

next April, to ensure that CCGs have the ability to help to influence the specialised mental health service spending that is going on for their populations.

Dr Bennett: It is also true that mental health trusts have been very effective at driving through efficiencies. Part of that is Government policy but, as you move care into the community, you can reduce the number of beds that you have; beds are very expensive.

Chair: We shall wait and see. The King's Fund, in its October monitoring report—

Q238 Mr Burrowes: It is not so easy if you just hear one trust. The North East London NHS Foundation Trust, in the Report, refers to the significant risk for the trust of moving to an activity-based system. It may not be able to recover the full cost of 10% of in-scope service users. I am not sure how many that equates to, but that could be a significant impact on services.

Simon Stevens: I saw that reference in the Report. As I said to the conference of the foundation trusts this morning in Liverpool, there is a paradox here: at the same time as the acute hospitals are saying, "Can we please get off this tariff treadmill and instead move towards more aggregated funding streams for longer periods of time?", the mental health trusts are saying, "The reason we've lost out is because we haven't had activity-based payment, so can you move faster down that path?" There is a bit of a danger of ships passing in the night. Yes, we want to get greater transparency about what is happening inside the block budgets that have sat with mental health providers, and we are working with them and the professions to do that. However, moving to an entirely activity-based funding model in mental health—which is not what we are proposing for next year—would also be a mistake.

Q239 Mr Burrowes: My CCG is one of those where there is a concern about the lack of funding for mental health—about 10% or so. The Committee has previously raised concerns about looking at the whole local health economy and trying to draw things up and everything. That still does not seem to be happening, particularly in these challenging times, in which the mental health end often loses out.

Simon Stevens: Yes, that is an accurate description of what has happened. To put some numbers on it, looking at the activity increases that have been occurring in different parts of the health service, in the mental health sector there has been growth of around 1.8% a year compared with 2.4% for local acute services and 4.4% for specialised services. There has been an advance and we need to change that.

Q240 Mr Burrowes: Is there any way of mandating—any way that you could shift that? Obviously, in the meantime, there are mental health patients who are losing out.

Simon Stevens: Yes. As I say, an important way that we are going to seek to do that, beginning in April next year, is by for the first time setting explicit access standards for the severe and enduring mental health spectrum and for the general psychological IAPT end of the spectrum, as a starter for 10. Over and above that, we have put in extra money this year for crisis care and liaison psychiatry. One of the unheralded victories that the mental health system has produced over the past year or so has been a big reduction in the number of people, at the time of mental health crisis, ending up in a police cell as opposed to a mental health treatment facility—the section 136s. Parts of

the country are really doing very well on this now. We have a big opportunity to view ending up in police detention at a time of mental health crisis as almost equivalent to one of the never-events that we talk about in other parts of the safety culture that we want through the NHS.

Q241 Chair: Two final things. We focused on the deficits this afternoon, but in a sense the deficits don't tell the whole story because you have put £1.8 billion of extra money in and people have drawn down on balances, hence the surplus going down, so it does not tell a true story of the real state of the acute trust sector. I don't know how much you will put through in 2014-15. You have put £700 million through on extra money on winter.

Simon Stevens: Yes.

Q242 Chair: I don't know what the public dividend capital is going to be this year. I don't know what you are going to get from CCGs. I don't know whether you are going to use some more of your specialist money to get in there. I don't know what you are going to do. How much extra are you expecting to put in in 2014-15? There is £1.8 billion disguised in the financial health of many of the trusts.

Richard Douglas: I don't think it is disguised. The public dividend capital that goes into organisations does not reduce anyone's deficit. It is a way of financing a deficit. That isn't hiding anything at all. The other figures in the table you referred to are public dividend capital. We are transparent about this. We are not hiding it. We put the cash in. We made a decision, first of all at the start of the year, that an organisation could not realistically manage to reduce that deficit further without impacting on other aspects of performance; so having made that decision, you then have to ask how you cash-finance it. We provide public dividend capital to ensure that they can keep the services going, they can pay their staff and they can pay their suppliers. That is totally transparent.

We talked earlier about bungs. It is not a bung; it comes with conditions for the organisation. They don't get off scot-free. David can say a little bit about the consequences for his organisations, but we attach conditions about things they have to do about engaging with the Department on some of its savings. It is engaged on procurement and on some of the estates things that we talked about earlier. We put conditions that senior management cannot get any pay increase when they are getting that money from the Department unless they come to the Department for permission on that. There are a whole range of things that make it pretty uncomfortable for the organisation.

Q243 Chair: Okay. That is the public, but the other stuff—people are drawing down balances. You cannot shift surpluses between organisations.

Richard Douglas: No, and when someone uses their reserves—their previously accumulated surplus—that shows up as a deficit in the year. So if I am a hospital that needs to draw down my accumulated surplus, that would be presented as a deficit, so it is very different. In local government, when you use your reserves, it wouldn't come through as a deficit. In our FTs it does.

Q244 Chair: What about the £700 million emergency funding for winter?

Simon Stevens: That is a good thing. It has been important for the NHS. The NHS is using that—

Q245 Chair: But it is a way of hiding extra money.

Simon Stevens: We are not hiding. It is subject to a press release and parliamentary statements. If that is hiding I don't know what concealment would look like. It is right out there. It is not just the £700 million. It is £250 million for getting waiting times shipshape as well. No, this is extra purchasing power that the NHS has needed and is using well.

Mr Bacon: I can assure you that making a speech in Parliament is a guarantee that no one takes any notice at all.

Q246 Chair: What about the money from the commissioners?

Simon Stevens: To trusts?

Q247 Chair: To trusts to shore them up. All I am saying is that you can sit here and say it to me, but I understand that some is out there.

Simon Stevens: This is the most transparent. Having come back to it after 10 years away, I can tell you that this is the most transparent ability to see the flows of funding through the national health service that there has probably ever been. The reason why some of these things are being thrown into such sharp relief in some geographies is because previously there was so much moving of the money around behind the bike sheds or in smoke-filled rooms that now is not occurring. It is a form of truth in advertising. Here is your funding, here is what you are doing with it and here is the gap—that is driving a set of difficult conversations that need to be had and that have been swept under the carpet for years in many parts of the country.

Q248 Chair: It is all so well funded, you are now telling us, that when the King's Fund—

Simon Stevens: No, I don't think those words crossed my lips. I said that I thought it was going to be used well and it was important.

Q249 Chair: The October monitoring report makes for gloomy reading in the number of patients waiting more than six weeks for diagnostic tests—performance targets were missed nine months in a row; the proportion of patients waiting for non-admitted treatment increased to the highest level for six years; and the number of people waiting more than 18 weeks for treatment was at the highest level for two and a half years. What is it going to look like next year?

Simon Stevens: First of all, the King's Fund are absolutely right that there are huge service pressures across the national health service. The health service is coping with a growing population, an ageing population and rising demand. There are 850,000 more operations now than back in 2010, 1.3 million more A and E attendances and millions more out-patient attendances. Clearly there are those pressures, and the King's Fund are absolutely right to say that. We are all doing everything we

can to try to ensure that for 2015-16, some very difficult judgments are made in smart ways so as to preserve services and to keep care of a high quality, but nobody is pretending that the outlook is not very pressurised.

Chair: Okay, we are there. Thank you very much indeed.