



Health Committee

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

Tuesday 9 December 2014

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Written evidence from witnesses:

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Members present: Dr Sarah Wollaston (Chair), Andrew George, Robert Jenrick, Barbara Keeley, Charlotte Leslie, Grahame M. Morris, Andrew Percy, Mr Virendra Sharma, David Tredinnick, Valerie Vaz

Questions 502 - 667

Witnesses: **Rt Hon Jeremy Hunt MP**, Secretary of State for Health, **Una O'Brien CB**, Permanent Secretary, Department of Health, **Richard Douglas CB**, Director General, Finance and NHS, Department of Health, and **Simon Stevens**, Chief Executive Officer, NHS England, gave evidence.

Q502 Chair: Welcome. Thank you very much for coming to the final evidence session in our inquiry into public expenditure. For those following this debate at home, could you introduce yourselves, please, starting with Simon?

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

Mr Hunt: I am Jeremy Hunt, the Health Secretary.

Una O'Brien: I am Una O'Brien, the permanent secretary.

Richard Douglas: I am Richard Douglas, director general of finance in the NHS.

Q503 Chair: Thank you very much. The additional funding announced in the autumn statement is coming from a number of sources. Could you set out in further detail for the Committee today exactly where that is coming from?

Mr Hunt: Who would you like to start?

Q504 Chair: Who do you feel would be best placed to open on that?

Mr Hunt: Maybe the finance director.

Richard Douglas: I can start off and let others add to it. If I look first at next year, we have, in total, an additional sum of just under £2 billion for the NHS front line; £1 billion of that is coming directly from the Treasury for the pressures that we have in the system, £700 million is coming from savings that, between the Department and NHS England, we have made on non-front-line services, and another £250 million is coming from the Treasury for capital investment in primary care. In total, you get about £1.25 billion coming from the Treasury and another £700 million from internal sources. However, it is all new money out to the front line.

Q505 Chair: You say that £1 billion is coming directly from the Treasury. Whereabouts within those equations are you taking the money that is coming from the banking fines?

Richard Douglas: The £250 million that is the first tranche of a £1 billion spend for primary care premises comes from the fines. That is £1 billion over four years. The numbers that I gave you were next year's numbers.

Q506 Chair: Are you saying that that is coming directly from the Treasury?

Richard Douglas: Yes.

Q507 Chair: Is that from the £1 billion?

Richard Douglas: No, sorry. First of all, I did next year. Next year, in total there is £1.25 billion from the Treasury. There is another £750 million over the next three years that comes from the fines. You get a total of £1 billion over four years for primary care investment.

Q508 Chair: Okay. You have the £250 million per year, adding up to £1 billion over four years—

Richard Douglas: Yes.

Q509 Chair: You are not counting that within the figures that you gave me with £1 billion—

Richard Douglas: Not the first time. I counted only the first £250 million, so I gave you only next year's numbers.

Chair: Okay. Barbara, you wanted to talk about that in more detail.

Q510 Barbara Keeley: I would like to go over those figures in a bit more detail. We keep having this expression “additional”; now we have another expression, “new money to the front line”. However, it is quite important that we understand exactly what the sources of this funding are and whether it continues. There were a lot of questions that were not answered last week after the additional statement. This Committee needs to know what is additional funding and what is short-term funding to avoid a crisis. It sounded to me as if the £1 billion from the Treasury for pressures was the latter. You said that it is for pressures. The documentation that we got with the autumn statement showed us that that is one-off. That is shown only for 2015-16.

Richard Douglas: No. Let us be clear—that £1 billion gets built into the baseline for the Department of Health. For future spending reviews, that £1 billion is into our baseline.

Q511 Barbara Keeley: Right. I did not hear anybody say that last week. In fact, the Chief Secretary was questioned on that after the autumn statement. You are sure now that that carries on.

Richard Douglas: That £1 billion is in our baseline.

Q512 Barbara Keeley: Fine. Could we look at the £700 million in 2015-16? That is important. Clearly any additional funding is very welcome, given everything that this Committee has heard about the pressures, but the £700 million seems to involve transfers from other bits of NHS spending. Can you be clear about where that is coming from? Where are you looking at now for that funding? We have heard that it is from Health Education England, Public Health England and other arm’s length bodies. Which budgets are being looked at for that?

Richard Douglas: We focused on where there is spending we could deliver savings from that would not impact directly on providers and front-line delivery. We focused on the combination of our arm’s length bodies, with their overall running costs, and budgets and programmes that were coming to an end in the Department of Health—things we had been spending money on that would not be continuing in future years. Rather than just trying to find another way of spending those, we have put them into this pot. We will also be doing some transfers from capital to revenue.

Q513 Barbara Keeley: Could you be more specific? As I said, people are saying that a lot of it may be coming from Health Education England, Public Health England or other bodies. We need to know, because in terms of the budgets of those organisations it is quite substantial. It would be quite surprising if £700 million were just kicking about and not being used.

Richard Douglas: It was definitely not kicking about and not being used. It was being—

Q514 Barbara Keeley: You referred to projects that were coming to an end.

Richard Douglas: Some budgets are coming to an end. In some cases, we have looked at arm’s length bodies like Health Education England and what savings you could make

without affecting training places or front-line delivery. We have released some of the contingencies that we had held in the Department. As a general rule, we hold contingencies effectively to cover off pressures in the NHS. When you can increase the funding to the front-line NHS, you will need fewer of those contingencies. It becomes a combination of all of those different areas.

Q515 Barbara Keeley: This funding does not continue. I have two extra points—
Richard Douglas: Again, this will get—

Q516 Barbara Keeley: Not if it is underspent.
Richard Douglas: We will put this into the baseline for NHS England. All of this money will go to NHS England and we will increase—

Q517 Barbara Keeley: But it is in the NHS now; it is just in other bodies.
Richard Douglas: No, it is in the Department. Let me be clear. It is in the Department of Health's budget. What we do then is give an amount of money every year to NHS England for commissioning services. The savings that we make in the Department will be added to the baseline that goes into the funding that Simon and NHS England get, so it builds into their spending recurrently.

Q518 Barbara Keeley: Will you be able to supply us with a list of which budgets it is coming from—which bodies and which budgets it is coming from?
Richard Douglas: We still have to finalise the details of some of these, but in broad areas we could—

Q519 Barbara Keeley: If you give us some ballpark figures—
Richard Douglas: We could say in broad areas.

Q520 Barbara Keeley: So we could have a list of those.
Richard Douglas: We could say in broad areas.

Q521 Chair: Can I clarify when that list will come, because I would like to be able to include it in our report? Are you able to say when you will finalise that?
Richard Douglas: We could give you the broad areas reasonably quickly. There will be some details that we have to finalise.

Q522 Barbara Keeley: The third element is the money from the foreign exchange fines. In the autumn statement it says, “£250 million per year will be invested in modern premises and technology”. That is very welcome, but it is also quite clear from the autumn statement book that that money runs out after four years, because it is coming from a source of fines. If it goes into premises—new buildings and extra rooms—they will have ongoing maintenance costs. If it goes into technology, technology has ongoing costs—replacement costs and maintenance costs. What will happen to that funding at the end of the fourth year? There are ongoing costs related to that.

Simon Stevens: The £250 million is a very welcome and substantial increase in the resources available in primary care.

Barbara Keeley: Indeed it is.

Simon Stevens: It will kick-start some of the improvement and modernisation that everybody wants to see, given that there is a lot of latent demand for general practice infrastructure upgrades. The £250 million compares with just under £800 million that is currently being spent each year, so you can see that proportionately this is a very substantial increase.

Q523 Barbara Keeley: But it runs out.

Simon Stevens: The fact that we have it not just for one year but for four means that we can now both deal with the immediate backlog of shovel-ready projects, if you like, for next year and plan for the subsequent two, three and four years, as part of kick-starting the kinds of service changes we talked about in the Five Year Forward View. Frankly, I have no concerns whatsoever about the fact that this stretches out for four years, given that that is three years longer than the entirety of the rest of the health service budget.

Barbara Keeley: Indeed.

Simon Stevens: We will get to that point when we get to it. In the meantime, this gives us plenty of latitude for making smart strategic choices.

Q524 Barbara Keeley: Do you acknowledge that, whatever it is spent on—whether it is premises or technology—there will be ongoing costs to be met at the end of the fourth year?

Simon Stevens: There will. As an addendum to the point that Richard made earlier, this £250 million is going to be a flexible combination of revenue and capital. It is not all capital. That means that we will be able to use a significant part of it, where that makes sense, for those kinds of costs.

Q525 Barbara Keeley: What do you expect the Department of Health’s underspend to be at the end of 2014-15? You had indicated to us before that you were saying that the Department’s budget would be in balance.

Simon Stevens: Yes, I had. I am sure that Richard wants to come in on that, but our expectation is that the Department of Health will meet its RDEL limit for the year. Richard has responsibility for DH—

Richard Douglas: I do not expect anything more than a very small underspend.

Q526 Barbara Keeley: Our inquiry is proving very interesting in terms of the broader issues around NHS funding that are emerging and announcements being made. Announcements have been made by both Opposition parties and now, in the autumn statement, by the Government. This is really a question for Simon Stevens. You chose to be part of the Government's pre-autumn statement announcement by going on PR visits with the Prime Minister and the Secretary of State, which is unusual for someone in your role and has caused some surprise. Will you be commenting on the other parties' plans for extra funding?

Simon Stevens: Whoever forms the next Government, I will be pleased to welcome investment that is made in the national health service by the next Government in line with the outlook we have asked for in the Forward View.

Q527 Barbara Keeley: That was not the question. The question is that you are commenting now, not with a new Government.

Simon Stevens: Absolutely. Whoever is the current Government, when they step forward with the kind of investment we talked about in the Forward View, it will be broadly welcomed across the health service.

Q528 Barbara Keeley: But this is a plan. You have not commented on other parties' plans. There is the time to care fund.

Simon Stevens: I do not think that anybody would expect me to comment on commitments other than actions taken by the Government of the day, whoever that may be.

Barbara Keeley: For the people I have talked to, I do not think that that extends to going on PR visits on this. It is worth saying to you that that caused a lot of surprise. I will leave it there.

Q529 Andrew Percy: Of course, it is not plans you are commenting on—you are commenting on actual money and firm proposals.

Simon Stevens: Precisely.

Q530 Andrew Percy: There is a significant difference. For clarity and for our records, can I check that the increase annually in the baseline budget for NHS England is £1.7 billion, which carries over every year hence?

Richard Douglas: There would have been a small increase anyway, but, yes, it builds into the NHS England baseline.

Q531 Andrew Percy: The £1.7 billion—

Richard Douglas: Anything that we add builds into that baseline—

Q532 Andrew Percy: So that is on a recurring basis.

Richard Douglas: That full amount is built into the NHS England baseline.

Andrew Percy: It is important to clarify that.

Q533 Barbara Keeley: Just to clarify, you have a commitment from the Treasury that the £1 billion carries on. The question that was put last week is that it is shown to run out after one year.

Richard Douglas: No. We are in agreement that that is built into our baseline.

Chair: That is clear on the record.

Barbara Keeley: We need to get that in writing, because that was not clarified last week. We may have to write to the Treasury.

Q534 Valerie Vaz: I want to follow up on the £700 million. I am slightly concerned that you do not know where it has come from. Presumably it is committed expenditure, so you must have identified it from somewhere.

Richard Douglas: No, it is not committed expenditure. There is—

Q535 Valerie Vaz: You have made an announcement, so it is committed expenditure.

Richard Douglas: I am sorry. We have absolutely committed the £700 million, but within a budget of a very large number—in excess of £100 billion—you work continually on refining the assumptions that you are going to make about future spending, whether it is the contingencies or budgets that are coming to a halt.

There are things I know about. We have a surplus land fund at the moment that has been pump-priming and releasing surplus land for new housing. I know that that is coming to an end this year. There are some adjustments in the funding between us and the Treasury about student loans that do not affect the loans themselves but involve a change in balance between us and the Treasury; I know that that is coming to an end. There are a number of things like that that are coming to an end. Then there is a judgment about the level of contingency we need to maintain.

Q536 Valerie Vaz: Are there any staff cuts?

Richard Douglas: There is nothing in there that plans for a staff cut. Clearly, as we reduce the administration costs in the system, we reduce staffing numbers in the system.

Q537 Valerie Vaz: So that is a yes.

Richard Douglas: There are continuing plans that do that. You cannot reduce the administration costs of systems without some reduction in the number of people, because most of the money is spent on people.

Q538 Mr Sharma: Can I ask a supplementary on that? You said that there will be surplus land. Have you identified the land in certain areas? You must have.

Richard Douglas: Yes. The money that we have spent with the surplus land fund this year has been to incentivise trusts to release land that is then used for housing. We have done that—

Q539 Mr Sharma: Have you identified that land somewhere?

Richard Douglas: We have identified the land and—

Q540 Mr Sharma: Can you announce, let us say, in Ealing, “That plot is ours”?

Richard Douglas: With every bit of land that we have identified for this and that will be generated from this fund, we will get to a point where contracts are exchanged before the end of this financial year. All of the individual pockets of land are in the public domain. There are numbers of them all over the country.

Q541 Mr Sharma: But you must be identifying those. Can’t you announce it?

Richard Douglas: Yes. Each individual one is announced as it goes along. These are pockets of land all over the country. All of this will be in the public domain.

Q542 Mr Sharma: It will be public knowledge.

Richard Douglas: If we are going to exchange contracts before the end of this financial year, which we will on all of these, that will be in the public domain through trust board minutes and other documents like that.

Q543 Andrew Percy: Valerie raised an important point about jobs. Will the £1.7 billion create more jobs, in terms of more clinicians—more doctors and nurses? Do we have any idea on that?

Mr Hunt: Yes. We do not believe in targets for a number of new posts, because then people would measure themselves by an input, not an output, and the output has to be

improved care for patients. However, the kind of funding we have talked about potentially could fund up to 30,000 additional posts in the NHS next year.

Q544 Valerie Vaz: It is specifically losing the jobs to pay for the £700 million. There are always going to be more doctors coming through the system, aren't there?

Mr Hunt: Could I correct that?

Valerie Vaz: Yes, do.

Mr Hunt: The £1.7 billion includes £1 billion of extra funding. The 30,000 is based on additional funding coming from the Treasury and the £700 million of economies and efficiencies, but the net is an increase in jobs—a very significant increase in the number of people employed in the NHS.

Q545 Valerie Vaz: Good. That leads me quite nicely to the next question. Which one of you two went to the Treasury to ask for the money?

Mr Hunt: We both did.

Q546 Valerie Vaz: Was that separately or together?

Simon Stevens: Both separately and together.

Q547 Valerie Vaz: How many times did you go to the Treasury? How many times did you see the Chancellor?

Simon Stevens: Three.

Q548 Valerie Vaz: Was that separately?

Simon Stevens: Twice together and once separately, I believe.

Q549 Valerie Vaz: Secretary of State?

Mr Hunt: I think that I saw the Chancellor five or six times.

Q550 Valerie Vaz: Was that before or after Simon Stevens?

Mr Hunt: My last two times were together. I saw him three times prior to that.

Q551 Valerie Vaz: Did you talk about the same things or different things?

Simon Stevens: I do not know what Jeremy talked about, but I talked about the need for extra investment in the national health service. That is obviously the result of the conversation.

Q552 Valerie Vaz: That is slightly unusual, isn't? It is usually the Secretary of State—

Simon Stevens: The Secretary of State did. He just said that.

Q553 Valerie Vaz: Yes, but after you.

Simon Stevens: No—before me as well.

Q554 Valerie Vaz: Hang on a second. We do not get a chance to question you in the House of Commons about the fact that you are having these meetings about extra money, do we, but we do the Secretary of State, don't we?

Simon Stevens: We are here in Parliament today and you are questioning me on this very topic. I would have thought that that answers the question.

Q555 Valerie Vaz: I am, but there are other colleagues not on the Select Committee who might want to raise some questions about certain things.

Simon Stevens: The Secretary of State gave a statement the day after.

Q556 Valerie Vaz: Very often he says, "It is up to NHS England," "It is an operational matter," or, "It is another matter," so we do not always get the answers that we want. Can I turn to exactly where that money is going to? In your statement, Secretary of State, you said that it is contingent on trusts behaving themselves, making efficiencies and making it sustainable. Simon Stevens said that it is going to be allocated from the general fund.

Mr Hunt: Let me answer that; I will then let Simon come in. We are both saying exactly the same thing, which is that of the extra £1.7 billion—just so there is absolutely no confusion over the numbers—£200 million is a transformation fund, which will invest in new models of care in line with the NHS England Forward View. The rest of it—£1.5 billion—is to deal with current pressures.

We do not want trusts simply to take that money and for it to be business as usual. We expect in return for that extra commitment from the Government that they will make good progress towards our long-term goal of making the NHS more efficient and safer for patients. There is a goal everyone has signed up to that the NHS should be paperless by 2018. To give you an idea of why that matters, it means, for example, that we can avoid what happens in some trusts now, where in the A and E department a nurse will tell you that two thirds of the time in the afternoon is spent filling out forms when they are trying to admit patients, instead of spending time with patients. Having good computer systems

in place frees up doctors' and nurses' time to care for patients. The one condition attached to this, which is something Simon will announce more on before Christmas, I believe, is that trusts should be making good progress towards their plans for a paperless NHS by 2018.

Q557 Valerie Vaz: So no one is going to input on to the computer. Who is going to do that? Will you get admin staff to do that or will the nurses have to do it anyway?

Mr Hunt: The issue is not that no one has to input on to a computer but, rather, only inputting once. At the moment you might find a trust that has 14 different IT systems, so people get input on to one system when they arrive in A and E, on to another system when they have a blood test, on to another system when they are admitted to the hospital and so on. That is the waste that we are trying to avoid.

Q558 Valerie Vaz: That is an inefficient trust, isn't it? There are many places that do the job quite well.

Mr Hunt: That is precisely what we want to sort out.

Q559 Valerie Vaz: How is that money going to be allocated? You are saying that it is for a paperless organisation. Mr Stevens, where do you think the money will go?

Simon Stevens: One of the conditions that we have set over the next several years is that, as part of their move towards improving the patient experience, making life less frustrating for staff and saving some money on the administrative costs of the NHS, people do indeed make these kinds of investments in moving towards a paperless NHS.

In terms of how the extra cash that is available to NHS England for next year will be used, as Jeremy has said, £1.5 billion of that will be allocated through a combination of allocations to CCGs, allocations for primary care and allocations for specialised services in the usual way, subject to decisions to be taken at the NHS England board meeting on 17 December. That will all be publicly transparent. Then there is the £200 million for the transformation fund and the £250 million for GP premises. Our aim will be to allocate that before the end of March, ahead of the start of the financial year.

Q560 Valerie Vaz: Could you expand a bit on the allocations? You said that they were for CCGs and primary care. Are you expecting each CCG to come up with some sort of plan for how they will use the money?

Simon Stevens: No.

Q561 Valerie Vaz: Are you just going to give it to the CCGs?

Simon Stevens: With the condition that Jeremy talked about, we will put the bulk of it out through the previously consulted-on and publicly transparent fair shares formula. In doing so, subject to the decisions that are taken by the board on 17 December, we will seek to

move those CCGs that are furthest from their fair shares and to give them more catch-up through this extra cash.

Q562 Valerie Vaz: Is that based on a distressed area—the distressed economy—or will you look at health inequalities?

Simon Stevens: No. We are going to use the CCG fair shares formula, subject to the decisions taken on 17 December at the board.

Chair: Charlotte has to leave, so we will let her come in at this point.

Q563 Charlotte Leslie: Thank you very much. One of the key themes of recent months and years has been transparency and how that will affect savings. With the increasing number of private providers in the system, how are you planning to ensure that the same transparency that applies to public sector providers applies to private sector providers? Is there any way that an FOI system can be constructed so that it feels like there is some kind of parity between the two sides?

Mr Hunt: Yes, we absolutely intend transparency to apply on an equal basis to the private and public sectors. It is not really about the public-private thing; it is about creating a structure where you allow innovation to happen in different parts of the country and you are able to be relaxed about innovation happening because you are measuring outcomes that are transparent. If a CCG in Lincolnshire decides to do something differently from one in Nottinghamshire, for example, on the provision of mental health services, we are happy for that to happen, but we are measuring and publishing what the outcomes are for people with mental health conditions. If you look on the My NHS website, which is a big step forward in that transparency agenda, the intention is to collect data on a totally equal basis between the public and private sector suppliers to the NHS. In most cases, we already do so. If we do not, we are in the process of collecting those data.

Q564 Charlotte Leslie: In an ideal world, that is great. The only things that you have to measure are what the provider is doing and what the results are. In the public sector, as many people here will know, I have not always been happy that value for money has been met and that things have been done in the way in which they should have been. Most of the time—not always—I have been able to get answers through FOI, but with a private provider I would not have been able to ask those questions, to check that appointments were being made satisfactorily, for example, or that the functionings of the provider itself were happening in a way that would meet public standards. We will need to be able to do that. Will you be working on some kind of FOI system so that, if we do have questions over how private providers are conducting themselves and operating within the public sphere, someone like me can ask the same, possibly difficult, questions that I have been able to ask of the public sector?

Mr Hunt: The transparency metrics allow us to compare the performance between providers. Take, for example, Hinchingbrooke hospital. It supplies the same data about its performance as every other publicly run hospital in the NHS. It is really important that it does that. It does exactly the same as Peterborough next door, Addenbrooke's or whatever,

so you are able to see its performance. The point about transparency is that you are able to compare performance. If the NHS is paying for services, we expect the same transparency from the private as we would get from the public sector.

Una O'Brien: I would add that the CQC's regime applies to all providers, whether public or private. As it undertakes its surveillance and inspection, those data are made publicly available. Simon may also wish to comment, because we have a contracting mechanism between commissioners and providers. In my experience, commissioners want to hold providers to account for their performance, so at a local level you do get information about what is happening in terms of that provision. Certainly we could do more to get the data available on the My NHS website so that they are easily accessible. However, I would not want to leave you with the impression that there is not information about the private sector, because there is.

Q565 Charlotte Leslie: One thing that has been very difficult—I remember doing this with the ISTCs when they came in—is that when you ask questions about parity of performance, you are told, “That is commercially confidential.” It was amazing how widely commercial confidentiality suddenly extended—to things that really did not seem very commercially sensitive at all.

Mr Hunt: That is not acceptable. It is not acceptable inside the traditional NHS sector either. A big Rubicon that we have been crossing, particularly in the last three months, is over very hotly debated areas of transparency such as surgery outcome data and GP performance data. The truth is that we are sitting on a huge amount of data. They are not always of the highest quality. The first thing that happens when you start to publish data is that you realise why the data are not as good as you want them to be. Then you start asking questions about how you could collect data that are better. Perhaps this relates to some of the other things you have campaigned on, but this is a very important cultural change. The more we are transparent about data, the less we need to rely on targets as a way of improving performance. That is a really important cultural change.

Q566 Andrew George: Charlotte asked a very direct question about the private providers being subject to FOI if they are providing a public service. Your answer to that question is, “No, they will still be able to avoid an FOI request in the same way as a public provider can be FOIable.”

Mr Hunt: I will ask the permanent secretary to comment on the legal situation. My understanding is that it would depend what the FOI request was on, because FOI requests are very specific to individual institutions. The policy answer that I want to give is that if you are talking about data that allow proper comparison of performance between providers—

Q567 Chair: But they do not—

Mr Hunt: In that case, the private and public sectors need to be treated on an identical basis.

Charlotte Leslie: I have a couple more questions before I move on, but I know Grahame has a question.

Q568 Grahame M. Morris: I am very interested in your answer, Secretary of State. I completely agree with the points that Charlotte and Andrew have made about transparency, which you have echoed in your response, but there is an easy solution. I have a private Member's Bill that is going through Parliament and is supported on an all-party basis by some members of this Committee; in fact, I believe that the Prime Minister supported it in opposition. Why don't the Government throw their weight behind it, put their rhetoric into action and make private health care companies subject to FOI requests?

Una O'Brien: Essentially, the freedom of information legislation rests with the Ministry of Justice, so it is not within our gift in the Department of Health. There are a number of issues about private sector providers in other arenas where the same matter has been raised; it comes up quite frequently on the Public Accounts Committee. I know that the freedom of information legislation is kept under review by Ministers and officials in the Ministry of Justice. On a policy point, to reinforce what the Secretary of State has said, we are very determined to make visible as much information as possible about performance of any care that is paid for by the NHS pound. The CQC regime has made significant progress in that respect. There is more that we can do.

Q569 Charlotte Leslie: I have two very quick points to touch on before, I am afraid, I have to leave early for another ministerial visit. To touch on some concerns that have been in the public arena before, there has been a concern that quite lucrative consultancy contracts have gone to people who have only just left the employment of the NHS. Can you say whether that revolving door has been slowed or stopped and whether all of those contracts have been properly tendered and competed for? I know that people are concerned about that idea.

Una O'Brien: I take your question as referring to people who have been made redundant and are then re-employed on an interim basis a very short time after they have received redundancy payments. We are clamping down on that. We are extending the period of time in which people cannot get work back in the NHS and are definitely making progress, because we have absolutely heard the concerns that have been raised about that. All proper management consultancy contracts have to be properly tendered and go through a procurement process.

Simon Stevens: May I add to Una's point on re-employment? We are using the NHS standard contract—the 2015-16 contract—which will take effect from April, to prevent an NHS manager or senior manager who has been made redundant from being rehired and paid for by the NHS at the same time as they are getting their redundancy payment for at least a year after they have left. The NHS standard contract will require that people repay their redundancy if they take up a new job. This is the first time we will have been able to do that. We will be consulting on that proposal in the next week or so. It will take effect from 1 April.

Richard Douglas: I will add a further layer to this. Any management consultancy over a very small amount for any organisation that is an arm's length body of the Department of

Health or the Department itself has to come to me for personal approval on a weekly basis. A key question in that is, “Has this person previously worked for us, when did they work for us and in what circumstances did they leave?”

Mr Hunt: Can I say, as a former management consultant, that there are some good ones as well?

Q570 Charlotte Leslie: Finally, a key thing in any organisation for value for money and saving money is valuing employees who raise concerns where they see value-for-money issues or problems in a system. Do you—or how do you—reward employees, non-executive directors or others who come up with difficult truths about gaining value for money?

Mr Hunt: This is an incredibly important issue. It is actually about how easy people find it to raise concerns in general. In too many parts of the NHS, people feel very intimidated about raising any kind of concern that they think might challenge their bosses. If they are a trainee doctor, they think that their future may depend on what consultants think of them, so they are very nervous about doing that.

My particular concern on this issue has been people who want to raise safety concerns. Following the Francis inquiry, that is something where there is unfinished business. That is why we asked Robert Francis to do his follow-up review, on which he will report very shortly. The challenge I asked him to think about was how we make the NHS as open and transparent as the airline industry when it comes to people raising concerns. The airline industry has reduced its accident rate very dramatically by making it easier for pilots to speak out about concerns. It is a very important piece of work that I want to make sure is completed before the election, to hear what Sir Robert Francis has to say and then put that in place.

In the end, this is all part of a culture change, where we start to think of the main driver of improved performance in the NHS as open and transparent information, so that you know how well you are doing against your peers. We need to tap into the natural desire to do a better job for patients that every doctor, nurse and front-line worker has, rather than make people feel that if they speak out about ways to improve things for patients it may cost them their job.

Q571 Charlotte Leslie: That would apply to people who might look at systems and say, “I am not sure we are getting good value for money through this.”

Mr Hunt: Absolutely.

Q572 Charlotte Leslie: Are you saying that, if they begin to challenge the system and the regime, they will not be smeared or booted out but rewarded?

Mr Hunt: One thing Robert Francis is specifically looking at is the issue of someone who ends up leaving their job, does not agree with the reasons that they were given for that and then finds that they are unable to get employment elsewhere in the NHS.

Q573 Charlotte Leslie: So you would expect someone like that to get a good reference from any NHS—

Mr Hunt: I do not want to pre-empt what Robert Francis will recommend to deal with the issue, but that is squarely what he is thinking about, to avoid that sense of the system closing ranks against someone who is “troublesome”.

Q574 Charlotte Leslie: That is the kind of behaviour that you would want from the NHS, the Department of Health and everything that you oversee.

Mr Hunt: Absolutely. It is the behaviour that we want everywhere. It is one of the big things. All of the evidence shows that that is the only way we will deal with the fact that we have around 1,000 avoidable deaths every month in the NHS.

Q575 Barbara Keeley: In addition to that revolving door, Secretary of State, in April this year I asked you a question about somebody who left the NHS—one of the 10 highest earners—who was then paid for a two-year secondment when she was not returning to the NHS. The bad practices were not just the revolving door that my colleague has raised but the fact that someone who left was then paid their salary for two further years, even though she was not coming back, at a cost to the NHS of £300,000. Is that sort of practice going to stop as well?

Mr Hunt: I do not know the specific details of that case.

Q576 Barbara Keeley: I laid out all of the details when I put the question earlier.

Mr Hunt: As you have described it, the answer is that that is completely unacceptable and we want it to stop.

Q577 Barbara Keeley: And you will make sure that it does stop.

Mr Hunt: The measures that the permanent secretary has just outlined are precisely designed to stop that kind of thing.

Q578 Barbara Keeley: Can the permanent secretary or anybody else say how that would be stopped now? There is the revolving door; we have heard how that works. I do not know how anybody ever sanctioned—it was only earlier this year—somebody to leave, not be coming back to the NHS and then be paid two further years of salary to do a secondment.

Simon Stevens: This particular case predates my arrival. I understand that the situation is that doing so was deemed to be cheaper than the redundancy pay to which that individual would otherwise have been entitled. Her post was not filled, so it was a redundancy situation. There is a legitimate question as to whether the redundancy entitlements in the NHS for senior managers are right—in some respects they are probably not—but, given the particular contractual entitlements that that individual had, as I understand it, the best way of saving taxpayers’ money on that occasion was apparently not to trigger the redundancy but instead to do what you have described.

Q579 Barbara Keeley: But do you understand that in the austerity that we have had—

Simon Stevens: I do completely, which is why I do not think that it is right. We should cap the maximum redundancy period that senior managers have.

Q580 Barbara Keeley: I am sorry—let me finish. The impact on staff who are not being paid 1% of seeing a six-figure amount like that—£300,000—being paid to one of the 10 highest earners—

Simon Stevens: I agree.

Q581 Barbara Keeley: It just looks like a smack in the face, doesn't?

Simon Stevens: I agree.

Q582 Valerie Vaz: I want to pick up on something you said, Secretary of State. We all want a safe NHS. Could you tell the Committee whether the negligence payments are going up or down now? You can write to us if you do not have the figure now.

Mr Hunt: I do not have the figure off the top of my head. I know that the payment bill is £1.3 billion a year at the moment. Is that right?

Richard Douglas: Yes. They are going up.

Mr Hunt: They are going up. The finance director has just told us that, so it must be right.

Q583 Valerie Vaz: Even though he does not know where the £700 million is coming from. That was just a joke.

Mr Hunt: I am glad that we are in such good form.

Valerie Vaz: Always, Secretary of State.

Mr Hunt: We can trade jokes, if you like, this afternoon. There is an issue, which is quite a difficult issue to deal with, as we move to a more transparent NHS. You may see in the short term an increase in litigation payments as we become more honest about things that have gone wrong. One of the big challenges that we have is where someone is told that a death was unavoidable when, in fact, it was avoidable. We need to create a culture where it is easy for people on the front line to talk about that, because then we learn from the mistakes, change things and make sure that it does not happen again. An increase is possible as you move to that more transparent culture.

There is also evidence that, because of the faith people have in the NHS and the public's commitment to it, when people are told the truth they do not seek financial damage nearly as often as you think; they just want to know that lessons have been learned. It is not necessarily right to look at the trend in litigation payments. There is evidence of this if you

look at one of the safest hospitals in the world—Virginia Mason in Seattle. It has seen a dramatic fall of 75%, I think, in its number of litigation claims as it has seen dramatic increases in the number of patient-reported safety incidents. As it has made it easier for staff to speak out, it has seen a reduction in the harm done to patients and the claims made against the hospital.

Q584 Valerie Vaz: Are you doing anything to address it in the short term, though?

Una O'Brien: Yes, a lot.

Richard Douglas: We try to address it at at least three or four levels. The first thing to be clear on is that the cost of the claims we are meeting today is generally the result of incidents four or five years ago, so there is quite a big time lag on this. The vast majority, in value, of clinical negligence costs tend to come from damage at birth.

There is a series of things to do. First, you want to try to reduce the incidence of damage in the system, so the whole approach to patient safety and the work that we do on that are focused on trying to reduce the incidence of damage.

Secondly, for damage—particularly for potentially smaller damage—you want to reduce the propensity for that to turn into litigation, which is the thing the Secretary of State is talking about.

The third area, which is one of the trickier areas to address, is that some of this has been driven by changes in the legal market. You see that quite a bit of this shift has come from a different approach. As other avenues become more difficult, the legal market around clinical negligence claims has become relatively more attractive, so there is something about how you deal with the legal costs on this.

We will try to deal with incidence and the propensity to claim as a result of injury, and we need to address the legal costs issue. Some of the legal costs, particularly on small-value claims, are incredibly high. The claimant costs that we are paying in a number of cases are way above the amount of money that the claimant ever sees themselves. Those are things we need to work on across Government with the Ministry of Justice.

Q585 Valerie Vaz: We are all incredibly grateful for this extra money, but a lot of commentators have said that it is non-recurring money that keeps recurring every year. In A and E there seems to be a big problem with recruitment and retention of doctors. I know that many of them are going off to Australia because they have a better life. Is part of this money going towards recruiting and retaining some of our wonderful doctors and staff?

Mr Hunt: We are on track, by the time we get into December and January, to have about 1,000 more A and E doctors in our A and E departments than we had four years ago, so net numbers of A and E doctors are going up. That does not mean that there are not vacancies—there are absolutely—although we have made good progress in working with the College of Emergency Medicine to look at the A and E contract to try to make sure that we reflect the antisocial hours that A and E doctors have to work and the particular pressures they work under.

This year we are putting £700 million into the NHS to help with winter pressures. The additional money does not include making an assumption that we will make a saving in that money, although it is one-off money that we are using to help with winter this year. We are having a discussion with NHS England about whether this is the best way of helping the NHS to cope with winter pressures. That discussion will continue. It is about whether there is a longer-term structure we should think about to help people to cope with winter pressures.

Valerie Vaz: I want to clarify something. It was really—

Chair: We are straying wildly. Are you going to continue with the line of questioning on CCGs?

Valerie Vaz: I am. I let my colleague Charlotte Leslie stray slightly, too.

Chair: I know, but we have a very large number of questions to get through. Are you going to return to the—

Q586 Valerie Vaz: I will. The question that I was going to ask was to clarify something in relation to the supplementary evidence that came in from the King's Fund, the Nuffield Trust and the Health Foundation. Mr Stevens, you said on radio and told the Committee that you thought that the vast majority of providers would be NHS providers. You gave us a figure of 94p in every pound—94%—yet in its supplementary evidence the King's Fund mentioned something like over £10 billion, which is effectively 11%, with non-NHS providers. Could you explain that discrepancy or clarify those two different—

Simon Stevens: Yes, very easily. As I said, about 6p in the pound is being spent with private providers—independent sector providers. About another 3p—this explains the difference with the King's Fund or the Nuffield Trust numbers—relates to payments to local authorities, charities and the voluntary sector. If you look at the accounts in total, on an expenditure base of £106.495 billion, £6.131 billion plus £413 million represented the private spending, another £510 million was to the voluntary sector, including hospices and the like, and £2.473 billion was to others, including local authorities.

Q587 Valerie Vaz: Yes. They have taken your figures. They have said that these are the figures that you have given them. Are you saying that your figures are wrong?

Simon Stevens: No. I have just given you the precise figures that demonstrate why 6p in the pound, which was my figure, is right.

Valerie Vaz: Thank you.

Q588 Chair: There is a wider point. I asked the King's Fund and the Nuffield Trust for a follow-up on this issue because, in fact, GPs are independent contractors to the NHS. They provided us with a figure of £10.2 billion that goes into general practice. In addition to that, dentistry, community pharmacy and general ophthalmic services are provided largely by private partnerships, professionals or private companies. That was a further £5.7 billion. They

estimate that, broadly, we should look at it being about £25 billion, or just over a fifth, of the total NHS budget. Do you think we should bring that into the total?

Simon Stevens: That is a philosophical point. A lot of GPs would claim that they are the foundation of the NHS, rather than some kind of private adjunct. However, if you want to classify them in that way, of course that is what the maths shows you, but that is not the basis on which I used the figure of 6p in the pound or on which most people would generally understand what we are talking about.

Q589 Chair: However, it is interesting, because GPs do take a profit from the NHS in varying degrees. In other words, do you think that there is now a case for saying that we should have much more transparency about the profit share that different practices have, so that we can be clear about where—I am sure in a small minority of cases—there may be some prioritisation of profit share over employing another member of staff? Do you think that that is something we now need to do for all private—

Simon Stevens: Under the terms of the GP contract for next year—2015-16—we will be publishing the earnings for general practice at practice level. That will give us a line of sight that we have not previously had.

Q590 Chair: Do you mean earnings as in take-home pay—as in the profit share from practices? It is very difficult, because sometimes the public have top-line figures for how much GPs earn and assume that that is all going in take-home pay. In fact, a lot of it is going towards premises and staff, so it can give a misleading impression of what salaries are. Do you think that it is time for us to be clear about how that is distributed or not?

Simon Stevens: Yes. Greater transparency would be beneficial. That is a principle that has been agreed with GPs' representatives for next year. We will be working with them as to the precise way of showing that.

Q591 Robert Jenrick: May I ask a quick follow-up question on the percentage of non-NHS providers? The pence in the pound today is obviously significant to members of the public, but the direction of travel is really what the current debate is about. We asked a number of the contributors in previous hearings where they thought those figures might stand in years to come, because there has been a degree of misinformation about that direction of travel. Would you be able to give your views on where those figures might be, were we sitting here in five years' time?

Simon Stevens: Yes; I have done so in the past. As I have said previously, my confident prediction is that the vast majority of NHS-funded care will continue to be delivered by NHS providers, but at the margin it will be patients themselves who make that choice. A relatively small number of operations—for example, about 450,000 non-emergency episodes—are being conducted in non-NHS providers at the moment. About half of those—I think the number is 53%—are for hips, knees, cataracts and gastrointestinal operations, based on the choices that individual patients make. I do not think that anybody wants to take that choice off people, but it is going to be at the margin.

Q592 Robert Jenrick: So you do not anticipate any material change in the immediate future.

Simon Stevens: It depends on your definition of materiality, but I do not see anything that is likely to give rise to that.

Q593 Robert Jenrick: Could I ask a second question? In fairness, the other question we also asked previous contributors was about charging in the NHS. Again, there has been a degree of misinformation about this, as some have conflated the use of non-NHS providers with the introduction of charging—or greater charging, because there was already some charging within the NHS. Do you have any information as to whether there has been any increase in charging within the NHS? Do you foresee, to the extent you can, any material increase in charging in the immediate future?

Simon Stevens: My belief is that one of the defining principles of the national health service is that care should be provided on the basis of need, not ability to pay. That has stood the NHS well through thick and thin. It is the principle that the people of this country continue rightly to support. Were there to be any change in that, it would require an explicit Act of Parliament, so that would be for you, not, obviously, for NHS England.

Q594 Barbara Keeley: As a point of clarification, you have just given my colleague the answer that you do not see great growth in private provision and that the choice is with the patient. How much choice will patients in Stoke and Staffordshire have if commissioning decides that all of those services should go to prime providers who are private providers? What choice would cancer patients and end-of-life care patients have there? A very big chunk—£1.2 billion of services—are going out to tender. Large numbers of the companies on the tender list—in fact, the majority—in each case are private providers. What choice would a patient have there?

Simon Stevens: Cancer patients should have more choices about a range of elements of how their care is provided—including, by the way, choice about where their palliative care is provided. We know that often people want support at home and at the moment end up in hospital. As I understand it, across Staffordshire there are real concerns about the variability that exists in the outcomes of cancer care, the proportion of patients who are getting a diagnosis early and differential spending. I suspect that, first and foremost, patients will benefit from an improvement in the quality of cancer care, however that is achieved. How that is achieved is principally a matter, of course, for the CCGs locally to determine, subject to the overall constraint and principle that care must be provided according to ability to benefit and that the constitutional standards in the NHS must continue to be met.

Q595 Barbara Keeley: Following on from your point, it could be that they do not have the choice you have just spoken about between NHS and private providers. If the prime provider directs and channels them to private providers, they will not have the choice that you have just said is important. That is a very big chunk of NHS funding, which would change the balance between private and NHS providers.

Simon Stevens: Obviously there are some services where it is easier for patients to exercise choice and others, such as emergency services, where it is not. Then there are urgent care services that fall somewhere in between.

Barbara Keeley: I am seeking clarification on the answer that you gave. I think that that example changes what is happening.

Chair: We now need to move on to Virendra's question.

Q596 Mr Sharma: My question is on the deficit. At the year end, it is estimated that the FT sector will have a deficit of nearly £271 million. At present, 60 trusts are in deficit, amounting to £531 million, but that will be offset by a £260 million surplus at 87 other trusts. The sector as a whole has been in deficit for the last two quarters, when it has always been in surplus. The question is, will trusts be able to use the additional funding we have been told about to reduce the deficit? If not, how do you expect trusts to get back into financial balance?

Mr Hunt: Let me answer that first, if I may, and then pass on to Richard Douglas for some more details. The first point is to understand why we have a growing number of trusts in deficit in the NHS. That is a combination of the pressure to do additional activity—the ageing population and more people turning up at the hospital door wanting emergency care—and the fact that hospitals are now very focused on delivering high-quality care, following the Francis review into what happened in Mid Staffs, and making sure that they deliver care to the standards that we would all want. That means that the process of dealing with a deficit takes longer than it did before, but for the right reasons.

It is important also to have some perspective. It is still, as a proportion of the total NHS spend, a quarter of the level that it was in 2005-06, which was the last time there was a big NHS deficit issue. It is also important to say that this has been planned in our numbers. We have made an allowance of £400 million in our budgeting for end-of-year deficits. The net deficit has increased more because trusts with surpluses have seen the level of those surpluses come down than because trusts with deficits have seen the size of those deficits increase.

That said, it is very important that all trusts achieve financial balance. It is, pure and simple, part of what management is about—delivering high-quality service within the budget that you have. We expect people to take measures that are appropriate and to do the right thing by patients, because in the end every pound spent on deficit is a pound that we cannot spend on front-line care. Richard, do you want to add to that?

Richard Douglas: I will follow through on a couple of things. First, the figures that you quoted were purely for the foundation trust sector.

Mr Sharma: Yes.

Richard Douglas: As the Secretary of State said, at the start of this year we planned that, in total, there would be about a £400 million net deficit across the foundation trusts and the NHS trusts. That was a balance-of-risk decision that we made about how quickly people could get out of deficit when at the same time we wanted them to maintain and

improve the quality of care. During the year, we have seen that that deficit has increased. About half of that has been a reduction in surpluses overall.

We all want to get to the position where all of these bodies' finances are sustainable and in financial balance overall. I do not think that next year we will be in a position where each and every one is. There are quite significant structural issues with some organisations that will take more time to deliver. However, as a result of the funding next year, we should see that overall deficit go down. For those organisations that are potentially in quite small deficit at the moment, we would expect to see those go. We expect that the NHS overall will be in financial balance.

Q597 Mr Sharma: Thank you very much for the response, but the question is that there is no way this additional funding will be used to reduce the deficit directly.

Richard Douglas: Not in this financial year because the money comes next year. The figures you quoted were the numbers this year; clearly, as the income will not come in until next year, it will not affect the numbers this year. As we go into next year, there will be more income in the system than people anticipate, so, as a result of that, it will help organisations. But there is a role for the organisations themselves in this. Some of these, as I say, are big structural issues. With others, there are areas where people can and should be making savings. At the same time as we are giving people time to get out of deficit, and while they are in deficit we give them cash support to make sure they can carry on operating—the deficit is there in the accounts, but we are giving them the cash to finance that so that they can pay the staff and the suppliers, and pay for their activity—we do that with conditions. We do it with conditions about where we expect them to make savings and how long we expect them to be before they turn the organisation round.

Q598 Andrew George: On that issue—and certainly I asked the Secretary of State this last week at the time of the statement—there will be some areas of the country where there has been a recurring deficit, which is part of a legacy of a period when that health economy has been substantially underfunded in contrast to what the then Government were indicating they should achieve in terms of their ultimate target funding. For example, my own area, which for over a decade received more than £200 million less than the Government were recommending or said that its target should be, left the Royal Cornwall Hospitals NHS Trust with a deficit that was significantly below that figure but, nevertheless, challenged. That is creating very distorting circumstances even now, some eight years after the initial problem. Does it not make sense in those circumstances for the Department to allow those trusts to start with a clean slate and to move forward? It is distorting the way in which they are planning their services and it is not necessarily helping them to achieve the efficiencies and the improvements in services that they require.

Richard Douglas: I will start off and then bring Simon in. The clean slate is difficult because the deficit number we quote is the annual number. This is not a legacy from previous years—it is income this year less expenditure from this year. But, as Simon said earlier, as he looks at the distribution of the money to CCGs, he would expect the NHS board to be focusing on moving areas to target allocations.

Simon Stevens: I agree.

Q599 Andrew George: Even in those health economies where the Government acknowledge that that health economy has been significantly underfunded and it has been a contributing factor to a deficit that exists within that health economy—and they have been at least achieving year-on-year balance—they are still left with the legacy of the debt that needs to be paid off. How are they going to retrieve the situation? There are many others like them.

Simon Stevens: One is naturally sympathetic towards the situation you describe, but the reality, of course, is that Parliament votes the NHS a certain sum of money each year, and in any given year some areas are going to be below their target share and others are going to be above. Those that are above spend their allocations. It is not as if that is sitting in a bank account somewhere to be used subsequently to pay off deficits that have been run up in those areas that were deemed to have been under. The principle has to be that Parliament expects the NHS and the entities within the NHS to live within the resources that are allocated each year. To the extent that that does not happen, in effect one part of the country is taking money from another part of the country in a way that has the potential to be itself unfair. If there were a magic wand, we would love to wave it, but, sadly, there is not.

Q600 Andrew George: You have no flexibility, so the answer that I can take back to Cornwall is, “It’s tough.”

Simon Stevens: The answer you can take back to Cornwall is that, as Richard said, we will look to ensure that as much as possible of the extra resources that have been allocated to the front line of the NHS are allocated according to the fair shares formula, but that in itself will not be a solution to all of the inevitable trade-offs that you describe.

Q601 Andrew George: Okay; I will take that message back—that it’s tough for them, and it will be.

May I change the subject, therefore, to issues of the balance of commissioning between NHS England and that of CCGs? Obviously, we do not expect that to be preserved in aspic for years, and NHS England, with the Department, will no doubt be looking at prescribed specialised services, whether they are better commissioned by NHS England or devolved to CCGs. Taking kidney dialysis as an example, you have opened a consultation at the beginning of this month for a six-week period—over the Christmas period, indeed—proposing that the kidney dialysis side of the renal services should be commissioned by CCGs going forward, potentially fragmenting it from the transplant services. I want to properly understand what the rationale was behind that. Was it because of clinical standards, was it financially driven or for some other reason?

Simon Stevens: If you take a step back and think about the context for this, quite rightly, when CCGs were established in 2013-14 they had a lot on their plate and, therefore, in order to give them the best possible start, some of these services that would previously have been commissioned locally were, for a period of time, the responsibility of NHS England. What we are seeking to do is have the best of both worlds—the level of local knowledge and insight that GPs and CCGs can bring to bear, together with some of the expertise at scale that comes from being able to commission on a broader basis. So for

quite a lot of the specialised commissioning budget, from next year we are sharing that responsibility with CCGs through so-called specialised services co-commissioning, which will then enable investment to be made locally, where appropriate, so as to avoid patients having to travel further afield, where that would make sense; and that shows up in mental health services, for example.

In a small number of cases, independent medical experts and patients groups, through the Prescribed Specialised Services Advisory Group, have made a recommendation to Ministers that it would be appropriate for the responsibilities to transfer more locally, and, as you just described, that is now being consulted on until 9 January, I think it is. Obviously, we will wait to see what the response to that is before decisions are taken, but the principle here is, given that many tens of thousands of people are getting dialysis locally, is it right to think that somebody sitting in a national office somewhere can figure out what is the best way of arranging dialysis in Truro in just the same way as they are doing in Carlisle? The answer probably is that it would be better if people in Truro or Redruth had more engagement with those kinds of decisions. That is what is being suggested as far as this particular matter is concerned.

Q602 Andrew George: If the CCG in Truro were to commission for, let us say, 250 patients for dialysis in any year, and 260 turn up, what happens in those circumstances?

Simon Stevens: We obviously want clear national standards for any of these services, so part of the consultation is making sure that there are appropriate safeguards in place. But what we are really trying to do here is have our cake and eat it—get the benefit of consistency, while also having the benefit of local flexibility.

Q603 Andrew George: You are saying that this was patient groups. Certainly, the British Kidney Patients Association do not seem to be terribly enamoured with this proposal, but you are saying that patients—

Simon Stevens: The Prescribed Specialised Services Advisory Group has a range of representation on it—it is an independent body—and they are the ones who endorsed the proposal for public consultation, which is now taking place.

Q604 Andrew George: In relation to the potential risk of fragmentation, which I mentioned in an earlier question, when you are talking about renal specialists who are responsible for planning transplant services and so on, if you are separating the work that they are involved in managing—which will be patients who are currently receiving dialysis—is there not a potential risk? Is this something that you will also interrogate as part of the consultation?

Simon Stevens: Certainly.

Q605 Chair: Could I give my apologies that we may be changing Chair in a minute because I gather business is about to collapse in the House and I have the Adjournment debate? Please excuse me if I slip away.

Before that, could I quickly squeeze in a question about local health economies relating to CCGs, following on from Andrew's point about how the money will filter down into the system and be used? You are probably aware of Northern, Eastern and Western Devon CCG, who, as a result of their deficit of £14.5 million, have introduced some changes, including changes in restrictions on how people can access surgery if they have a body mass index over 35. They are not saying they cannot have surgery, but there will be delays if they cannot lose 5% of their BMI and so on. There are also restrictions on, for example, smokers. There will be an eight-week delay while they try smoking cessation.

The issue here is that that may be a policy that could be of benefit across the NHS if it has a good evidence base, but it is the fact that it has been linked in very directly with a funding challenge. Would you propose, with this additional funding coming down to local economies, that they would be able to ease back on that? In other words, do you think that, if financially they are more solvent next year, they should abandon these proposals, or do you think quite the converse—that we should be looking at rolling that out across the NHS—because there are implications locally? I have a patient registered within my constituency, for example, who lives near the border of NEW Devon, who could opt to change from one surgery to another. Do you think that is going to create all sorts of anomalies within the system?

Simon Stevens: I know that there are pressures facing the CCG, and, rightly, they need to respond to them in that, if they do not, then, in effect, they will be taking money from other parts of the south-west or other CCGs in a way that would be unfair. That said, we want to ensure—and they are obliged under the terms of the NHS constitution—that patients get care where they can benefit from it according to reasonable criteria; that there is proper consultation on any changes that are being made there; and that the NHS constitution provisions are in place. Frankly, we do have some reservations about the particular approach that is being proposed there. I know the CCG are reflecting on that in the light of the public consultation and response, so we will have to see what they decide, but I would be surprised if that turns out to be the principal route to getting themselves shipshape going forward.

Q606 Chair: How much independence would they have in making that final decision? Is it a decision that you, as the chief executive of NHS England, could overrule?

Simon Stevens: There are a set of obligations on them, as framed in the statute. CCGs commission two thirds of the health services with the resources that are given to them, but, in doing that, they need to demonstrate that they are properly taking account of local need and meeting the requirements of the NHS constitution. That, I know, is something that they are giving further attention to.

Q607 Chair: By saying that, do you mean to say that you do not think that gives sufficient attention to that constitution?

Simon Stevens: I think questions have been raised that the CCG will want to reflect on.

Q608 Chair: Ultimately, who has the final say, I guess, is the question here.

Simon Stevens: The CCG—the governing body—have the say, provided they have gone through a proper process and have come up with a fair decision, but, obviously, NHS England has oversight responsibilities in terms of the governance and the way in which the CCG is being run. To the extent that the CCG were to depart from the broad framework, then we would have the ability to step in.

Q609 Chair: It also applies to other procedures such as, for example, hearing aids, and only having one hearing aid rather than two, and changes to—

Simon Stevens: Absolutely. No health care system in the world has the ability to do unlimited everything that everybody might want. It has been a defining feature of the national health service since 1948 that people have had to make choices, and a lot of these choices, rightly, get made locally. Some of them get made nationally. That is why we have NICE, but NICE cannot arbitrate on every single thing that the health service might do. There will always be a combination of decisions that are made locally, nowadays by local clinicians rather than by local managers, as well as national frameworks, with external inspection through the Care Quality Commission to try and ensure greater uniformity of care, backed by much greater transparency about quality and outcomes than we have ever had before. There is not a single answer to this question, but nor has there ever been and nor is there in any other country's health care system.

Chair: Thank you very much. I am going to hand over to Robert now and leave David to Chair the meeting.

The Chair being called away, Mr David Tredinnick took the Chair in her place.

Q610 Robert Jenrick: One other question we have before we end this section is about staffing. We had a number of witnesses come to previous hearings to talk about the use of contract and agency staff within the NHS. Monitor has noted that the NHS has spent about £831 million on contract and agency staff in the first six months of this financial year, which is more than double—these figures say £377 million—that they had planned to spend. We heard from the Royal College of Nurses, the King's Fund and others about what might lie behind that. Clearly, this increase is a major concern to the NHS. I know from my own constituency the practical consequences that can have. Newark hospital spends approximately the same on doctors as Louth hospital, but because of the use of agency and locum staff they get one doctor on call in the hospital 24 hours a day while Louth gets at least two, which means that they can admit 24 hours a day while we cannot. This is not just about efficiency saving. It can have a very practical effect on the management and the service of the NHS.

What is the NHS doing to try and tackle this? We have heard that it is a reflection on the pressures, both of trusts and staff, but also it is a wider cultural issue about the way that many people in the NHS want to see their careers developing and live their lives. What can we do to tackle it in the short term but also to try and change that culture, which is at the heart of the problem here?

Mr Hunt: Let me address that first. You are absolutely right that we are spending too much on agency staff. It is important to understand the reason. The reason is because, in the wake of the Francis report and what happened at Mid Staffs, trusts rightly decided that it was a high priority to make sure that they had safe staffing on their wards as a matter of urgency, as a matter of patient safety. When you need to recruit people quickly, sometimes there is no other option other than to go to an agency. But as this is effectively a permanent increase in staff, because they are recognising that this is a big sea change—that we need to make sure we have safe staffing—then you would expect that to change over time. You would expect it to change, over time, partly because people would be investing in processes and IT systems that mean you can increase patient contact time without necessarily increasing the number of nurses, but also because, over time, you would want to recruit people on to permanent contracts, which are much cheaper and—we know—clinically safer, according to Mike Richards and the CQC.

This is something where the performance of trusts is variable. We have actually put up on My NHS how much different trusts spend on agency staff, so it is up there for everyone to see. We have got into an unhealthy position in some trusts where they have become over-dependent on agency staff. Also, we have got into a situation where there are some staff who are making a conscious decision to permanently be agency staff, where they can get a higher salary than people on permanent contracts. In the end, it is not right for the NHS to create that kind of parallel market. That is why it is a big priority to do something about this. I do not know if you want to add anything, Simon or Douglas.

Richard Douglas: Thinking in both the short and the long term, there is a volume issue there that relates to both supply and demand in the system and there is a price issue. There are things we are trying to do in the short term on both of those. We currently have Lord Carter leading the efficiency programme across the NHS. He is looking at the moment at 22 trusts in detail. One thing he will be looking at in those 22 trusts is demand for agency staff and the extent to which there are better ways of managing the work force to reduce demand. We may get something in the short term from that. There are lots of toolkits available already from various bits of the NHS to help people manage the work force side, so there is some stuff on the short term there.

There are some agencies as well where it does look as though the rates that are being charged are very high compared with others. We have frameworks for agency staff that we encourage people to use, but it may well be that we need to approach those agencies particularly that are charging very high rates and have a national conversation with those. There are some things where we are not quite a monopsony buyer of agency nurses but we are a big element of this, and there is something about using our national leverage on that.

There is work as well just on the supplying of health education, the supply side of initiatives around return to practice for nurses, to try and increase the supply side. This is something we are trying to address, but it has grown very quickly in the last year and a half, so it is really about trying to turn that around.

Q611 Robert Jenrick: What is your expectation for the close of this financial year, and do you have a target for the next financial year that you would like to get down to—presumably considerably lower than this current financial year?

Richard Douglas: I would like to see it lower. We have to go through the planning process with organisations and see what is possible on that. Our expectation was that the growth in agency staffing would turn around, as the Secretary of State said, as people started to find ways of replacing with permanent staff and re-ordering their work load. We are not seeing that at the moment, but that is what we would expect to see next year.

Q612 Robert Jenrick: Do you have a target for next year?

Richard Douglas: We do not have a target, but I have an expectation on it, which we will then try and test out through the plans.

Q613 Robert Jenrick: To follow up on the work-life balance, the Royal College of Nursing and others raised the point that a lot of the continuing issue will come from people who work in the NHS who want to have more flexible working hours than the NHS is perhaps always providing, and that is what using temporary agency employment can give you. What is the NHS doing to correct that and provide perhaps a more modern working framework for people to encourage them back into the NHS?

Simon Stevens: NHS Employers are taking that very seriously. We are seeing that happening in lots of different areas. We are seeing that with GPs, where GPs increasingly want more flexible working, including part-time working, not just as a result of more women in the work force but younger doctors coming in and saying that the previous somewhat inflexible approach to training and working practices was not something that made sense. In a sense, what the NHS is getting is a very clear signal from our front-line staff that we have to become more flexible as an employer; we have to change the way our pay systems work, and, if we do that, then we will be able to continue to engage with new generations of people for whom work in the health professions is incredibly motivating and attractive. We are on that journey and, if the foundation trusts or the NHS trusts were sitting here before you, they would describe many different examples across the country of where they are doing that.

Q614 Robert Jenrick: Yes, but we have heard from people like the RCN, who feel that, while there are good examples, there is a long way to go and progress is probably far too slow in achieving that.

Simon Stevens: Yes, and they are probably right.

Andrew George: In terms of the overall numbers of nurses, the RCN have also provided us figures showing that over the last four to five years the numbers of registered nurses within the NHS—particularly in the mental health and learning disability fields, where there have been very significant falls in actual numbers—leaving aside the agency nurse numbers, has fallen by 5,500 over that period. So it is not just agency nurses: it is a shortage of nurses across all sectors, particularly in mental health and learning disabilities.

Mr Hunt: Overall, nurse numbers have gone up in the NHS, and that is excluding additional agency staff. The right way to approach this is the way we have approached it in

acute hospitals where we have not had an arbitrary target. We have looked at what is the nursing requirement in terms of clinical needs; we have NICE guidelines; and we ask people to publish whether they are meeting those guidelines. That is a process that I think we could copy in other areas. We are now starting to look much more closely at the number of nurses that are employed in out-of-hospital arenas, because that is a very big part of the NHS England Forward View. We would expect to see increases in practice nurses, district nurses and mental health nurses as we start to implement that plan.

Q615 Andrew George: Is it possible to have those figures? The RCN have given us figures of 318,500 in 2010-13 and 300,000 now. It would be helpful to see how your figures compare with theirs on that.

Mr Hunt: Yes.

Chair: Thank you. Good afternoon, Secretary of State. As the Chair said, she has to be in the Chamber so I have been asked to take over. Andrew Percy.

Q616 Andrew Percy: Yes, and I have to leave, though I hope to come back. My question is related to TTIP, around which there has been an awful lot of misinformation, and I think it could do with some clarity. Can you clarify what the Government's position is on TTIP? Do the Government want the NHS to be included in TTIP?

Mr Hunt: The Government are absolutely clear that we will not allow TTIP to change the way that the decision is made about whether NHS services are contracted in the public or private sector, which is a matter for local CCGs. We have it in writing, from not just the European Commission but the US trade negotiator as well, that they are not seeking it and there is no risk to the decision about whether services are in the public or the private sector. So you are right to say that there is a lot of scaremongering about this, which is a great shame, because the point about TTIP is that it will create huge numbers of jobs in the UK, it will be a big boost for the British economy, and that, in turn, puts us in a better position to put funding into the NHS.

Q617 Andrew Percy: Thank you. It frightens people. There is something called the People's NHS, which has a pledge out at the moment, and they are supported by Unite the Union, of course, who fund the Labour party. They say on their website that the Conservative party supports the NHS being included in the controversial deal TTIP. Is that true or a lie?

Mr Hunt: The NHS will not be changed by TTIP with respect to the crucial decision as to whether services are contracted to the private sector or not. That is the important point. Health care is part of TTIP because we want opportunities for British biotech companies that want to export to the United States; we want them to benefit from the easier trading arrangements that happen when you have an arrangement such as is envisaged by TTIP. The fundamental question about the contracting out of NHS services to the private sector will be decided and continue to be decided by the Government, and in this Government's case we passed legislation that gives that decision to local CCGs.

Andrew Percy: It is obviously important to know where the—

Grahame M. Morris: Can I—

Valerie Vaz: He is—

Chair: Just a minute. I will let you come in in a moment. Order, order.

Andrew Percy: Grahame, I have sat here today and heard people ask six or seven questions, veering wildly from subject to subject.

Valerie Vaz: And you interrupted me every time.

Andrew Percy: I have not interrupted you once, and I have asked two questions and I seek to ask a third.

Chair: Order. I am chairing this Committee.

Valerie Vaz: If you want to—

Chair: Order, order.

Andrew Percy: If you let me finish my questioning—

Chair: Order, order. I will decide who is asking the questions, if you do not mind. I would like Andrew to continue. This is clearly controversial. Grahame, I will go to you next, and then to you, Valerie, or to Barbara, if you want, because I want to hear the voices here. Then we will ask the Secretary of State.

Q618 Andrew Percy: I simply want to ask half as many questions as some other people have asked. My final question is this, and the reason I ask it is that it is important to know where the various coalition parties' policies are because, after all, they form the Government's position. Just to be absolutely clear, the Government's understanding is that the NHS is not included in TTIP. How confident are you that we should rely on the assurances you have received? This is something that does cause a lot of concern, largely driven, as I said in the first question, by misinformation. How confident are you in those assurances, and perhaps Mr Stevens can answer that too?

Mr Hunt: I am 100% confident. I would say to people who are concerned about some of the scaremongering that has happened on TTIP that they do not have to take it from the Government or from a Conservative politician. They can take it from the Labour head of the all-party group into TTIP, who himself has expressed his confidence that TTIP will not affect the NHS in the way that is described. They can take it from the chief negotiator for the EU who has said this. They can take it from the chief negotiator from the US who has said this. There is a real danger here that we lose sight of the big picture—that, actually, health is 9.2% of the British economy. It is a very important potential way to generate wealth for the country, to generate the strong economy that can in turn pay for a strong NHS. Many people will be very disappointed that TTIP is being used as a political vehicle in this way.

Q619 Andrew Percy: Can I ask Mr Stevens if he has anything to add?

Simon Stevens: I do not have anything to add to what I said last time on that.

Q620 Grahame M. Morris: I think it is important to set the record straight here, Secretary of State, in relation to my party's position—the Labour's party's position. Our position is that we would seek to exclude the NHS from TTIP. You referred to the all-party group there, but my understanding is that our position is absolutely plain. Would it not be a simple matter, I put it to you, Secretary of State, to end the speculation—you mentioned how important the institution is to Britain, to individuals, to patients—as France apparently are doing, to exclude a specific sector? In France's case, they wish to protect their indigenous film industry. Given the record of some predatory corporations—I am thinking here of the Hospital Corporation of America, who have been involved in very serious irregularities, fraud cases and so on—would it not be a simple matter for the Government to say, “We recognise your concerns and we will specifically exclude the NHS from TTIP”?

Just before I finish, part of the problem or the fear is that the negotiations are being conducted in secret. The Committee has raised concerns in specific questions to the European Commission negotiator, but because there is no transparency—we were talking about this a little earlier in relation to private health care companies and how it is desirable to know precisely what is going on behind closed doors—would not the simple solution be to exclude the NHS, and that would end all of the speculation?

Mr Hunt: Perhaps I can put your mind at rest by stating categorically, as I have stated many times before but I am absolutely delighted to do so again, that the NHS is excluded from TTIP if it comes to the critical decision as to whether or not services are contracted to the private sector. TTIP will not affect whether a service is contracted to the private sector or not. If a service has been contracted to the private sector and national Government wishes to bring it back into the public sector, TTIP will not stop that. You can rest assured on that matter.

In terms of the secrecy of the negotiations, they are being conducted in a pretty transparent way. After each negotiating session, they have a press conference in which the negotiators are quite public about the areas that have been discussed and the progress that has been made. So TTIP will not have any impact whatsoever on the contracting of private services in terms of that crucial decision as to whether or not the service is contracted to the private sector.

Q621 Grahame M. Morris: Secretary of State, we have sought clarification with the EU, and the Committee has raised various questions. I might say there is a difference of opinion. I have participated in a number of debates with representatives who have a rather different view of whether the legislation or the agreement would apply and whether large global corporate interests could use those provisions of the court to seek redress against Governments. There is a difference of opinion. We have sought clarification and, unfortunately, we do not have that back yet; but we are seeking to do that. I come back to my original question. The simple solution is just to exclude it and then the question does not

arise, because everyone would be assured that, whatever happens in the negotiations, the British Government have taken a decision to exclude our national health service.

Mr Hunt: When it comes to the things that you are worried about, the NHS is excluded. But I appreciate that there is a big issue of party politics in this. So, if you don't want to take it from me, I suggest you take the word of the former Labour shadow health secretary, who himself has made it absolutely clear that the discussions he has had with the EU have satisfied him that, on that critical issue of the contracting out of services to the private sector, TTIP will not have an impact.

Chair: We will now have Robert Jenrick and then to—

Valerie Vaz: Chair, would it be helpful if we give the question?

Chair: Order. After Robert's question, I will come to you.

Q622 Robert Jenrick: To clarify, so that there is no misunderstanding, we have asked the EU Commission's chief negotiator, but they have not replied yet. So at the moment we do not know if there is any difference of opinion because we have not had their response yet. They may be—and I suspect they will be—completely in tune with what we have just heard.

Could I make one other point? There is concern, as we have just heard from Mr Morris and others, about so-called predatory companies in the United States taking action against the British Government. Is your understanding in the advice you may have had as a Department the same as mine, which is that of the 94 bilateral trade investment agreements this country has had, which in aggregate we have now had for 2,000 years, the British Government have not lost a single such case in all those varied investment treaties when we have been against a whole range of very powerful US and other multinational companies? It is really important for people to understand that, despite the scale of the companies who may be interested in this market, the British Government have not lost a single one of these cases.

Chair: Is that your understanding, Secretary of State?

Mr Hunt: That is absolutely my understanding, and it is really important that we do not fall into the trap of saying, when it comes to health care provision, automatically, "Private is bad: public is good." The last Labour Government reduced waiting times for over 300,000 people every year by introducing the private sector into performing operations on hips, knees and cataracts and so on. About 600 people in every constituency would have to wait longer for an operation if we did not have the very good working relationship that we have in the NHS with the private sector. We all recognise that, among the public, there is suspicion about politicians making a decision about the private or the public sector for ideological reasons, not on the basis of what is right for patients, but the thing that has changed in this Parliament is that this Government have given that decision to local doctors so that they can be reassured that that decision is always made on the basis of what is in the best interests of patients.

Chair: I am going to go to Valerie Vaz, but I will remind the Committee that we have a long agenda and we are not a long way through it.

Q623 Valerie Vaz: With the greatest respect, you talk about not being ideological and playing party politics with the NHS, but you decided about not giving NHS staff the pay rise. That is an ideological issue. I was actually trying to be helpful. You say that it is okay, but, just picking up my colleague's point, we do not want the NHS to be paying out thousands and millions of pounds to lawyers getting through a court case. That is the key thing. Can I also say that there are many people in your party who want a public NHS and want to protect the NHS? This is a cross-party issue to protect the NHS as it is now. I wanted to try and be helpful and ask if you have seen a list of our questions. Should we send you a copy?

Mr Hunt: Do you mean the list of your questions on TTIP?

Q624 Valerie Vaz: On TTIP, to—

Mr Hunt: You are most welcome to send it and I would be delighted to reply to them.

Q625 Valerie Vaz: I think it would be fair if we do send that to you.

Mr Hunt: Would you like me to address those issues or not?

Valerie Vaz: Yes.

Mr Hunt: First of all, it was not remotely ideological to take a decision about NHS pay. It was a decision that was taken on the basis of what is right for patients. It was a very difficult decision to take, but we have said that we are going to give everyone in the NHS a 1% rise, which, in the circumstances, was the right thing to do. When you say that there are many people in my party who want a public NHS, I want a public NHS. I want an NHS that is free at the point of use, available to everyone no matter their background or their financial circumstances. That is something that I subscribe to passionately, but it does not mean that I do not think there are times when it is helpful and beneficial for the NHS to work in partnership with the private and voluntary sectors if that is the right thing to do for patients.

Q626 Chair: Thank you. Just before we move off the TTIP subject, can I ask you a question myself about this, Secretary of State? Do you think it is fair to say that one of the aspects of TTIP is that they will bring innovative ideas to this country—that they will bring in new ideas on health care from the United States? Is that a fair thing to say?

Mr Hunt: Were you thinking about homeopathy in particular, Chair?

Q627 Chair: I was actually thinking about what the Americans call integrative health care. Where we talk about integrated health care, they talk about integrative health care. In fact, I do not think it is any secret that this Committee was hoping to visit Canada at

one point, and I think at Toronto we were going to look at a clinic there, but we were not able to do so for various reasons earlier in the year. I am trying not to be too ideological here, but I put it to you that one of the effects—shall we say?—and not advantages of TTIP would be to bring in innovative processes and ideas.

Mr Hunt: What TTIP is really trying to do is to remove hidden barriers to trade. It is not trying to second-guess Governments about whether services are provided by the state or by the private sector. The broader point here is that opponents of TTIP have turned this into a public versus private battle, and I do think it would be a mistake for the NHS to close its eyes to the innovation that happens by people who are not formally part of NHS structures. There is a huge amount of innovation in the voluntary sector, in the private sector and inside the NHS. If we are going to succeed going forward, we have to be open to innovation wherever it happens.

Chair: That is very kind. Barbara.

Q628 Barbara Keeley: This is a comment as much as a question, but I think—

Mr Hunt: I am sure it will be a generous one.

Q629 Barbara Keeley: Secretary of State, you have not reassured with the things you have said. You particularly have not reassured me because I have a particular concern about data and care.data. The actions of this Government around relationships and the selling of data to the United States, the memo of understanding that you have come with and the points you have made today about biotech and easier trading arrangements, have made me much more alarmed than I was.

Mr Hunt: Okay.

Q630 Barbara Keeley: Very many people wanted to move ahead with care.data for the good that could come to research, and every single time somebody like you talks in the way that you do it puts it back on the “alarming” footing. It is worth my pointing that out to you.

Chair: I am going to ask the Secretary of State to answer that and then we are going to move on.

Barbara Keeley: I do not need him to answer. I just wanted him to—

Mr Hunt: Having alarmed you so much, I would like the opportunity to reassure you, Barbara, if I could. There is a lot of concern about the sharing of data.

Q631 Barbara Keeley: There is, yes.

Mr Hunt: Patients are quite understandably very concerned. They can see the huge benefits that happen. If one of your constituents went on holiday to Andrew George’s constituency and was able to go into hospital—

Barbara Keeley: I am going there myself at Christmas.

Mr Hunt: Indeed, and I have been there many times myself. To be able to go into that hospital to access their medical records, particularly in an emergency situation, if it was a pensioner who had a stroke, for example, it could be hugely beneficial, and people understand that.

Q632 Barbara Keeley: Indeed, but not sold and uploaded to the cloud in the States—not dealt with that way.

Mr Hunt: Could I possibly finish my point?

Q633 Chair: Barbara, I want to move on, but I will let the Secretary of State finish.

Mr Hunt: They understand the benefits, but they also want to be sure that their personal data is safe.

Q634 Barbara Keeley: And it is not.

Mr Hunt: And so we have thought very hard about how we can give people that confidence. In the end, we decided that the model that seems to work best—I think this now has cross-party support, although it did not initially—is to have a chief inspector of hospitals, who says that it is his job to speak without fear or favour about standards of care in hospitals, and, in a way, to be the patient's champion, the patient's voice, to be there and to talk openly, to call a spade a spade. We have now appointed someone to do the same job in terms of the safe use of data. The result of that is that you will have—

Q635 Barbara Keeley: Who is that?

Mr Hunt: Dame Fiona Caldicott is going to be the national data guardian. I do not think anyone knows more about safe use of data than she does. Her job will be to speak without fear or favour, and that will give people confidence. The independence that is invested in her role will mean that there is a voice there—a knowledgeable voice within the system. I hope that will give you some reassurance as well when it comes to things like care.data.

Chair: Thank you, Secretary of State. We are going to move on to future funding and transforming care now.

Q636 Mr Sharma: The Five Year Forward View estimates that to close the funding gap expected in 2020-21 will require an additional £8 billion of funding per year on top of efficiency gains of 2% to 3%. Do the Government accept this recommendation for future funding increases?

Mr Hunt: We do accept the need for increased investment in the NHS. We have shown that we have put our money where our mouth is next year by increasing it in real terms by around 1.5%, which is about the kind of scale that you are talking about. We cannot, obviously, speak about what will happen in future funding rounds, but we have made a

very clear commitment that we will implement the Forward View. Simon will be able to tell you more, but it does not specify an £8 billion figure. It says that there is a range of figures depending on the amount of efficiency savings that you are able to achieve. But it does make the point that you will need real terms increases in funding to match those efficiency savings. We accept that, and we are very keen that 2015-16, starting from next April, should be the first year of implementing the Five Year Forward View.

Mr Sharma: Thank you.

Chair: Thank you very much.

Q637 Grahame M. Morris: Again we are looking towards future funding and transforming care. You touched on it in your earlier answers when Simon Stevens referred to the £700 million one-off for winter pressures and you, Secretary of State, were talking about the future funding models, the result of the autumn statement and the Five Year Forward View. Can I just ask this? NHS England argues in its evidence to the Committee in favour of flat real terms funding increases per person over the period of that Five Year Forward View to take account of population growth, rather than flat real terms funding as a proportion of GDP. Secretary of State, do you accept the logic of that approach? Are the Government going to agree to funding on this basis—so population rather than a proportion of GDP?

Mr Hunt: In the Five Year Forward View they talk about different scenarios for increasing funding, whether you increase it on the two different bases that you have discussed. They say that, if you were, for example, just to continue with flat real, which is not what we have said because we have committed to substantially above flat real for next year, but if you were to increase funding by the 0.1% increase in the budget that we had over this Parliament, then you would need to find much greater efficiency savings. But, in fact, we have increased spending by around 1% in this Parliament. We recognise that there do need to be real terms increases in funding, not just flat real.

Simon Stevens: If I could clarify, Mr Morris, the proposition, as you say, was flat real per person but adjusted for age as well—so demographics, over and above just a growing population.

Q638 Chair: For the record, can you tell the Committee how much above flat real the spending would be? You just mentioned it being beyond flat real.

Mr Hunt: It is about 1.5—

Richard Douglas: Over this spending period it would be around 4% real terms growth overall at the end of this year.

Q639 Chair: Over what period?

Richard Douglas: Over this Parliament it is about 4% real terms.

Q640 Chair: That is a 4% increase above flat real in this 2010 Parliament.

Richard Douglas: Yes.

Chair: Thank you very much.

Q641 Grahame M. Morris: Can I continue?

Simon Stevens: That is over a more extended period, yes.

Chair: Sorry, Mr Stevens.

Simon Stevens: That is over the life of the Parliament.

Chair: Four years.

Q642 Grahame M. Morris: Can we ask about those efficiency gains that are being assumed there—the 2% or 3% that my colleague asked you about earlier? Various witnesses have told the Committee, when he described that assessment of 2% to 3%, that they thought it was really optimistic and some said it was not realistic. What are your thoughts on that, and what do you see as the main strategies for realising efficiency gains? Where are they going to come from? I want to go back to your comments about the 1% pay rise being in the interests of patients. Do you see that money as coming from staff costs—and I do not necessarily mean reduced numbers, because you did tell us that we have 1,000 more emergency doctors, but in terms of the proportion on the pay bill, or non-staff spend? I want to come on to a question about tariffs in a minute as well.

Mr Hunt: I will comment and then pass on to Simon, if I may. The answer is that we do need to make those efficiency savings. We have made efficiency savings in this Parliament, which I hope will get close to the £20 billion that David Nicholson outlined in the Nicholson challenge, but I do not think we will be able to make the same savings that we made. Some of those savings were because we did not just have a 1% pay offer but we had a pay freeze for two years. That will be much harder to achieve, so we recognise that. The answer is that we need to be much smarter in the way that we go about trying to make efficiency savings. One of the ways we do that is by giving hospitals and chief executives a longer horizon. One of the things that I announced in the statement to Parliament was moving towards multi-year commissioned contracts with trusts—multi-year tariffs—so that people have more stability over the income that they are going to get in order that they can then look to make process improvements that would reduce costs in terms of investment in IT and other process improvements, for which the pay-back might not be one year but could be two, three or even four years. At the moment, because everything is done on an annual basis, they do not see the incentive to invest in those changes as much as we would like.

Q643 Grahame M. Morris: While you have raised that, how do you see the £200 million transformation fund being used? We have looked at the Better Care Fund and gone and seen some examples of best practice as to how the money is being invested. One concern we have is that we are not learning about best practice and rolling it out. What lessons are we learning from that in relation to the transformation fund?

Mr Hunt: I will ask Simon to talk about how the transformation funding might be used because it is very much to start the process of the new models of care that are in the Forward View that he authored, but we have learned a number of things from the Better Care Fund. The programme so far—it is obviously early days—has been a success. We have learned from it that you need to have metrics that show you whether it is successful and that are transparent, and not things that are about assuring a plan and getting the graphs in a business plan to point in the right direction. What we have landed on as the primary metric that we look at for the success of Better Care Fund programmes is the impact on emergency admissions to hospitals. If you improve care in the community, you ought to see a reduction in the number of people taken to hospital in emergency conditions. You will never eliminate it, but you should see a reduction in those numbers.

We have also learned from the Better Care Fund that it is possible to have really good co-working between different organisations—in this case the local NHS and local authorities. They have built very good, strong working relationships in a way that has not happened before. That will help us in developing the new models of care where we will want community care providers, local NHS, acute trusts and local authorities all to be working together. Simon may want to answer on the £200 million.

Simon Stevens: Yes, I will answer on that and perhaps on the prior point about the £22 billion as well. There are three broad categories where we still have efficiency opportunity. There is efficiency opportunity inside individual provider organisations; there is efficiency opportunity in the way different parts of the health service work together; and, thirdly, there is efficiency in the way in which we get serious about prevention, the work with social services, and the broader integration agenda.

I will give you a few examples of each, and, by the way, my experience, from wandering round the health service, is that, if you speak to any ward nurse, junior doctor, patient or visitor, they will be able to tell you manifold examples of where they can see opportunities for efficiency improvements. The claim that we have run out of road on efficiency, despite the fact that in aggregate we are an incredibly efficient health care system—probably the most efficient in the world—does not disguise the fact that we still have efficiency opportunity in front of us.

When it comes to efficiencies inside individual hospitals or providers, it is still the case that, even with the big pressures there are on in-patient beds in our major cities, often you have a twofold difference in how long somebody admitted as an emergency—an older patient—stays in hospital. That is not due to the differences in how long they need to be there or whether they want to go home. That is due to differences in terms of the efficient care processes that are taking place inside the hospital.

I was talking with a group of district nurses a few weeks ago and the figure I was given—I do not know if it is right or not—was that a typical district nurse, and this is not a fault of the district nurses but just the fact of the way the service is organised, spends 21% of her time in face-to-face contact with patients. Without being flippant, that is Mondays. If we could double that to Tuesdays, we would, in effect, have got a huge efficiency improvement. These do not have to be cash-releasing efficiencies; they just have to be freeing up the time of people working in the health service to be able to deal with the extra pressures that are going to arise from an ageing and growing population. So we have a set of opportunities for individual providers and a set of opportunities in the way different

parts of the health service work together, and that shows up in all kinds of ways. We know that, if we invest more in primary care, that will have some impact on the proportion of people who end up in A and E departments or other parts of the health service. We know that, if we invest more in local child and adolescent mental health services, it will have an impact on the number of people who end up out of area in much more expensive in-patient facilities. That is the second category.

The third would be the broader agenda—health and social care prevention. A recent report suggested, for example, that we are now spending more as a country on the health service consequences of obesity and diabetes than we are on police, courts, the criminal justice system and the fire service combined. I do not know if that is true, but as an order of magnitude it is staggering, and we know that we have a continuing rise in obesity that we set out in the Forward View that we seriously need to tackle. We know that we have perhaps 380,000 older people often who fall at home and then are admitted as emergencies. Traditionally, the health service has not defined a fall at home as being a preventable condition because it was not something that the medical care system itself could do anything about, but by expanding our remit and vision we have opportunities there.

All I am saying is that, yes, in headline terms, of course, it is a big number, but when you think about the practical examples and do the economic analysis—as independent analysts such as Deloitte have done—we have some pretty big opportunities in front of us. That was a rather long answer, but I wanted to make it as practical as possible.

Q644 Grahame M. Morris: While you are on that theme in relation to those three categories that you identified, I want to come back to the staff spend, Mr Stevens, just while you are on that route, in relation to tariff reform. We have some thinking time, have we not, with this £700 million for winter pressures? Is the game plan that we need to reconfigure the service, because you have talked about working smarter, freeing up more nurse time and, Secretary of State, new computer systems? Does that necessarily involve substantial reconfiguration? If it does, is a new tariff system part of that road map to achieving these efficiencies?

Simon Stevens: Yes. We clearly are going to evolve the way in which funds flow around the health service. The tariff system was principally put in place in the early 2000s—and I have to hold my hand up and say I was involved at the time—to achieve a particular goal, which was to use the extra money coming into the health service to ensure that we got more operations to cut long waits for waiting times. Paying for activity helped us to do that. We all remember that you used to wait up to six months for an outpatient appointment and another 18 months for your in-patient operation, so up to two years in total; the median wait for an operation right now is under 10 weeks. That was a sensible part of the solution to a particular set of problems that we were facing in the 2000s.

We have a different set of issues over and above those that we are now facing. So, yes, we are going to want, increasingly, to move away from a tariff system that pays for every episode of treatment, every click of the turnstile, and move, instead, to one that provides more bundled payments that span different parts of the provider situation. Monitor and NHS England are working together and have said to local areas that we will be flexible on what the payments might look like that they want to come up with to work with us at the

beginning of next year, if some geographies want to do that. Certainly, when we talk about the new care models in the Five Year Forward View, they all imply new payment models as well.

Q645 Grahame M. Morris: Can I go back on the point that the Secretary of State raised, because you got off very lightly there in relation to the—

Mr Hunt: Never—

Grahame M. Morris: —staff and non-staff spend in a reply you gave to my colleague Valerie Vaz a little earlier, where you said you thought it was in patients' interests to have the 1% cap in terms of staff salaries? I am sure lots of people are very concerned that whole groups of workers—midwives, nurses and paramedics—have voted to take industrial action because we have had this sustained period of pay freeze. Mr Douglas has told us in the past about low-hanging fruit and selling off the estate, but they need to deliver these efficiencies. If that is going to be on the back of the staff, surely that is unsustainable. I want to ask you, Secretary of State, what are you doing to resolve it? I believe it has resolved in Scotland and in Wales. Why can we not make similar moves in England to resolve this? This is a group of valued staff. They will be in at work on Christmas day when we are enjoying our Christmas lunch with our families. Why can we not reward them for engaging in this process and helping to deliver a more efficient service?

Mr Hunt: I want to make it absolutely clear that we will be open to discussions with the unions at any time, but we have always been clear that it has to be within the current pay envelope. We would have preferred to have reformed the system of increments—which I think is very unfair because it gives more rewards to higher-paid staff, and I do not think it is logical or fair particularly to lower-paid staff—as a way of being able to implement the Pay Review Body recommendations in full. They have not been willing to have negotiations on that basis, but I made clear to them that all the advice that I received is very clear. If we were to accept the Pay Review Body's recommendation in full, because around three quarters of hospital bills are pay bills, the only way that they would be able to fund that additional cost would be by laying off between 6,000 and 14,000 front-line staff. Not only would that be bad for patients but I do not think it is what front-line nurses want either. That is why it is not possible to negotiate on any basis other than within the pay envelope that is on the table.

Chair: Valerie, do you want to come in?

Valerie Vaz: No; I just want to apologise to everyone. I do not normally like to leave meetings, and certainly not when you are here, Secretary of State, but I have to go to another meeting on the governance of the House. I am really sorry, but thank you.

Q646 Chair: Staying with transforming care for a moment, witnesses have warned us that transforming care may produce benefits in the quality of care for patients and service users, but it does not necessarily bring savings or efficiencies. You touched on this in the

questioning from Grahame and you might expand on it. Do you agree with the proposition that transforming care may produce benefits but not necessarily bring savings?

Simon Stevens: It depends on what we mean by savings and what is the counterfactual. As we were just talking about with Mr Morris, when we did the modelling on the pressures that the health service would continue to face over the next five or six years, we looked at the likely increases in demand in patient need that would present based on the growing population, an ageing population and the availability of new treatments, and then compared that with different funding levels and identified the gap. We are not saying that we need, as it were, to cut services or take cash out to the tune of 2% efficiency. We are saying we need to be able, in an expanding cake, to absorb some of those pressures through better ways of doing things, through new ways of working. I cannot remember whether we have previously discussed this or whether it was with one of the other Committees, but the Nuffield Trust, I think, for example, project that, if we carry on doing the same old, same old, then over the course of the next five or six years we would need 17,000 more in-patient beds just to deal with the extra emergencies that would show up, which is equal to 34 hospitals. We do not have to build those 34 hospitals. That is a choice. What is going to be the nature of the care that we provide?

Our choice is, instead, to redress some of the imbalance in out-of-hospital services, including primary care services. Using the £250 million—£1 billion over four years—to kick-start that process will, I think, improve the quality of care and, as the Royal College of General Practitioners have just shown with a report they themselves have commissioned, will offset a lot of that extra demand going into hospitals. They published that report 10 days ago. It makes that case.

Q647 Chair: What troubles me overall is that there is an emphasis on increasing supply and not enough emphasis in our general health strategy on reducing demand. In our exchanges earlier in another meeting, Mr Stevens, we touched on Public Health England's view that we should be dealing with risks rather than conditions. Duncan Selbie, in his paper which was published at the same time as your strategy document, said that we should be focusing on five key risks, starting with tobacco; the second is blood pressure; the third is diet; the fourth is lifestyle; and the fifth is alcohol. Do you feel that that is the correct strategy and, if so, how are you going to incorporate the philosophy that Public Health England have set out?

Simon Stevens: Yes. I completely agree that is the right strategy, and, of course, the NHS Forward View was co-authored by Public Health England. As you recall, it was Public Health England, Health Education England, the Care Quality Commission, the Trust Development Authority, Monitor and NHS England—all six of the national leadership bodies of the NHS—that came forward with this document for the NHS. PHE are saying that the extent to which we can make greater progress on the prevention agenda will offset what would otherwise show up as the need for new supply in the health service and so that all counts towards our 2% or 3% efficiency that we need.

A number of us have been speaking at another meeting today, Britain Against Cancer, which the all-party parliamentary group on cancer has been sponsoring. One of the points that we have been making there is that over 40% of cancers are potentially preventable through tackling tobacco, obesity, exercise and alcohol. The extent to which we get

serious about that will, in turn, help offset the demands that will show up for funding in downstream health services.

Q648 Chair: When you came before the Committee, Mr Stevens, last time, you very generously shared your personal experiences of working in the United States when you told us, if I recall correctly, that the company you had been working for offered financial inducements to reduce weight. You told us that you had actually been on that scheme and lost a lot of weight.

Simon Stevens: Three stone.

Q649 Chair: Would you then—presumably you would—be very much in favour of financial inducements to reduce these conditions, which are costing the health service a fortune?

Simon Stevens: We should certainly be open-minded.

Q650 Chair: In the workplace.

Simon Stevens: We should look to test these models in the workplace. I know this can be a controversial topic, but I am certainly going to be next week with a group of NHS staff and employers in Sheffield who are already making progress on this workplace health agenda. I am going to be discussing with them what their successes have been through different approaches. I do not think there is one particular recipe that we should be mandating across the board, but that is something that, yes, the NHS as an employer, as a healthy workplace and as an ambassador for the broader sorts of changes we want to see across the workplaces of this country, needs to get serious about.

Q651 Chair: I have two other questions to ask on different but related subjects. What is your view, Secretary of State, of the use of properly regulated practitioners who are not necessarily doctors or nurses in the national health service? I am thinking of the groups that are now regulated by the Professional Standards Authority and, in particular, the acupuncturists, who have just been brought under the regulation and oversight of the Professional Standards Authority. Also, Mr Stevens, we had an exchange about lower back pain, and I think you said—

Simon Stevens: We did, and I am very supportive of acupuncture in that context.

Q652 Chair: I think you were really arguing that it should be widened, whereas, of course, the use of acupuncture in China would be used for so many more conditions, and they would argue they have 2,000 years of usage. It is often put to me by conventional practitioners—or has been over the last quarter of a century in this House—that they cannot refer to complementary practitioners because they are not properly regulated, but most of them now are properly regulated through the Professional Standards Authority or the Complementary and Natural Healthcare Council, which is itself regulated by the Professional

Standards Authority. The Secretary of State touched on homeopathy, which I happened to have been debating on the “Today” programme yesterday morning. You might have heard my exchanges with Lord Winston, whose wife follows homeopathy as her mother was a homeopathic doctor; we had that out in our exchange. If we are going to regulate acupuncturists and now the Society of Homeopaths—2,000 of them—who are non-medical homeopaths, what is the point if we do not make greater use of them? Surely we have to trust the practitioners. The doctors who are homeopaths have been regulated not just by the General Medical Council but they are double-regulated by the Homeopathy Act 1950. Parliament specifically brought in an Act of Parliament. We have had this enormous weight of campaigning against them by a very small number of people, but these therapists are properly regulated. So why are we not using them to reduce demand for services and to take the weight off doctors and surgeons?

It is a very long question, but, as you know, it is something that is close to my chest and I was not expecting to be in the Chair and have the opportunity to not be called to order.

Mr Hunt: I have thought about these issues a great deal, not least because I know that you will always be very consistent in asking me about them. There are three points about this. The first is that we must be open to the scientific evidence and follow that evidence. That is a very important principle that everyone would subscribe to. We need to make sure that we follow what the evidence says is going to work in particular cases. Secondly, we need to make sure that the public are safe. That is why I welcome the fact that increasing numbers of alternative medicine practitioners are being properly regulated. Thirdly, with respect to whether or not an individual patient receives that kind of treatment, in the end that is a matter for their GP to do. There are GPs who prescribe homeopathy and GPs who prescribe acupuncture, but the system we have is that we allow GPs to decide whatever they think is in the clinical interests of their own patients.

I do not want to give you false hope, but one thing that is quite interesting is that GPs are taking a broader view of what the appropriate thing to prescribe is. We are seeing a big growth, for example, in social prescription, where GPs are saying things such as, “The root cause of this person’s problem is isolation and loneliness, and so, effectively, I am going to prescribe that you join a lunch club,” or something like that, “to make sure that you have company in your life.” We need to be open-minded to CCGs which say, “This is the kind of thing that is going to help deal with the root causes.” There are other CCGs that look at housing problems, which have been sorting out the damp in someone’s flat because they have realised that is a root cause of some of the problems they face. The NHS is taking a more holistic view of what it takes to address people’s medical problems than it did before and I do not think that is something we would want to stand in the way of.

Q653 Chair: There are two intellectual issues here, if I may call them that, in not very elegant English. The first, going on from what you are saying, is that, with complementary medicine, the practitioner is asked to provide scientific evidence that it works—double-blind placebo-controlled trials. But the same standards are not applied to general medicine. There are a lot of products out there that have not gone through that rigorous process.

Going on from that, to go back to what I was saying about regulation, if you have properly-regulated practitioners—for example, homeopathic doctors, acupuncturists or the Society of Homeopaths—surely you can trust them, particularly given their safety record, which is extremely good, and the oversight, which is extremely strong. Why do we have to say to them, “What you are administering has to be tested in such a way”? The Medicines Control Agency and the other agencies are never, ever going to be able to test all these products. So what is the point of having properly regulated practitioners if you do not leave them to get on with it?

Mr Hunt: The regulation helps to address the second issue that I raised of the three issues, which is: is what someone is offering safe? That is the bit that you hope effective regulation will deal with. It does not necessarily deal with the question of whether a course of treatment actually works.

Q654 Chair: Is that right?

Mr Hunt: The sensitivity here in terms of NHS money being used for these treatments is that we are now not allowing all treatments that we know scientifically work to be made available on the NHS because no health organisation can say that absolutely every single medicine that works is going to be available in unlimited quantities. That is why it is the sensitivity to start making it much easier for people to access alternative medicines.

Chair: I am very grateful for your reply. We are going to move on. We are nervous that we might lose our quorum, for various reasons, to do with other Committees in the House. Thank you for those exchanges.

Q655 Robert Jenrick: We have heard, obviously, about the financial pressures on the NHS and we asked those who came to us in previous hearings for innovative ideas. I have to say that there were relatively few forthcoming specific ideas, but one that was raised, which took our interest, was how we could better manage the NHS property portfolio. There was a view from a number of contributors that the NHS is sitting on a huge asset. Whether it is worth £7.5 billion, or potentially considerably more, we do not know, but perhaps the NHS is not that well positioned to make use of that property portfolio in the most imaginative and efficient way. Could you comment on that?

Also, one of the specific proposals that came out of those hearings was whether that property portfolio could be placed in some kind of endowment fund or sovereign wealth fund for the benefit of health care and the NHS in the future, and placed in the hands of people who are specifically instructed to make the best use of it. I know a lot of NHS property is obviously very sensitive, because some of it is hospitals and so on and can't just be sold off or moved around with ease or without great sensitivity. But what are your thoughts on that and whether there could be a strategy for making better use of that property portfolio?

Mr Hunt: Perhaps I will ask Richard to deal with that.

Richard Douglas: I agree that we do not make the best use of the assets that we have in the NHS. That is a general consensus across the service at the moment. We have created some vehicles to handle part of the asset portfolio. We created Property Services, where

we brought together everything from the PCTs and the SHAs to manage their property and to try and get better value from it, but the bulk of the assets are out there with the provider organisations. As to trying to get as much value as we can from either the surplus or potentially surplus assets we have, we have a long way to go. We are doing quite a lot of policy work on this at the moment—to try and find ways of incentivising organisations to release surplus assets. There is a general view—and I think most people can see it when they walk round the NHS—that there are a lot of potentially surplus assets there. In some cases it is because organisations do not feel incentivised to release it. Sometimes they are keeping it for a rainy day. You will get some organisations who will say, “I do not have a financial issue now, but I might have in five or six years’ time. If I have got that tucked away, I can get something for it.”

There are other issues about the capability and the capacity to generate the best value from assets. As we go into the next spending round, this is one of the biggest areas that we need to focus on. It is not straightforward coming up with the answers. For every incentive you create for organisations, you have to think, “What is the other side of that?” But definitely there is something there and we do want to engage the NHS more widely in what is the best way of doing this.

Q656 Robert Jenrick: What do you think of the specific idea about placing the property in a fund that could be managed perhaps more imaginatively or aggressively, whichever way you want to say it?

Richard Douglas: I am a bit nervous about that. We start from the position that these are health assets, so the primary driver—

Q657 Robert Jenrick: But that is the point, is it not, instead of selling off surplus land to meet short-term deficits, to see whether it could be used for the long term?

Richard Douglas: There is a question about whether we are selling off to deal with short-term deficits. We are trying to maximise the sales of our assets for reinvestment in the system so that when we sell assets we do not lose the cash for that. That is our source for generating further capital investment. So, yes, as to whether there are other different types of vehicles that would allow us to do that in a better way, we are open to discussion, but that would change quite fundamentally the regime we set up for foundation trusts at the moment. Foundation trusts hold most of their assets—they are in their ownership—so you would be talking about handing that over to some other organisation.

Q658 Robert Jenrick: That is one of our questions to follow up. Do you view property as an asset of the foundation trust, in principle? It is not an asset of the wider NHS and health economy of the country.

Richard Douglas: It was a fundamental premise when we created foundation trusts. One of the significant freedoms—and I cannot remember whether this was in primary legislation or not—was giving them control over their assets, giving them ownership of assets, and guaranteeing that if they sold those assets they took the value of them.

Changing that would be quite fundamentally re-opening the basis on which foundation trusts were established.

Q659 Barbara Keeley: Can I make a comment? I am sorry that we seem to have completely lost our structure today and sometimes we have to make comments on a question that came much earlier. On the point that was being made about efficiencies and numbers of nurses, I want to make a point about district nurses, because the RCN made very strong comments to us about the numbers being reduced from 12,000 to 5,500, which seems more illogical than anything I have heard, given that we know that need is increasing with older people, that adult social care is being cut by £4.3 billion and that more people want to die at home. We had a discussion around those things. It will prove to have been a very bad time to allow those district nurse numbers to have declined as much as they have and I hope we can see them restored. The point about them only having face-to-face contact on Mondays is very worrying. Whenever I end up talking to people about palliative care and that sort of thing, it seems to hinge on what the district nurse, the GP and specialist nurses can put in. It is alarming that we have let that decline to the extent that we have.

The Committee's question relates back to the point you made about using the investment funding of £250 million for advanced care. Could you tell us—and I am sorry this takes us back to something we started out on when we were in the section on financing—what kinds of improvement this is intended to support and how will the money be allocated? We did not ask those questions earlier and I think they are quite important.

Simon Stevens: The £250 million.

Q660 Barbara Keeley: Yes, the foreign exchange £1 billion that is being split over four years. What sort of improvements will it support and how will it be allocated?

Simon Stevens: Obviously, from the point of view of the NHS it makes not a ha'p'orth of difference as to what the funding source is. It is new cash for doing good things in primary care. That is our lens.

Q661 Barbara Keeley: That is just so we know what we are talking about.

Simon Stevens: Yes. In terms of how that is going to be used, as I said a bit earlier, a significant proportion of it will be used to boost the ability of GPs through their premises to sustain and expand the range of services that they are undertaking. A survey undertaken by the GPC—the General Practitioners Committee of the BMA—I think found that about 70% of respondents said that they would be constrained in their ability to expand primary care services for out-of-hospital services just by virtue of the premises constraint. Obviously, this will substantially help with that. But, more broadly, we see, too, quite a lot of enthusiasm among GPs for some of the new care models that are talked about in the Five Year Forward View, including this idea—not very elegantly titled—of the multi-specialty community provider, which will bring together not just GP services that obviously have historically been separate from district nursing, social care, mental health services, from indeed some specialist parts of hospital services, into these new integrated organisations. Frankly, that will, in turn, help address the concerns that you rightly raise

around community nursing in that we are going to see strong nurse leadership inside these organisations as well. That has been welcomed by the nursing bodies.

Q662 Barbara Keeley: Surely not unless we boost the numbers.

Simon Stevens: No, but, you see, part of what is going on here is that we have got ourselves, over the course of a decade or so, into a bit of a treadmill where, through lack of focus on the out-of-hospital part of the health service, more patients at the margin end up being admitted as emergencies, often for short periods of time. We have talked previously about the fact that the National Audit Office has remarked that there has been a 124% increase in the number of emergency admissions over a 14-year period for people who stay for just two days or less, and only 7% of that 124% increase is explained by the ageing of the population. That tells us that our system is out of balance, and, as we have talked about before, the opportunity that we talk about in the Forward View is to shift investment and put more of that into community nursing services and other out-of-hospital infrastructure.

Q663 Barbara Keeley: How will you allocate the funding? That is the second part of my question.

Simon Stevens: We have to make decisions on this formally at our NHS England board on 17 December, but the proposal that will be in front of the board for consideration will be that there will be a combination of bids from GPs and from local areas, compared with plans that they have already got, but also showing, frankly, how this helps kick-start the process of broader change that we want on the back of the Forward View. But for next year, deliberately, a high proportion of this funding will, I suspect, go to projects that people have had in mind for quite a while.

Q664 Andrew George: There is consensus that we need more integration between health and social care. The Barker commission has helped to reinforce that. Given that that is in place, how quickly can any Government move to a single budget, a single commissioner and a streamlined health and social care system?

Mr Hunt: That is exactly what we want the Better Care Fund to do. It is perhaps understandable—given that it starts next April, and so people have not had the chance to see it working in practice—that people who have not been involved in the planning process around it sort of say, “We’ll believe it when we see it.” But for those of us who have been involved in this process, there are detailed plans, painstakingly worked out by 151 local authority areas with their local NHS. It is about joint commissioning, sharing of electronic health records, a single accountable person for someone, whether they are in the health or the social care system—exactly the kind of things that you need. We are trying to achieve this without a structural upheaval, because there is a big desire within the NHS for stability. We have seen from the Better Care Fund a model of—the lingo is—co-commissioning, but really it is about people from two different organisations sitting round a table, pooling their budget and agreeing a common strategy as to how that budget is being used. I am very hopeful that we can have that as a model, not just for social care but also for the integration of what NHS England do with primary care and with what

CCGs do when they commission secondary care, so that we can get to a much broader version of integration rather than just the integration between health and social care, important though that is.

Q665 Andrew George: So it will be based on the incentives of the Better Care Fund and it will take as long as that particular kind of initiative base incentive process takes to work. It will take, what, five or six years—or what period of time?

Mr Hunt: I think it will be quicker than that. £5 billion has been pooled into Better Care Fund budgets. That is a significant amount of money. We will see some impact from that next year in terms of the impact on emergency admissions in hospitals.

Q666 Andrew George: Can I move on to one other subject, which is the issue of regulation? The House is up already and we are on to the Adjournment. The accusation is that the Government are running out of a legislative programme. Yet the next Government may find that the housekeeping matters, like the implementation of the Law Commission's recommendations, may not be sexy enough for the first year of an incoming Government. Since there is political consensus on it, why not do it in the remaining tail-end weeks and months that we have available?

Mr Hunt: You will have to ask the Government Chief Whip, but my understanding is that, in terms of the volume of legislation, we are putting through quite a bit more than previous Parliaments have put through in their final year.

Q667 Andrew George: I am sorry to interrupt, but if you were asked to bring this forward, does the Department have the capacity to bring it forward quickly?

Mr Hunt: We support the Bill; we would like to do it and we think it is a very important Bill. As soon as the Government are able to find legislative time, yes, indeed, we would want to give it that time.

Andrew George: That would be helpful.

Chair: Secretary of State, Simon Stevens, Una O'Brien and Richard Douglas, thank you very much for coming. We have had a long session—two and a half hours—and it is very much appreciated.

