



Health Committee

Oral evidence: [NHS current issues](#), HC 323

Tuesday 21 July 2015

Ordered by the House of Commons to be published on 21 July 2015

[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Dr James Davies; Liz McInnes; Paula Sherriff; Emily Thornberry; Maggie Throup; Helen Whately; Dr Philippa Whitford

Questions [1-152]

Witnesses: **Simon Stevens**, Chief Executive, NHS England, **Professor Sir Bruce Keogh KBE**, National Medical Director, NHS England, and **Jane Cummings**, Chief Nursing Officer, NHS England, gave evidence.

Q1 Chair: Good morning and welcome to the Health Committee. Thank you for coming today. Could I start by asking you to introduce yourselves to those following from outside this room, starting with you, Jane?

Jane Cummings: Good morning, everybody. My name is Jane Cummings. I am the chief nursing officer for England.

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

Professor Sir Bruce Keogh: I am Bruce Keogh, the medical director for NHS England and a cardiac surgeon by background.

Q2 Chair: Thank you. Mr Stevens, given all the challenges that face the NHS, which problems are keeping you awake at night?

Simon Stevens: Absent interruptions—my children sleep well, but the fact is that there are some pretty big challenges in front of us right now. I might point to three that spring to mind immediately. First, we have to keep current services running well while also redesigning what a future-proofed health service will look like over the next three to five years on the agenda we set out in the Five Year Forward View. How to manage for today while transforming for tomorrow would be the first of them.

Secondly, the public and Parliament rightly expect to hold the national health service accountable for the performance that is being delivered, but at the same time we need to create the space for the 1.4 million nurses, doctors, therapists and other staff of the health service to themselves chart the course for the direction that they believe the health service

should be taking in their local area. Getting this local energy and national accountability balance right would be the second thing I might refer to.

The third thing would be that we have consistently made the argument that the national health service is important in its own right, but it exists as part of a broader ecology of services and communities, so what is happening in social care, what is happening to public health in prevention and broader economic wellbeing—all of that—is important to us as well. We have to juxtapose our focus on the national health service with our focus on the broader determinants of health and wellbeing. Those would be three pretty fundamental questions that confront all of us.

Q3 Chair: I am interested to hear you say that the financial position is not keeping you awake at night.

Simon Stevens: That is the first really. When I talk about managing for today, that includes the financial pressures across the health service this year.

Q4 Chair: Yes, thank you. Looking back at the Five Year Forward View, based on a consensus position that there was going to be a funding gap of £30 billion, could you give some more detail on what assumptions that was based on—is that still the accurate figure?—and elaborate on the scale of the challenge of achieving £22 billion? Is it achievable?

Simon Stevens: Yes. In the forward view the national leadership bodies of the NHS that came together to produce that consensus view for the next five years said that if you, entirely unrealistically, assumed that the health service got no extra real-terms cash over the next five years, produced no incremental efficiencies and had to deal with the historic rate at which demand was increasing by virtue of a growing population, an ageing population and changing disease patterns, and then wound the clock forward five years, we would be facing a gap of nearly £30 billion. Then the question is what combination of efficiencies and investment do you need in order to close that gap. That is the argument that we advanced last October and going into the election.

Q5 Chair: What I meant was how accurate do you think those assumptions are?

Simon Stevens: At least two of the three we want to be inaccurate: we do not want to have flat real-terms funding and we do not want to have no efficiencies. Furthermore, we would like to moderate the rate of growth in demand in the national health service as well. We are trying to act on all three variables that create that £28 billion or £30 billion pressure five years out. Obviously since last October at least four things have changed. One is that that was the proposition that we were setting out in 2014-15. We are now in year one of the forward view, so we have rolled forward into the first year, including some of the efficiencies that have been delivered across the health service this year, so they count towards that total. Secondly, we have had the announcement last autumn in the autumn statement. Thirdly, we have had the Budget announcement which has changed some of the assumptions around what pay pressures are going to be in the national health service. Fourthly, we have had new cost pressures bubbling up, as witnessed in the financial pressures that are particularly showing in hospitals, but not just hospitals.

Q6 Chair: So £22 billion was the figure in the Five Year Forward View. What do you now currently see as the gap that the NHS has to fill, given that there has been the £8 billion that was announced in the Budget?

Simon Stevens: The process that is under way right now is a big exercise across not just NHS England, Public Health England and all of the national bodies but also engaging with front-line leaders across the national health service between now and the autumn so that, come the outcome of the spending review, we will have, obviously, clarity about the investment profile and the phasing of the extra investment, and we will have an updated set of deliverables in terms of the efficiency that will be securable over the course of the remaining four and a half years of the five years of the forward view. The autumn is the point at which those two will converge.

Q7 Chair: You are not in a position yet to give us an updated appraisal on what—

Simon Stevens: I am not going to give you a point estimate today, but we will in the autumn.

Q8 Chair: What would be the consequences for the NHS of failing to meet that?

Simon Stevens: We obviously have said that the health service is going to need at least £8 billion more in real terms by the end of the decade. That represents a higher rate of funding increase than the health service has had over the last five years, but, in historical terms, nevertheless a lower rate of increase than the health service on average has enjoyed in its 67-year history. That is partly a consequence of the fact that there are clearly pressures across the totality of public spending. There are many enormous strengths of a tax-funded health service, but, as I have said before, one consequence of it is that, when the British economy sneezes, the national health service catches a cold when it comes to our funding. The health service in 2020 will be bigger, better funded and providing more treatments. That is what at least £8 billion means, but over and above that we need to create ourselves additional headroom in order to be able to manage the extra demands that will be placed on us, and in order to do the good new things that we ourselves want to do. On Sunday, for example, we published the results of the independent cancer taskforce charting a course for substantial improvements to cancer services over the next five years. That is going to require investment plus the headroom we can create from efficiency.

Q9 Chair: That was not my question. My question was, what are the consequences for patients if the NHS does not manage to fill the £22 billion, or whatever it is forecast to be, in the autumn? What will be the consequences for patients? How will it look? What things will not be there, should that not be met?

Simon Stevens: There will be missed opportunities to provide the range of services, the improving services, that we want to do, such as the cancer point, mental health services and the changes we want to make across a whole raft of urgent and emergency care—stronger expanded primary care. This is what we will be able to do with investment plus the headroom from efficiency.

Q10 Chair: In your view, it will be more a case of the things that you cannot do over and above existing services. You are not foreseeing that there may be cuts to existing services or lengthy waiting lists.

Simon Stevens: In a scenario where there is £8 billion extra of real funding but no efficiency, which is not the scenario that is going to come about, obviously that leaves this gap that we have talked about. That gap was to create headroom to deal with the extra emergency admissions that there are going to be, the need to expand the number of GPs, given that consultation rates are going up—real pressures in primary care—but also to do new things. It is some combination of those two.

Chair: Thank you. I will hand over to Helen.

Q11 Helen Whately: You outlined that the numbers are, to some extent, a work in progress because of recent announcements, but clearly there is still a large challenge somewhere in the order of £22 billion, and in order to close that gap the work very much needs to start now or already be in progress.

Simon Stevens: It is, yes.

Q12 Helen Whately: What would you say are the major changes that need to be made, or are being made, to achieve both that productivity improvement and also the quality improvement that we want to see as well in that time frame?

Simon Stevens: Roughly speaking, at the moment the efficiency chunks into three main categories, one of which is prevention and moderating the rate of increase in demand, which is perhaps worth about a quarter of the size of the efficiency opportunity; a further quarter is going to come from the health service more actively managing the prices we pay for things that we use; and the remaining half is going to come from improving the productivity with which care is delivered. Underneath those three categories there are individual work strands and substantial programmes mobilising to deliver them.

Just to give you a sense of what some of that looks like, we know that, like most health care systems, there is still far too much variation in clinical practice across the country. Professor Tim Briggs, the former president of the British Orthopaedic Association, is leading work on that, and Bruce might want to talk further about some of that. We know that we are not using our collective purchasing power effectively when it comes to things like the big explosion in temporary staffing costs or the buying of orthopaedic prostheses. We know there is too much of a “go it alone” approach, leaving individual institutions to improve their efficiency rather than thinking on a whole health economy basis, and indeed sometimes beyond the scope of just what the national health service is doing, including local government. We know that there are often, for understandable reasons, penny wise, pound foolish decisions made about cutting back on stuff that would spend now and produce an offset down the track. We see that in mental health services and other areas of our activity.

Sometimes we have opportunities to do more nationally on some of the stuff that only the Department of Health itself can control. We have opportunities around surplus property premises across the national health service. Ara Darzi's review of London said that there was enough surplus property in London to fill Hyde Park. The King's Fund has estimated that as being at least £1.5 billion-worth, and some estimates put it up to as much as £7.5 billion. There are lots of zones where we are now mobilising folk to go at this hard.

Q13 Helen Whately: There is a huge amount going on and also, as you said in your answer on the three things that, to some extent, keep you awake at night, the need to continue to provide health care as you do it. Is there the capacity and the ability to achieve all that change, and the leadership and the management capacity to do so, or what changes need to happen in order for there to be that capacity for all the change?

Simon Stevens: As you imply, this is obviously going to be a tremendously challenging period in the history of the national health service. There is no doubt about that, and we have all been very clear about the honest truth that that implies in terms of how we have to change the way we all work. What do those changes mean? First of all they mean a clear national sense of direction based on consensus for what people want. That, I think, we brought about last October. Secondly, they mean more alignment between the various national bodies in the NHS, and the Secretary of State announced last week the de facto combining of, for example, the two provider-facing oversight bodies to try and streamline that part of the system. Thirdly, they mean an approach to change that recognises that it does not have to look the same everywhere. You can have—in a phrase I use all the time—horses for courses: different parts of the country can take different routes to improvement, and rather than try to pretend that everything has to be identical, which ends up constantly leading you towards administrative tinkering, recognise that those kinds of differences will be required. It means, frankly, backing the leadership, as a consequence, of local communities and local clinicians, front-line health service staff, when they want to make the kind of changes that we are seeing in the first 29 vanguards covering 5 million people across the country. Bruce or Jane may want to add to that, given the clinical leadership point.

Professor Sir Bruce Keogh: I would like to come back to one of your remarks earlier about how clinical practice can start to eat into some of the £22 billion. For those who did not read it, the *British Medical Journal* had an interesting editorial entitled “Overuse, over here”, which was based on the observation that certainly in north America a very substantial, double-figure, proportion of health care cost was on overuse of treatment and that, if you could get that right and shift the money from overuse to areas where it is underused and focus more on appropriateness of care, you could save a very significant proportion of money.

There is quite a bit of work going on on that, and a colleague of mine, who is also a friend, who was director of a centre for Medicaid management in one of the previous American Administrations, did a study looking at surgery—in this case coronary surgery—and found that in Virginia, where all the hospitals were performing pretty well, the difference in cost between a good unit and a really good unit was 30%. At a good unit, the surgery would cost \$30,000, which, I have to say, is a lot more than it costs in this country, and at a very good unit it would be \$20,000, so you could chop out 30% there. We have also done work

with the Royal College of Surgeons and others on identifying procedures which they think are of low clinical value. You will also be aware that the Academy of Medical Royal Colleges have taken up the gauntlet, if you like, of a programme called “Choosing Wisely”, which is where you invite different specialties to determine what procedures or endeavours they think are not as effective as others. I think there is quite a lot of room for manoeuvre in terms of clinical practice.

Q14 Helen Whately: Thank you. The final thing, to wrap up, taking a step back to the finances, is that it would be helpful to get a bit of a picture of how, year on year, the productivity improvements look like they will pan out and, on the other side of the picture, what investment is needed, to some extent, to front-load some of the changes envisaged as well.

Simon Stevens: Yes. Over the last five years, on one measure at least the health service has managed to deliver about £19 billion-worth of efficiency. It is the same sort of order of magnitude but the composition of it is going to have to change over the course of the next five years. To start with, we obviously have to go hammer and tongs at the so-called practice variation, or the productivity differences, between individual providers, which Monitor described as the catch-up process. Then, over time, we have to generate more of our efficiencies from doing things differently and better—the so-called frontier shift. Our opportunities look different as they are phased over the course of the five years. We have a substantial set of things that we need to kick off now, and we are doing so, in order to produce that kind of pay-off three or five years out. There are various other dependencies with what is going on outside the national health service for some of that as well.

Q15 Helen Whately: What about the front-loading side of the investment needed now to do that?

Simon Stevens: Obviously that is a decision that the Chancellor will need to make in the spending review, but there clearly needs to be investment to enable some of those efficiencies, such that by 2020 we are able to deliver the opportunity that we can see in front of us.

Q16 Emily Thornberry: Can I follow that up? I have not really met a health professional in the last two months—I have been speaking to them about this—that entirely believes that we can have £22 billion-worth of efficiency savings. Some of them have even been cheeky enough to say that they do not really think that you believe it either. It would reassure us, I suppose, if you were able to come to this Committee and perhaps be a little more specific. I hear the general sweep and so on, “We will be doing this and we will be doing that,” but not to be able to come to us with even a ballpark breakdown of where the figures are—we are quite happy to put pressure on the Chancellor of the Exchequer saying that the NHS needs more money and if X amount was to be invested in the NHS then you would be able to reap the rewards by way of being able to get this amount of efficiencies—is, if you do not mind me saying it, a bit woolly.

Simon Stevens: I do mind you saying it.

Q17 Emily Thornberry: But after making the announcement that the £30 billion shortfall could be made up with the £8 billion-worth of investment and £22 billion-worth of efficiencies, to come to us nearly a year later and not be able to give us any more specific detail than that is very disappointing.

Simon Stevens: I can, I have and I will give you more on those details. As I said, we think a quarter of that is going to come from prevention and demand moderation. By demand moderation, we mean changing the models of care and reducing the rate of increase in emergency hospital admissions and bed days per 1,000. To do that we have to invest in out of hospital; we have to strengthen primary care services. We know we have to do that anyway, but there clearly is a no-brainer: if you do not invest in primary care and community health services, you will see at the margin higher rates of emergency admission, so part of it—a quarter of it—has to come from a combination of the things that are going to be done on prevention and on alternatives to hospital admission. A further quarter has to be done through reducing the prices that the health service is being charged for things. There is quite a detailed overview of what some of the contours of that will look like from Pat Carter, and that estimates up to £5 billion savings from a variety of measures set out. What is going to happen now is that each trust is going to be given its own opportunity, per the Carter measures, by the autumn, and I will come on to what we would like to be able to do with that. That is the second chunk.

The third chunk, as I say, is the work that Monitor has produced—voluminous data—on the productivity opportunity in front of the provider sector, and that is going to have to contribute about half of the efficiencies. But what we would like to do—we cannot do as we sit here today—come the autumn and the spending review, is to be able to set a three or four-year tariff for the national health service and three or four-year funding allocations for CCGs, so that everybody can then see with certainty what they have to plan against over that period and can make the kinds of local decisions that they will need in order to get going.

Emily Thornberry: Thank you.

Q18 Rachael Maskell: I would like to keep with the theme, so to speak. NHS Providers had a deficit at the end of last year of £823 million. How is that going to change by the end of next year, particularly if we are talking about £22 billion efficiency savings?

Simon Stevens: There are very substantial pressures, particularly in NHS hospitals, and if you look at the financial position, generally speaking, smaller hospitals have seen more financial pressures than larger hospitals. Those, at least, are the figures that Monitor have reported, and the size of the provider deficit last year is more than explained—there are many moving parts—by just one thing, which is the overspend on temporary staffing in the national health service. The provider sector overspent by more than £1.5 billion on temporary staffing versus the £823 million figure that you gave—on some measures 842, per accounts that have been released today. But the question then is that the single most important thing we have to do—it is not the only thing—to stabilise provider finances this year is to dial back the spending on agency staffing. I can describe to you the work that the Department of Health, Monitor and TDA have kicked off on that. If we do that, it is the

single biggest item that will help. It is not the only thing, but it will help. It is absolutely critical that we get that right.

Q19 Rachael Maskell: One of the things we know is that we still have a changing health service, which is driving more services into acute medicine as opposed to treating people in the community—there has not been a turnaround in that—and also the creeping demographic, which we hear is so prominent in the costs of the NHS. How will the changes you have just mentioned impact on that?

Simon Stevens: I do not think they will. They need to happen anyway. We have to end off-framework use of temporary staffing; we have to dial back the prices we are paying for on-framework agency staffing; and we have to convert agency staffing spend into well-paying permanent nursing jobs. Jane can explain more about what is going to be required. But you asked, I think, a separate point, which is how are we going to make sure that we strengthen the primary care investment and the investment in out-of-hospital services. This year we have made a start on that; primary care spending is going up by 4.1%, a higher rate than the overall growth of 3.4% in CCG-commissioned spending. We have announced £1 billion of investment in primary care premises and infrastructure, a new deal to try to substantially grow the number of GPs in the national health service over the next five years and a whole range of other investments to expand access to primary care services. But let us be under no doubt. Your analysis is right: looking back over the course of 10 years, there has been relative underinvestment in primary care and we are now paying the consequence.

Q20 Rachael Maskell: I would like to pick you up on some of the issues you talked about on efficiency savings. You talked about a quarter coming from prevention. Is that realistic in five years? Prevention surely happens over a longer time line.

Simon Stevens: It is not a quarter from prevention but a quarter from prevention and demand moderation. What I mean by demand moderation is that, in the construction of the original £28 billion or £30 billion funding pressure by the end of the decade, one of the three assumptions, as you will recall, was flat real funding, no efficiency and demand continuing to grow at its historic rate of about 2.7% on a cost-weighted activity basis. We are saying that we want to put a kink in the rate at which expensive hospital activity grows over the next five years. That is not prevention per se in the sense of getting tough on tobacco, alcohol and sugary drinks for kids, all of which we need to do; it is more around substituting for what would otherwise have been emergency admissions, with support for people in primary care and community services at the margin.

Q21 Rachael Maskell: Can I also question you about what you said about managing price? Many clinicians say that at the moment the tariff is too low, and I assume with managing price you are talking about setting a framework for four years. If it is too low now, making further efficiency savings surely is going to challenge clinical services, skill mix and clinical outcomes ultimately as a result.

Simon Stevens: Price is the sort of thing that Pat Carter talked about in his report, where he shows up to £5 billion efficiency opportunity available through better procurement and

harnessing the collective purchasing power of the national health service. Right now you have different hospitals paying, in one instance, £1,000 for a plastic or metal hip replacement—the prosthetic—and you have a hospital paying £1,800. You have somewhere between a 50% to 75% variation in what hospitals are paying for implantable cardiac defibrillators because we have left it to individual bits of the health service to plough their own furrows. We cannot afford to do that any more.

Q22 Rachael Maskell: Can I come on to your issue of productivity? When staff have had a real-term pay cut of 15%, how do we expect productivity when that is the biggest expenditure to increase?

Simon Stevens: We are going to need, and I think we will if we have at least £8 billion of service expansion over the course of the next five years, more staff working in primary care, and more staff in the health service as a whole, as indeed we have now compared with five years ago. We want to recruit and retain the staff that we are going to need over this next period, and particularly when it comes to nursing, as I say, we have to convert a lot of the temporary agency staffing into permanent positions.

Q23 Rachael Maskell: You are addressing this partly through skill mix as well, so down-banding is something we can continue to expect to see, which is quite widespread now.

Simon Stevens: No, I think we are going to see continued expansion of all grades of staff, but Jane may want to talk about nursing specifically.

Jane Cummings: I can. Simon has pointed out that we have to move the number of people currently working for an agency into permanent staff. Part of that is about the way in which we manage staffing and how we provide flexible opportunities. A lot of people choose to work for an agency because it gives them the opportunity to work flexibly, so we want to be able to do that and to shift people back. We also know that by looking at the whole work force, not just looking at one particular profession but at how the whole work force can combine and work together, you often get better outcomes and better service delivery. That is what a lot of front-line professionals want. They want to be able to work in good teams where they feel supported and empowered. Over the last three years we have spent quite a lot of time looking at things such as how to improve culture, how to measure that. We have launched the cultural barometer. We also have very good evidence from Professor Michael West about how having well-structured teams leads to better outcomes, and that in itself leads to better productivity and a shorter length of stay, and so on. There is a lot of work we are doing around that.

Health Education England have also increased the number of training commissions for all staff, particularly for nursing staff. The vast majority of those increases are in acute adult care but also to a smaller degree in mental health, learning disability and children's nursing. Their prediction is that, by around 2019, approximately 23,000 additional nurses will be available for the NHS and the health and social care system, which is a significant factor and one that is very welcome. That takes into account things like retirements and turnover. If organisations, wherever they work, whether in community or in hospital, are able to provide the environment which means people want to stay, reducing turnover and improving the health and wellbeing of staff has a significant impact, and that is one of the

key things we need to focus on. It is not just about bringing more in; it is about making sure that the staff we have are treated well, are supported and are able to have a good work experience. We know that that means they want to stay and not leave.

Q24 Rachael Maskell: Mr Stevens, I have two further questions for you. One is on the commissioning environment we are now in. How much is the internal and external market now costing the NHS?

Simon Stevens: I believe the Department of Health are going to be releasing the data today, as they are required to do, showing what has happened to the cost of running the overheads of the national health service, and they will show that they have fallen by about £7 billion cumulatively since 2010. The overall costs, the administrative costs of running the commissioning system, the oversight of the national health service, have fallen from around 5 pence on the pound to around 3 pence on the pound, so I suspect we are now probably the leanest when it comes to the management costs of any industrialised country.

Q25 Rachael Maskell: We have seen some rather large contracts being put out for tender of late—section 75 regulations and things like North Staffordshire CCG; that whole bidding process—costing over £1 million. Is that really a good use of public resource?

Simon Stevens: CCGs, as you know, control two thirds of the commissioning responsibilities, the funding in the national health service—groups of local GPs and other clinicians—and obviously the test that they apply is what will be the best way of improving services in their local area. That is a judgment that they make, and the degree to which there has been the kind of processes you describe is rather lower than people probably predicted a couple of years ago.

Q26 Rachael Maskell: We are only at the start of this journey, and one of the things we have learned from so many of these processes now is that clinicians who have the skill and understand the service could have made that decision without the spend being put on those contracts. How are you planning to review to ensure that this is not draining money from front-line services and being, I would say, wasted—one of your efficiency savings, perhaps?

Simon Stevens: Through the autumn we are going to be giving people the chance to chart the direction that they think the health service in their area should be taking over the next three to five years, and we are putting on the table some new options that in some cases dissolve the distinction between the commissioners and the providers. In some parts of the country, as part of our new so-called vanguard programme, hospitals and community health services are coming together as an integrated organisation serving the total needs of the people in their area. In other parts of the country it will be groups of primary care, social services and community nurses who will come together and take that population responsibility. We are not fixated on the idea that there has to be a single approach here. We are responsive to the kinds of choices that people want to apply locally.

Q27 Rachael Maskell: That is moving beyond the section 75 regulations of the Health and Social Care Act.

Simon Stevens: It is certainly not hidebound to an interpretation of what they might mean and that, in fact, the statute does not require.

Q28 Rachael Maskell: I think it says in regulation 5 “unless there is no other provider to be found”.

Simon Stevens: You will see from the approaches that are being taken in different parts of the country, including our integrated care vanguards, that people are finding flexible ways of ensuring that the integrated care we need is what we bring about.

Rachael Maskell: I have another question on that theme.

Chair: One more.

Q29 Rachael Maskell: I want to ask about PFI, because clearly we have a huge deficit around PFI. While you are talking about pooling opportunities to bring greater efficiency, how could you see that working with the PFI environment?

Simon Stevens: Where the opportunity presents itself to change those PFIs, as has happened in one or two parts of the country, that is an opportunity that will be looked at hard by the Department of Health, but where it would not be value for money to do so, obviously we have to work with the set-up that we have.

Q30 Rachael Maskell: Would you say there are opportunities now for nationalising that debt, to pull it into the centre, and perhaps to be able to renegotiate some of those contracts?

Simon Stevens: All I am doing is pointing out that in one or two parts of the country, thinking, for example, of Hexham in Northumberland, they have taken a look at that. Where it would be value for money for the taxpayer to do so, there is no impediment to equivalent arrangements. However, I think—this is obviously a matter for the Department of Health rather than for NHS England—the assessment is that at the moment there are not many places that would fall into the equivalent category of Hexham, but I am sure it should be looked at with an open mind.

Chair: Philippa, you had a supplementary before we move on.

Q31 Dr Whitford: My understanding is that the predicted figure for deficit at the end of the current financial year is over £2 billion, which means that we are accelerating into debt—and, obviously, over the last few years the number of trusts. Have the savings that have been made in the last five years not predominantly been based on the freeze in staff pay? As to replacements, I know from working in trusts that, when money is tight and someone leaves, gaps are left, which puts a lot of strain on the staff. You are describing bringing a lot

of extra people in, yet I find it hard to see how you will be in a position to do that when you are trying to save so much money.

Simon Stevens: Yes. Despite the difficult circumstances that you describe, obviously there are now more professionally qualified clinicians in the health service than there were five years ago and we think that there will be more in five years' time than there are now, which is not a surprise when you think about the fact that we are going to be treating more people, and providing a wider range of services with at least £8 billion more of investment to support that. But your underlying point is entirely right, which is that there is a huge job of work to be done this year to manage back down the forecast deficit in providers that was being contemplated at the start of the financial year. That is a responsibility that in statute sits with Monitor and the Trust Development Authority, who are coming together under the rubric of NHS Improvement. The legal accountability for the operational and financial oversight of NHS trusts and foundation trusts sits with Monitor and TDA, but the £2 billion number that you talked about was prior to action being taken on temporary staffing. Some estimates suggest £400 million—I think the Department of Health has put a goal of at least £400 million—of cost take-out from that this year, with further action to reduce the spend on management consultancy, which was running at about £580 million across the health service last year; and further investments in hospitals that CCGs have made as a result of upping their funding for both emergency and elective care this year, anticipating emergency care growth of about 2.3% and elective care growth of 2.7%. That is also subsequent to the original estimates. Monitor and TDA are now in the process of going back and scrutinising the plans of individual providers and agreeing with them what their year-end out-turn position should be.

Q32 Chair: Part of the question was how much of the saving—the £19 billion that you referred to—was through pay restraint and how much you anticipate that to be over this Parliament.

Simon Stevens: The estimates of the pay piece obviously have changed a bit since the Budget announcement on public sector pay restraint across the board. That has increased the share of savings likely to come from that source. But it is still going to be far and away the minority of the efficiency savings that we have to generate over the course of the next four and a half years.

Q33 Chair: This Committee repeatedly commented in the last Parliament that a very substantial part of the efficiency gain had come from pay restraint. Have you arrived at a figure of how much that was in the long run in the last Parliament?

Simon Stevens: Yes. The Department of Health have, and I cannot remember it; but it was not the majority of the £19 billion. I think that, plus other constraints on tariff increases and so on combined, represented about 80% of the saving, so perhaps about 40% was pay restraint, but I might be wrong on that.

Q34 Chair: 40%.

Simon Stevens: It might be. I need to get back to you, Sarah, on what the actual figure was. Does that ring a bell, Bruce?

Professor Sir Bruce Keogh: I think it was somewhat less than that, Simon.

Simon Stevens: Okay. There we are—the blind leading the blind.

Chair: We will go back to this. Liz, can I ask you to come in next?

Q35 Liz McInnes: Thank you. You have touched on the issue of smaller hospitals and mentioned that they tend to face more financial pressures than the larger hospitals, but what is your view on the sustainability of our smaller hospitals and community hospitals? How do you see their future?

Simon Stevens: I have a slightly contrarian view on this, which is that I do not think the right answer for England is to end up with 15 hospitals that everybody has to travel miles to get to, and then some kind of very local GP services. I think that district general hospitals, suitably networked with primary care and tertiary centres, have a sustainable and important future. You can see that that is what the most forward-thinking district general hospitals are doing. For example, I was visiting Wigan infirmary last week, and their cancer services are provided by the Christie hospital at Wigan together with support from Macmillan. If you go to Kent and you look at the hospital in Dartford and Gravesham, Darent Valley, again they have Moorfields providing some of the eye services and a close relationship with their GPs. You can sustain smaller hospitals, as long as they are part of integrated networks. Obviously quite a lot of the pressure is around the way urgent and emergency care services work, so for some of those services, emergency surgery, you may need more concentration. Greater Manchester have just decided, on 15 July, to do that, as you know, concentrating emergency surgery services in four sites, but networked to the other local hospitals across the 2.8 million people they serve. Bruce's urgent and emergency care review is looking at how to get those networks right.

Professor Sir Bruce Keogh: Can I say one other thing about smaller hospitals? We have to be very careful that we do not undermine them, because the way that medicine progresses is that what is specialist one decade is ubiquitous the next. We have seen that with pacemakers, with angioplasty and with a whole bunch of things. There are many reasons to believe that there is a lot of stuff that we think is specialist now which, in relatively short order, will be very safely and effectively introduced in smaller hospitals. That is an important part of the network, so that it keeps innovation going in the bigger places and rolling it out to people closer to their own homes.

Simon Stevens: On the subject of Wigan, of course, Wigan is part of Wrightington, Wigan and Leigh trust, and Wrightington hospital was where Charnley invented the hip replacement. The proud history of innovation in the national health service—for the world—often comes out of places like that as well.

Q36 Liz McInnes: I am also concerned about the number of trusts that are running a deficit that are never going to achieve foundation trust status. I believe there are 93 trusts that fit into that category. You mentioned the Greater Manchester “Healthier Together” programme, and there are hospital trusts in that programme that are not foundation trusts. I

am concerned about the future of those trusts. How do you envisage them operating in partnership with foundation trusts?

Simon Stevens: Increasingly, for many providers the foundation trust/NHS trust distinction is a distinction without a difference, and, frankly, lying behind that, exactly as you say, is that the kinds of tests that were being set by Monitor for becoming an FT are unlikely to be met by some of those institutions despite the fact that we are going to continue to need them to provide valued and important local services. One of the tasks for the newly paired Monitor and TDA will be to answer the exam question you have just set, which is, “Let’s not kid ourselves that, for some of these institutions, they are on a path to FT status, because they’re not, but we need them, so what is the right way of recognising their governance and ensuring that in concert with other parts of the health service locally they have a future that works?” We have to stop pretending that everybody is going to meet the current set of FT tests, and instead just get real about the circumstances facing different parts of the country.

Q37 Liz McInnes: How do you propose to get real about them?

Simon Stevens: As I say, that is a task that the combined Monitor and TDA board will have to address, but, increasingly, we are saying that the future of high-quality health care is not just individual institutions: it is health care systems; it is health communities; it is more networked arrangements; it is people thinking beyond the boundaries of their own hospital. That applies both for people who are doing really well and also in parts of the country that have been struggling for a very long period of time. Often what shows up as a problem in the hospital is a consequence of more deep-seated pressures across social care, community health services, primary care funding flows, so rather than just doing a series of inspections and governance interventions for individual institutions you have to look at the total health economy.

Q38 Liz McInnes: Will you be investing more in social care?

Simon Stevens: It depends who the royal we is addressed to, because for NHS England, thanks to yourselves and your colleagues, Parliament votes us a sum that we have to spend, the principal purpose of which is for the national health service, but there are opportunities under legislation dating back to at least 2006 to pool budgets with social care, and that has happened to the tune of over £5 billion for the year we are currently in. Some parts of the country are wanting to go further and pool most, if not all, of their health and social care spending, and obviously the Devo Manc proposition is the most substantial version of that, but I do not think that will be the universal model for England, no. I think, alongside the health service playing its part, we also need to ensure that people are well aware of the consequences for changes in social care funding in terms of the impact that then has on the health service.

Liz McInnes: Thank you.

Q39 Maggie Throup: Mr Stevens, are there any plans to introduce the success regime to further health economies?

Simon Stevens: In time, yes, but first of all we need to demonstrate some success in our current three success regimes.

Q40 Maggie Throup: What do you base that on?

Simon Stevens: This actually picks up from the conversation we were just having, in a way. As you know, the proposition in the first three areas, which are Essex, North Cumbria and North, East and West Devon, is that there are parts of the country that are systematically, because of finance, performance or service configuration, out of balance. They have deep-seated, long-standing problems, and just poking and prodding individual institutions, sending in teams of management consultants, has clearly not worked to produce a sustainable future. This is a test of a new way of working, if you like, between local leaders and the various parts of the national health service nationally to see whether by taking a more expansive view of the kinds of changes that might be required we can get a better result than just the institution-specific intervention regimes that have occurred hitherto. The honest answer is that we need to take this model out for a drive and demonstrate some impact in the first three places we have identified before going further.

Q41 Maggie Throup: Do you think the success regimes are an important part of the ongoing implementation of the five-year plan?

Simon Stevens: Yes. The underlying thought is that, often in parts of the country where there are these difficulties, it is not just that you have—in many cases you haven't even got—people who are doing difficult jobs and doing them well under trying circumstances, and you are just constantly rotating new chief executives in and out. But if that was going to have worked it would have worked by now, so it has to be a different recipe and that is, at one end of the spectrum, part of what we have to do through the forward view. At the other end of the spectrum we are also letting those parts of the country that are doing well but can see they want to do even better chart their course for improvement. We have done that with the first 29 vanguards. We are going to announce this week the first set of urgent and emergency care vanguards that will redesign their primary urgent care, 111, out of hours, their seven-day urgent care services and hospital services, in seven parts of the country, which we will be announcing on Thursday, I think. The selection process is just wrapping up now. Yes, the notion of horses for courses backed by support that local leaders themselves can help to influence is part of our model of change over the next five years.

Q42 Maggie Throup: Do you think it is going to lead to radical reconfiguration at the local level?

Simon Stevens: Reconfiguration sometimes is a dirty word, so we have to have an open mind about what that will look like, but let us all be clear: in the three places we have identified to start with, the status quo is not working.

Q43 Maggie Throup: You keep mentioning vanguard sites and have brought that into those answers. Are all the 29 vanguard sites moving forward at the rate you would want them to?

Simon Stevens: Yes. Hey, they've only been going since the end of March. I know the weight of expectation is bearing down upon them, but it is reasonable to allow them to tool up. Certainly the vanguard events that I have been at are high energy, but not just pie in the sky. They also have some quite practical things. How do you get information sharing right between different parts of primary care and the hospital services? How do you think about the new work force models that are going to be required? How do you move money around while sustaining the parts of the service that you need to? People are having all the right conversations, I would say, and we are trying to make it very easy for them to bang the drum with us nationally about crazy things they see they want to get changed. There are six national NHS leadership bodies involved—now seven with NICE—so we have given the 29 my mobile phone number and that of the other chief executives and said, “When you come across something really crazy, give us a call.” If my phone goes off during the course of this morning’s hearing, you will know what it is.

Q44 Maggie Throup: I say that because there were quite a few different projects a couple of years ago, with regard to the Prime Minister’s challenge fund, and some of them took quite a long while to get off the ground and we missed opportunities, so I think it is important that we learn from that.

Simon Stevens: As to the Prime Minister’s challenge fund, I would perhaps have a slightly different take, which is that we now have 18 million people covered by the programmes that are going in the Prime Minister’s challenge fund and they have been remarkably successful, not just in terms of providing more evening and weekend access to GP services but also in getting practices to come together and to think in different ways about how to strengthen primary care in their area. It has been hugely catalytic as well as service expanding.

Q45 Maggie Throup: What do the vanguard sites have to achieve in order to demonstrate that the new systems are viable and therefore should be implemented across England?

Simon Stevens: They are expected to do two things. One is obviously to chart a course in their own areas, and they come in different flavours. If you are in Harrogate, that is the Harrogate hospital and the community health services working together. If you are in west Birmingham, that is a large group of GPs coming together with the community health services. If you are in Gateshead, it is the GPs and the community nurses doing in-reach into care homes and, as a result, since they happen to be one of the people who have my mobile phone number, they were telling me that they have something like 1,500 care home beds across Gateshead and South Tyneside. The work they are doing has led to a 14.5% reduction in emergency admissions for people from care homes into hospitals. Again, if you connect that with the discussion we were having right at the start around what it would mean to do the demand management, understood as moderating the rate of growth in emergency admissions, it is things like that. We have a huge opportunity to provide stronger support in care homes right across England, given all the pressures that are

showing up in the care sector, and that will in turn have an impact on emergency inflows. The first thing they have to do is deliver on the proposition they set out for their local areas, but the second thing they have to do is produce generalisable insights that other parts of the health service can then beg, borrow and steal.

Q46 Maggie Throup: It is not just about processes but also about patients, so what will you do to incorporate the patient experience and patient outcomes into deciding the success of the vanguard sites?

Simon Stevens: Our big proposition, if you like, at the heart of the forward view is that, as you know, there are three fragmentations that have been hardwired into the way health and care have been set up in this country since 1948: one between primary and hospital specialist services; the second between physical and mental health services; and the third between health and social care. The right way of answering the question “Are we getting the triple integration we want in place of the triple fragmentation?” is ultimately from the patient’s point of view. We are working on a set of specific measures where patients themselves get to say, “Yes, the left hand knew what the right hand was doing; yes, my needs were taken seriously; and, yes, the carers involved in supporting me were being looked after.” Those are the means to the ends, but the ends are ultimately, “What does it feel like on the receiving end of care?”

Q47 Helen Whately: I have a question on the vanguards. You set out a range of objectives. What level of transparency will there be into the objectives of each of the vanguard sites, and how will progress against those objectives be published or communicated?

Simon Stevens: We are going to be publishing pretty shortly a sort of prospectus setting out the national support that the vanguards themselves have asked for, and they in turn will be setting out their stalls locally in terms of what they are aiming to deliver over the course of the next several years. Being frank about it, we have had a lively internal debate and a debate with the vanguards about exactly what is the right balance between setting some kind of national expectation for them versus letting them shape their own pacing and metrics. That goes to Sarah’s first question to me, the “What keeps you awake at night?” question; the second piece of it is the balance between national accountability versus letting people chart their own destiny. We could smother them: “Here are 900 indicators against which your fantastic success will or will not be judged”; or we could say, “You go through this process, develop your proposition and you tell us.” But, fundamentally, we know that they have to succeed on three broad thrusts: they have to demonstrate how they are helping the health and wellbeing, the care redesign and the efficiency challenge in their part of the health service. They have to do their part of the 22¹. They have to do their part on the lives that we want to save; they have to do their part of the care redesign for the triple integration.

¹ Mr Stevens intended to say: “they have to do their part of the £22 billion savings.”

Q48 Helen Whately: Their objectives are set at a high level nationally and then they will develop for themselves much more locally, and that will be something which will be made public, and then you will know.

Simon Stevens: Yes, absolutely.

Q49 Helen Whately: It will be clear to the public what they are trying to achieve, and how.

Simon Stevens: Yes. Part of their success, frankly, is going to be a different type of community engagement, because the health service is loved, treasured and trusted in every community across the country, with almost no exceptions, but sometimes the health service is not terribly good at systematically engaging with those communities on how it itself needs to change, so they know that part of what they are being judged against is how they change their terms of trade on that.

Chair: Thank you.

Q50 Dr Davies: I would like to talk about the voluntary sector and its role in today's NHS. I have spent some time as a clinical lead in my CCG and I know, on a local level, that we worked very closely with the Alzheimer's Society, for instance. What is your assessment as to the relationship between the voluntary sector and the NHS nationwide at present?

Simon Stevens: Jane, do you want to kick off?

Jane Cummings: I can answer that to some extent. I think it is increasing and improving. There is still more to do, but we have some very good examples of fantastic work that has been done hand in hand with the voluntary and charitable sector. For example, Age UK in Cornwall are doing some work with elderly people, where they are providing voluntary services to people who are vulnerable and are at risk, and they have had a significant impact on people's health and wellbeing, with a reduction in admissions to hospital, increasing discharge and so on. There are some really good examples there and that is now being replicated. There is work with areas like Macmillan. Through my patient experience team we have done some fantastic work with Macmillan around their experience measures. They have gone into providers to work with them to improve the experience of patients suffering with cancer or recovering from cancer. Again there are very strong links with the charitable sector and the voluntary sector. Subsequently, another good example of where we are working hand in hand is with learning disabilities, and our very large transformation programme of people with learning disability, as we improve the numbers of people who can be cared for in the community. We are doing that with a range of providers, some of them NHS, but also supported in many cases by voluntary sector organisations who are very innovative in some of the work they are doing. I can see that increasing. The key thing, or the important thing, for me—we have given you some of those examples—is what is the right thing for the patient. What is it that the patient needs, and then who is best able to provide that service? Very often the voluntary sector are able to do that in concert and supporting the NHS and other health and care social systems. It is a positive way forward.

Q51 Dr Davies: There are certainly examples of very good practice, but I know that there are views within the voluntary sector that they perhaps do not have the role that they had hoped for, in terms of commissioning, for instance, in local CCGs. How do you think that could be improved?

Simon Stevens: One way into that conversation is to look at the approach we have taken to developing the broad commissioning route maps for big health improvement for England over the next five years, of which cancer, mental health, learning disabilities and maternity would be four examples. When we were deciding how to set the goals and the direction for cancer, we did not decide, “We will just do this in NHS England, or NHS Public Health England and the other national bodies.” I invited Harpal Kumar, the chief executive of Cancer Research UK, together with Macmillan and a number of the other patient groups, to do it in a co-produced way. They produced a fantastic report that sets an evidence-based direction for cancer that can improve, or save, 30,000 lives, they estimate, by the end of the decade if we get it right. On mental health services, I have taken the same approach. I have asked Paul Farmer, the chief executive of Mind, to lead that for us. Obviously, it is one of the leading voluntary sector organisations in mental health services, so, in terms of the national commissioning strategic direction, we are absolutely doing that.

Q52 Dr Davies: On a local level, though, is there a danger that funding can be inflexible, so contracts can limit innovation and funding can be—

Simon Stevens: No danger of that whatsoever: there is complete flexibility and utter creativity in every turn. *[Laughter.]* No, there is indeed. One practical thing that we have done just recently, at the urging of National Voices, which is a great umbrella organisation for the voluntary sector, is to introduce a very stripped down flexible version of the national standard contract, because the national standard contract for getting things funded on the NHS is a bit of a phone directory to cover every eventuality, which, frankly, is not relevant if you are a small local voluntary organisation. We have worked with them on that stripped down voluntary sector contract. We are looking at greater use of grant-making powers rather than everything having to be on a commissioning cycle, and, as part of the work that is going on in different parts of the country on the vanguards, they have been specifically plugging into the huge asset that is represented by the voluntary sector in their area. I am not trying to pretend that everything is sweetness and light.

There are funding pressures right across the system, and that includes the support that the voluntary sector gets, but again I go back to my answer to Sarah’s first question. The third of the three things was that the health service needs to think beyond the narrowly drawn notion of the national health service itself, because we are heavily dependent on the broader support of the voluntary sector—3 million volunteers and 5.5 million carers, 1.4 million of whom are full-time, doing more than 50 hours a week unpaid as carers. Just because they are not part of the paid work force, it does not mean they are not part of the huge care support sector that the national health service and our families depend on.

Q53 Dr Davies: Clearly, it is recognised that they have an important role. It is also recognised that there are limits and challenges in the current set-up, but it is a case of CCGs and the voluntary sector being brought together. Do you have any strategies in place to get

them talking, essentially, and to increase the role of the voluntary sector further, to encourage the dialogue?

Simon Stevens: In addition to what we have just been talking about, the main goals that NHS England have set for ourselves and for CCGs on the back of the mandate that the Government have given us for this year obviously relate to mental health services, learning disability services, cancer services, maternity and others underpinning that—urgent and emergency care, primary care and so forth. For all of those, the reason we have co-produced with the voluntary sector a national set of strategies is so that at local level the local Macmillan group, the local Mind group, Rethink and YoungMinds will then also engage. We want to reproduce the shared conversation we have been having nationally in every part of the country.

Dr Davies: Thank you.

Q54 Chair: Can I take that a little further? In our last inquiry on children and adolescent mental health services, the evidence we heard from the voluntary sector was that they were just limping from one tiny grant to another, and that the minute they were established they were no longer able to access many of those grants because they were told they should be commissioned. The new services were assessing funding, but the existing established services actually providing a valuable role in their local community were running out of funding. We see this picture continuing. In fact, one of the groups you visited down in Dartmouth—a mental health charity, Cool Recovery—has had to close for that reason. Although the intention is there to support them, in practice we know that around the country they are struggling. One of the points they raised was the need for more stable, longer-term funding. Is that something you envisage being added to the list? You mentioned the stripped-down contracts and the greater use of grant funding powers. What can we do in reality to stop the closure of these charities? Can you go further than that?

Simon Stevens: I would like to see, as I said earlier, a three or four-year funding settlement for the national health service, which then would mean that the CCGs themselves would know what they had to invest over that period of time and hopefully could then share some of that certainty with those voluntary sector partners. Right now, of course, they are on an annual funding cycle, so they themselves are subject to some of the same uncertainties that get reproduced in their relationships with the voluntary sector. Having said that, I do not think it entirely excuses the situation, because the reality is that funding is going to be increasing, so people know at least what their baseline level of spending is. We are not proposing, even in the interests of redistributing funding between different parts of country, that people should get cash reductions. It is just about the rate of increase. People have more certainty than they might in other sectors, but nevertheless there are, year on year, pressures that get piled on to that.

Q55 Chair: Is there a message that you would like to send commissioners about the voluntary sector today?

Simon Stevens: The message I think is clear, which is that it may not be highly visible but it is highly impactful in terms of the benefits it provides, not only for the residents of your local CCG but also for the well functioning of your local health service. If you want to get serious about demand moderation and the rate of growth of services showing up in

expensive parts of the health care system, do not forget about all the good work that is being done, and in fact more that can be done, by those other parts of your local community.

Chair: Thank you.

Q56 Dr Whitford: How do you see the integration of health and social care going? We are talking about it right across the United Kingdom, and we see it as the solution to everything, but what is your vision of what it would actually look like?

Simon Stevens: I believe we are going to have a mixed model, which is appropriate for the circumstances. In some places you will have health and social care full-budget blending of the sort that the 10 local authorities in Greater Manchester are contemplating. Sheffield is an area where the health service and the social care services have been in that sort of conversation. But you will have other parts of the country where that is not something that either the local authorities or the health service want to contemplate just yet. Certainly talking last week to groups of health service leaders and local authorities across the west midlands, that was not at the top of their agenda for the way they want to move forward right now. That is a model but it is not the universal model, I do not believe, for England. A separate model will be where, through our integrated hospital and community services in the vanguards, you may take in some of the social care provision but not necessarily the funding. A third model will be in places where for individuals with high needs and high costs—particularly people with learning disabilities, severe injury, mental health problems, and children with complex needs—the experience from social care is that actually more person-directed care, personal budgets and blended health and social care budgets for individuals can make a huge difference to the services they get and the efficiency of care. A number of local authorities and parts of the NHS are testing that model this year.

In terms of integration, some of it will be full-budget blending, some will be at the level of the place, some will be at the level of the individual and some will be with providers blending work forces, but with separate funding streams that they bring together. It is reasonable that we take an evolutionary path. However, under any circumstances, what we need over the next five years is mutual aid between the health service and social care. We talked a moment ago about the role that the health service can play in helping to keep people in care homes out of avoidable hospital admissions. Likewise there is sometimes more that the health service can do when, particularly, frail older people are discharged from hospital to give them the rehab and home support they need, such that they do not then automatically get assessed as needing to go into a care home if they could have been supported further in their own home, which is what most people want. For some people care homes would be entirely appropriate and it is their rightful choice, but for probably too many there is an absence of that kind of rehab. That will in turn help local authorities and some of the funding pressures they are facing. Horses for courses.

Q57 Dr Whitford: Isn't that interface the problem if you do not go for a more integrated model? What we have had throughout my career in the NHS is, "They're in a bed, so at the moment they're not an issue," and "We need them out of the bed, so we want to

make them your issue,” which inevitably means, “My purse or your purse?” Isn’t actually combining the budget so that at least that barrier disappears quite an important part of it?

Simon Stevens: It could be. Let us test the proposition. As I say, we have, what, £5.5 billion of budget blending at the margin now on the back of the Better Care Fund happening across England this year. We want to evaluate the impact that has on the kind of things that you describe, but the reality is that simply putting together two budget blocks does not create person-based integrated care, and there are risks, at a time of substantial funding pressures, on both sides of the equation.

Q58 Dr Whitford: Yes, I certainly agree that just putting budgets together with no other effort would not achieve anything. Is there not quite a big danger in that the NHS is hopefully going to be given an increased budget but local authorities are likely to face diminishing budgets, and that in actual fact NHS money will just haemorrhage out of the back door?

Simon Stevens: I have said right from the get-go—on the first day I took up post in April 2014—“Let’s not kid ourselves. Just combining two leaky buckets does not produce a watertight funding solution for health and care in this country.” The quantum matters as well as the combination.

Q59 Dr Whitford: Obviously you were talking about the high users, the 5% of people who use 40% of the service, but does there not need to be a contract so that the ordinary patient, the ordinary person getting older, or the family of that person, has some idea of what will be available in their local area to support them? Obviously in Scotland we have free personal care, which is helping to keep more people at home, but if it is totally different in one place from another, do we not go back to a postcode provision if everyone is just doing their own thing?

Simon Stevens: There has been standardisation of the eligibility criteria for access to social care in England. Obviously, there is an argument about, “If money were no object, would one want to set it at a different level?”, but nevertheless there is now going to be more consistency than there has been.

Q60 Dr Whitford: Okay. What about the University of York report? It suggests that putting all our eggs in health and social care will make great savings for the NHS, but obviously they feel that that may not be realised, in that you may just find unmet need, which is a good thing in itself for those patients, but we are pegging a lot on this solving financial problems,

Simon Stevens: We are pegging some share of a quarter of the efficiency challenge, as I described earlier in terms of the buckets that we are talking about, and I think they make an important point that, if you just expand services in an undifferentiated way, what you describe might be a good thing, but it will not at the margin make a difference to the person who would otherwise have been the person who was admitted to hospital for emergency admission. The way you are able to identify prospectively who are the people who will most benefit from this targeted alternative investment and make sure that they get it is obviously crucial. Many of the studies that previously have been implemented did

not have that kind of approach embedded in population or in primary care, so you do not necessarily get the effect. Just to argue the point momentarily, imagine the alternative: if we really do not believe that there is any connection between primary, community and social care services and what then happens in other parts of the system, are we telling ourselves that if we were to dispense with general practice in this country and dispense with community health services and social care that there would be no extra demand flowing into hospitals? I do not believe that at all. It is pretty obvious that one consequence of having expanded, for example, hospital consultants three times faster than GPs over the last decade or more is that we have the kind of rates of increase that we have seen.

Q61 Dr Whitford: I do not think I would remotely be suggesting that, or my husband would hit me over the head, as he is a GP. One question, as a Scottish MP and having worked in the NHS in Scotland for over 30 years, is that we have four different services and, therefore, four laboratories all trying to face the same challenge. What connections or explorations have you had of what is happening in the other devolved nations, to look at what they are doing—share what you are doing or nick what they are doing?

Simon Stevens: Yes, obviously, there are those kinds of points of learning and connection at many different levels. Bruce and Jane may want to talk about other professional connections. Scotland was one of the first of the four countries to do important work on their clinical outcomes measurement. There has been a strong tradition of public health leadership in places like the Greater Glasgow Health Board, as was, so, yes, there are some very good things. On the other hand—not so much in Scotland—if you look at, say, Northern Ireland, a lot of commentators say that model demonstrates that the mere combination of health and social care under a single administrative entity does not by itself produce the kind of pay-off that we would otherwise want to see. In every part of the UK you can find really interesting things that we should be learning from.

Q62 Dr Whitford: I just wondered whether you had any actual connections, collaboration or forum within which you get to meet people from those other authorities.

Jane Cummings: Yes, we do. I have very strong close relationships with the CNO in Scotland; in fact, I was on the interview panel that appointed her. We work very closely as a group of CNOs for the four countries and often have joint pieces of work. For example, Scotland led on a piece of work looking at nursing for learning disability, which led on behalf of the other three countries, and we learned from that. Jason Leitch does huge amounts of work around patient safety and health improvement and is very actively involved with the director of patient safety and the work we do overall on safety, and a lot of learning goes on between the two countries. Dr Catherine Calderwood—who of course is the CMO in Scotland—sits on our independent maternity review, predominantly to be able to provide a link with the review of maternity services that is going on in Scotland. There are quite a lot of examples; in fact I was up in Edinburgh a couple of weeks ago discussing different work and how we can learn from each other. It is very active from my point of view.

Professor Sir Bruce Keogh: The issues in medicine, as opposed to nursing, are similar. Part of our work is done specifically with the colleges and specialist associations, who do

not recognise the national boundaries that you describe because they work across them. We get quite lot of distilled information as a consequence. I also have a group of regional medical directors, and the medical director for Wales joins us for that. Our national clinical director, who worked in maternity, has, as you know, recently been appointed chief medical officer and medical director in Scotland. Now that there is a medical director in Scotland we propose to keep that relationship a bit closer. To be honest, the relationships with Northern Ireland at medical level have not been very close.

Dr Whitford: Thank you.

Chair: We are going to change themes now and come on to prevention. Would you start on that, Rachael?

Q63 Rachael Maskell: Is public health the poor relative of the NHS at the moment?

Simon Stevens: I hope not. It certainly needs not to be over the next five years because health care is what happens when we do not have health, and since we want to give maximum opportunities for wellbeing for everybody in England—and indeed Scotland, but that is the cross-border effect—we have to get very serious about prevention. We have to get serious about tackling the major health risks that face us as a population, and that means a more assertive posture on tobacco, alcohol, junk food, sugary drinks and many of the other things that are causing avoidable type 2 diabetes, cardiovascular disease, cancer and a whole host of conditions that we could well do without.

Q64 Rachael Maskell: How will the 7.4% cut the Chancellor announced impact on that plan, to ensure that it is not left behind?

Simon Stevens: I do not think we want more of that kind of approach, going forward.

Q65 Rachael Maskell: I want to ask about the organisations providing public health. We have the NHS, Public Health England and we have local authorities. We have, essentially, three bodies providing a service around prevention. What are your thoughts about whether this is the most effective way of delivering a public health strategy?

Simon Stevens: Anybody who thinks long and hard about public health, as you do, knows that it requires multisectoral action by a whole host of stakeholders. The idea that any one body could somehow do it all misses the point of what is the prevention agenda. Inevitably we want schools, employers, local authorities in respect of their licensing powers, technical experts in infectious disease and tuberculosis and GPs in their role in respect of secondary prevention all to be involved—all of those groups. As a consequence, it means that, yes, we have a leadership role for local authorities and for the public health experts in PHE; and the NHS, I believe, has a huge role there as well. That is the consequence that you describe.

Q66 Rachael Maskell: When the ring fence comes off the local authority budgets—I think of my own local authority’s 46% cuts in the last five years—is it a reality that the benefits of being integrated into local authorities will be realised?

Simon Stevens: Time will tell. I hope so. That is certainly the message I sought to give the Local Government Association when I spoke at their annual meeting a few weeks ago. I think the LGA have—I do not want to put words in their mouth—been arguing against the idea of a continuing ring fence, but they have to demonstrate that they are able to use that investment to generate health improvement in a way that would not have been the case had it been more narrowly siloed. That is the test.

Q67 Rachael Maskell: The separation, though, between public health, which is obviously part of the long-term plan around cutting costs in the NHS, and the local authority priorities such as they are at the moment, which is about trying to keep some essential services on the go, surely is a conflicting agenda, in the sense that they are the ones that could impact on your ultimate aims. However, you have no control over that agenda.

Simon Stevens: The point of local authorities’ leadership role here is that, of course, they have the ability through their democratic accountability to do things that a nationally accountable NHS cannot. You see progressive local authorities—I am thinking now of people like St Helens on Merseyside, or some of the London authorities—using their powers to prevent new junk food or fried chicken joints opening up next to schools and so on; that is something they can do through their regulatory powers. That is not something that the NHS itself could do. When I look at the example of places like the Manchester Health Academy, an academy school chartered by the Central Manchester healthcare trust, together with Manchester city council and the Manchester United football foundation, those are the kinds of partnerships that you only get when local authorities are in the mix. There is potential there, but there is risk.

Q68 Rachael Maskell: If you read into Marmot, he very much talks about moving as far upstream as you possibly can on the public health agenda, yet the average child in the country gets 12 minutes a year school nursing, and that is around child protection, health prevention and the whole agenda there. How can that be when we see services in a local authority so minimised in providing such a crucial service to ensure that the life chances of children change?

Simon Stevens: Jane might want to talk specifically about school nursing. Schools are an important place where we can do better for our children, but there is a whole range of other things we have to change as well. Many of you will have clocked the discussion that has been going on over the last week or so after the advice from the expert group on nutrition about the need to reduce the amount of added sugars that our kids are getting. Some of that is schools, some of that is us as parents, and some of it is the food industry. Again, we are going to have to take multisectoral action. You cannot just put the responsibility for that on school nurses, not that you are trying to. It is not just about what individual health professionals can do. It is broader action and we have to mobilise support for that.

Q69 Emily Thornberry: Isn't part of the problem with local authorities, when they are so strapped for cash and they are democratically accountable, that public health—if they did nothing—is not measurable? That is the point. The temptation is to spend the money on things that the public can see, so you might get one local authority that does nothing right next door to one that does a lot. How are they ever accountable for that and how do we measure the lack of success? Isn't this the problem?

Simon Stevens: I am not going to be Panglossian about it. Those are indeed the risks, and the judgment that has been taken is that those risks are nevertheless outweighed by the potential benefits of local authorities being able to deploy the full tools that they distinctively have at their disposal to improve the health of their local populations. How the net effect of the risk and the opportunity plays out, we will have to see. I am not going to sit here and say I think it is a one-way bet.

Q70 Rachael Maskell: There is often a focus on children, despite what I have just said, but obviously we know that there is growing health inequality built on the back of economic inequality, and certainly we can expect to see that continue to grow. Therefore, how are we tackling the issue of adults and their health needs on a preventive basis?

Simon Stevens: Your point particularly is about economic participation, wellbeing and joblessness. One of the most encouraging sets of conversations that I and colleagues have been having with some local authorities around the country is with those who want to get serious about connecting the impact that they can have on their local economies and communities with the impact that the health service and the national Government can have. One area where this plays out very clearly is in respect of mental health. We can see that underinvestment and lack of availability of upstream mental health services often then in turn mean that people end up out of work, staying out of work and, as a result, needing national benefits. If that money instead had been available for progressive mental health services, you could have had a triple win—for the person, the taxpayer and for the availability of the local national health service as well. One thing that the mental health taskforce under Paul Farmer's direction is going to look at is whether there is an opportunity with local authorities to change the way that that will work—getting people into jobs and producing better health on the back of it.

Q71 Rachael Maskell: I would like to ask a final question of Sir Bruce. Later this year we are expecting an obesity strategy, and we know some of the impact that early prevention could have on preventing cardiovascular disease later in life. What kinds of things would you like to see in that obesity strategy?

Professor Sir Bruce Keogh: From our point of view the obesity strategy needs to span a number of Government Departments. It needs to start with education, which is very powerful because it gets to the kids, who in turn get to their parents and to their siblings. It needs to start also with consideration of the sorts of things that Simon has already alluded to with respect to sugar and other additives, which relate to the formulation of some commercially available products in our supermarkets. Finally, it needs to relate to issues about transport and exercise.

Q72 Chair: Mr Stevens, you were tactful in your opening remark to Rachael when you said it was an example of the approach that you did not want to see going forward. When the cut of £200 million was announced back in June, it was described as non-NHS spending. Do you agree with that appraisal, or do you think this is very much part of the front line of the NHS?

Simon Stevens: It is non-NHS spending in the sense that it was sitting, as I understand it, as a reserve in local authorities' books rather than running through the NHS England expenditure limits for which we are accountable.

Q73 Chair: But where do you see the role of public health as central to achieving what you need to achieve from the Five Year Forward View?

Simon Stevens: It is central. In terms of the money, the impact of a more co-ordinated and assertive posture on prevention will be felt towards the back end of the period and, frankly, opening up even further, subsequent to this next five years. Nevertheless, it is clearly the right thing to do. The question is how much of it is about funding individual clinical preventive services. Some of it is. How much of it is about creating new models of prevention? The work we are doing on diabetes prevention with Diabetes UK is an example of that. Some of it, though, is about changing the way in which we tackle things like smoking rates. The fact is that we still have 8 million smokers in this country, and although the smoking rate has been coming down, half of the class-based life expectancy difference in this country is explained by different smoking rates, so it is no surprise that the work of the cancer taskforce on Sunday pointed to the need to see continuing substantial reductions in the smoking rate from north of 18%. If current trends continue, that would be at about 15% by the end of the decade. They talked about wanting to get it to 13%, and an ambition to try to get substantially below even that. These are big health risk factors with huge consequences for avoidable illness and early death, and therefore we need to take an all-of-the-above approach to tackling them.

Q74 Chair: Do you think that taking £200 million out of the public health budget will impact on front-line services? It is not just about long-term prevention; it is about other areas of current provision that we think of as NHS services, be that preventing teenage pregnancies, sexual health clinics, obesity services and all those things. What impact do you think that £200 million will have on those kinds of services?

Simon Stevens: It is too early to say, because local authorities are still working through what the consequences will be for those services, but, as I say, going forward, that would not be a smart approach across the rest of the portfolio.

Chair: Right. Paula, would you like to take your section next?

Q75 Paula Sherriff: Yes, thank you very much. You alluded quite extensively to agency costs. From my own experience of working in a hospital, agency costs increased significantly over the period alluded to in the report. What research has been done into why so many nurses were leaving? I think there was a 29% increase in the rate of, particularly, nurses leaving the profession between 2011 and 2013 approximately. What engagement has

taken place, because surely staff retention is one of the crucial factors in terms of using agency staff?

Simon Stevens: Definitely.

Jane Cummings: NHS and the TDA in particular have done quite a lot of work with their providers, and I have spent considerable time with provider directors of nursing during the various visits that I do round the country, which are quite extensive. I think there is a range of reasons. Some of it, as I alluded to earlier, is around flexibility and the desire to be able to work flexibly as and when people want. Some of it will be about the fact that agency rates are higher, so people will get paid more to do, effectively, fewer hours. That is not the only reason, but it has—

Q76 Paula Sherriff: Do you think that was impacted on by the pay freeze that, effectively, most nurses were subjected to?

Jane Cummings: To be fair, nobody has said that to me, but we have had people who said, “I know I could earn more money if I wanted to do that,” so it would be naive of me not to say that that is the case. But overall the biggest reason has been flexibility, the fact that people can choose where and when they want to work. That has been something that has been very attractive to many people. We also know that people have worked under a lot of pressure. Simon and others have alluded to that. It has been quite a pressured time. Agency staff tend to have slightly less responsibility.

One piece of work we have been doing, both through NHS Employers and with the providers, is to think about what we can do to really bring back—not even bring back but just enhance—pride in wanting to work for an organisation. A good example of that is that many student nurses now get very strongly affiliated to a particular provider. When they qualify they go to work in that provider, they do a year of what is called—as you will know but others may not—preceptorship and they get a hospital badge. When I trained as a nurse that was something I got, and I was very proud about my hospital badge. Now that has come back and I have spoken to lots of nurses who have gone through it and feel a very strong affiliation and professional link to a particular organisation, which means they want to stay, support them and work with them. It is part of the culture, as I mentioned earlier, the need to feel that people are empowered, supported and encouraged to work, and are listened to. We have seen improvements in that, sometimes through the 6Cs, which I introduced back in 2012, and the significant attention on improving staff experience as well as patient experience. Where organisations have started to do that and to work hard with their teams and encourage them, we get staff who either want to come back or want to stay. A good example is the Health Education England return to practice programme that has been run for the last few months. They have had over 1,500 nurses who had left the profession, for a variety of reasons—maybe brought up family or gone off and done something else—but decided they wanted to come back, so they undergo a return to practice programme. About 1,500 have done it in the last few months. That, for me, is a positive sign of people saying they want to come back into the profession and to go back and work in organisations.

Q77 Paula Sherriff: While I acknowledge that the vast majority of agency nurses and staff will be clinically sound and of utmost professionalism, has any analysis been done of clinical risk and complaints specifically around agency staff? One could argue that the consistency you have with using permanent staff that are familiar with the surroundings may be lost with the use of agency staff.

Jane Cummings: There is definitely a link between having consistent staffing in a team—the research by Michael West that I alluded to earlier was very clear about well-structured empowered teams that understand the service and work together well—and better outcomes in terms of patient mortality, for example, and patient experience and staff experience. I do not think you can say that about every agency nurse—

Paula Sherriff: Of course.

Jane Cummings: It would depend on how many. If you have a ward where 75% of the staff are agency, I would have real concerns about the consistency, the knowledge of patients, the ability to understand the system and the organisation—how to get hold of equipment and so on. Agencies are accountable and responsible for ensuring that the staff they provide are of a suitable quality.

Q78 Paula Sherriff: I have two further questions and then I am afraid I have to go to the Chamber very soon, or I could possibly keep you all day on this issue. How did we get to the situation where we are spending what we are on agency staffing? I think we can all agree that it has grown exponentially. How on earth did we get there without some sort of work force planning intervention? Surely, we must have seen this coming.

Jane Cummings: I think some people did; not everybody did. There is absolutely no doubt that back in 2010-11 the numbers of staff that were requested, and therefore the number of training places that were commissioned, reduced. That coincided with a significant increase in attention on staffing. Some of that happened before Robert Francis reported, but it certainly kicked off afterwards. Trusts funded something in the region of 18,000 or 19,000 additional posts. We therefore did not have enough staff to fill those gaps, and that is why we have that gap. Organisations who thought they needed fewer staff then realised that they needed more, so they started to try and recruit more. They funded more posts and we did not have enough staff coming out of education and training to be able to fill them. There are a couple of things that are important about that. One is the work that Health Education England have done since they have been put in post to provide a national overview of training commissioners. Through their local education and training boards, working with commissioners and providers, they have a national oversight in terms of what is needed and what we think is needed. That has improved it, and you can tell, as I said earlier; they are increasing the number of commissions. Their prediction is that there will be something like 23,000 extra nurses in the system by 2019-20.

The other point we need to concentrate on is making sure that the attrition of nurses going into education is as low as it possibly can be. That is partly down to the recruitment and the support that happens in universities, but it is also down to the quality of the clinical placements and the support that students get when they are working out in the system. That is exactly the same for medical students as it is for any other health care professional who is doing their clinical placements. A lot of attention has been paid to that over the last few years. I spend a significant amount of time talking to student nurses in universities.

We appointed, or we have, over 1,000 care makers, the ambassadors for compassionate care. Many of those are students. They are providing a fantastic role, championing both compassionate care and also the positive work that can happen in organisations to keep people really focused and keen. There are organisations that have an attrition rate that is below 5%, for example, which is great, and more universities are learning from that as we go forward.

Q79 Paula Sherriff: Just to change tack slightly, management consultancy fees are something I am incredibly concerned about. My local trust has allegedly spent something in the region of £10 million over five years. What is your view on that? Should this not be on the front page of the national newspapers?

Simon Stevens: Our view is that we need substantially to reduce the amount of spending that is going on that kind of thing across the national health service. That is part of how we are going to dial back the projected provider pressures this year. As a result, to make that a reality, for Monitor, TDA and NHS England, there is now an approvals process required for any spending proposed over £50,000, I think it is, on consultancy.

Q80 Paula Sherriff: Does that include existing contracts?

Simon Stevens: That is for any new contracts that are being let. Obviously if they have already signed a legally binding thing, I am not sure that can be done, but it should have a substantial impact on cutting back new spending.

Q81 Rachael Maskell: I would like to come back on a point from the previous question when you were talking about work force planning. You said that some did see but not everyone saw the issues coming. Who were you referring to?

Jane Cummings: Some provider directors of nursing expressed that they felt they were likely to need more nurses and in fact, therefore, put those requests in. But across the system not everybody thought that. Some people thought that they would be able to manage, or would potentially have fewer beds in the future so would need fewer staff. It is very easy, with the benefit of hindsight, to say, “We should have known this or that.” There is a lot that has happened in the last few years about thinking very differently about the way care is provided. We obviously had the Robert Francis review which, with its 292 recommendations, put a very different focus on the way we were staffing and the way we were looking at care. Some of that was predictable, but some of it was not. There is a mix of issues that led us to where we are.

Simon Stevens: On that last point, the good news about this—not the agencies, but the expansion of better, safer staffing in in-patient wards—is that I am convinced that we are going to see improvements in the measures that we track for the safety of care that has been provided to patients. In the first year of the safety thermometer that NHS England publishes, for 2012-14 we saw a 27% reduction in falls with harm, a 25% reduction in venous thromboembolism and a 15% reduction in pressure ulcers of new origin. I think this is going to produce for us a clinical and patient benefit on the back of it.

Jane Cummings: We have seen an increase in the number of patients saying they feel they have been treated with care and compassion as well, so we are seeing some significant benefits from that, and to staff. I was in a hospital last Friday where staff described how they now had more nurses on each shift and that meant that they were able to provide more care; they felt that they were able to give better care, and that their patients and friends and family survey test results were showing increases and improvements. When you walk around hospitals—I know you used to work in them—and see the notices that say, “You said, we did,” and they put up the comments, quotes and responses from patients about the care they received, it reinforces why increasing the staffing not only has had obvious patient safety improvements but has also had improvements in the way patients feel about the care they have received.

Simon Stevens: But we have to convert a very substantial chunk of that £3.3 billion of temporary staffing cost into well-paying, permanent, flexible nursing jobs.

Jane Cummings: Yes, and that is what we are concentrating on at the moment.

Chair: Helen, you have a supplementary and then we will come on to Philippa.

Q82 Helen Whately: On nursing numbers, I think you said earlier that there will be 23,000 more nurses by 2020.

Jane Cummings: Yes. That is the prediction.

Q83 Helen Whately: That is something to welcome.

Simon Stevens: Just to recap, that is the prediction for the extra supply that will be available by 2020. Obviously, the net numbers will depend on a whole range of things, but that is what Health Education England are forecasting.

Q84 Helen Whately: Can you comment on whether there is a plan to ensure there is a pipeline of school leavers to become those future nurses, to make sure that we have high quality and hopefully more British nurses rather than having to recruit overseas to fill those posts?

Jane Cummings: In order to hit that number, clearly there is an expectation that the number of commissions that universities will provide will increase. We know that there are significantly more applications for training places than there are places available at the moment, so there is a very good supply of people in the UK who want to become nurses or midwives. I do not think we have a particular issue about supply. At the moment we have a short-term gap and we need to look at all the different ways of filling that gap. Some of that is international recruitment and some, as Simon has alluded to, is making sure that we can convert the people who are currently working for agencies into flexible permanent posts that suit their needs and deliver the care that patients need. We are looking at it across the board, as well as looking at the role we can take to encourage some of our health care assistants to progress through different levels of education and support to enable them to become nurses if they choose and want to do that.

Q85 Helen Whately: In fact my second question on this topic was about health care assistants and some of the recommendations from the Cavendish review, the plans to make that happen and any comments you can share.

Jane Cummings: One thing that Camilla Cavendish talked about was having a care certificate. That is now in place, so that happens for health and care assistants who go in at an initial level. We want to take that further, to look at what competencies are needed and how to allow health care assistants to be able to progress to do different things and then, potentially, to use those qualifications to enter nurse training, to be able to become a registered nurse but maybe do that in less than three years. If we have an ability to recognise prior learning and prior competency, prior education, hopefully we can start to reduce that three-year programme to make it slightly less. It is a really important factor because health care assistants do a fantastic job. They are a really important part of the team. They are supervised by registered nurses, but they are a really important part of the team and they need to be recognised as such and given the opportunity to develop, as can therapy assistants, the people that support physios, OTs and speech and language therapists, for example. All of that is key.

Helen Whately: Thank you.

Q86 Dr Whitford: After the Francis report, they commissioned NICE to look at what kind of balance of numbers were needed, and obviously that is different in different settings. Can you explain why it was moved away from NICE to the NHS? Is it that it is going back to NHS Improvement? I understand that work has been done internally, but having an independent measure that is not from the person supplying the care is obviously an advantage.

Jane Cummings: The reason we looked at changing it was that NICE were asked to look at nurse staffing levels and to base that on available evidence. They did that exactly as they were asked and for very good reason. There are already two things that are published: one is around adult acute wards and the other is around maternity. Most of the evidence that exists is based on medical and surgical wards only. That is where the research and the evidence exist. There was very little evidence elsewhere. But, more importantly, as we have shifted how we approach care through the Five Year Forward View, through the vanguards and different models, it has become increasingly clear, and it is something that has been articulated by many people in the service, that looking at one profession only—I say this as a nurse—is not helpful and is not the right thing to do. We needed to look at it in the round. We needed to look at the contributions that allied health professionals, physios, OTs, doctors and other people can play, so that you look at the whole-team approach.

You also need to look at how patients' pathways will change. It is not just about a hospital and it is not just about a particular community setting. You have already heard Simon talk about horses for courses. We need to think differently about the way we provide care and therefore the work force modelling needs to be much more flexible to be able to adapt to whatever that area is.

Secondly, we have always said that NICE would continue to support the work, so, where evidence existed, NICE would still provide that. We would commission new evidence reviews from them, they would provide an oversight, we would use their methodology and we would work with them and use some of their staff. They were always going to be engaged as we moved forward. Now we are in that position, very helpfully, I think. Many of you will know that back in June I wrote about wanting to make sure that patient safety was not compromised and said that we would look at the whole system. We now have Mike Durkin, the director of patient safety, who is going to work with us on that very strongly. We will have a very strong patient safety focus in the work and will continue to do that with NICE, with clinical and academic experts, to look at the whole work force in a variety of different settings. I can go through those if you want to, but, more importantly, we are going to get whatever we do signed off through NICE and through the Care Quality Commission and also ask Sir Robert Francis for his views on what we are doing. I have discussed that with Robert Francis in some detail and he is very happy to support it and is pleased with the work that we have put together so far. I do not know whether Simon wants to add anything.

Q87 Dr Whitford: It is just that there is a perception of criticism of this being moved around, and while of course there are lots of different settings and lots of things are changing, the issue in Staffordshire did also appear to be on common or garden sized wards with numbers of patients and just not enough nurses, and people feeling that they could not deliver the care that they thought they had trained to do. Having a guide for this common size of ward or number of patients, “We would expect X number of nurses”, still does create an external pressure and a standard that—

Simon Stevens: Yes, but in a desirable way. That was a good thing.

Dr Whitford: Yes.

Simon Stevens: As you say, for acute in-patient wards, having the nurse staffing guidelines that have been set out there will continue. The question is, if you are thinking about, say, community mental health teams, can you do that in quite the same way or do you also have to think about psychologists, therapists, the full multidisciplinary team, and do you have to recognise that the way those are run in Camberwell will be different from the way they are run in Carlisle? Trying to square that circle, the discipline of focus on, say, staffing with the flexibility of the interdisciplinary team and the local circumstances, is what we have to get right in this next phase.

Jane Cummings: I am absolutely clear that the plans we have in place to do this meet recommendation 23 of the Robert Francis review. We absolutely will be delivering on what he said.

Q88 Dr Whitford: That is quite important. Certainly you have already referred to doctors and other members of the multidisciplinary team, and that was my other comment, in that obviously our manpower planning for medics in my whole 33-year career has been woefully inadequate. We never got it right. We have always had a surplus in one specialty

and a shortage in another. Perhaps you could describe how you think we are going to finally get past that to have some idea of both doctors and allied—

Simon Stevens: We are looking forward to the answer to this one.

Jane Cummings: Come on, Bruce.

Professor Sir Bruce Keogh: I fear I am going to disappoint you. That is one that we have grappled with for years and years, and I have seen my own specialty, which is relatively small, being woefully out and the predictions of either excess or too few being proven wrong within a year of the prediction. I am glad to say that that is really an issue for Health Education England.

Q89 Dr Whitford: It is just that there has been a lot of discussion recently by the Secretary of State of an extra 5,000 GPs by 2020 and obviously—short of actually knitting them—it takes longer than that, and clearly we have lots of empty jobs. Breast cancer is my specialty and it is a shortage specialty throughout the UK. How do we tackle that when we have these acute issues, and it takes so long to make one?

Simon Stevens: You are talking about GPs specifically.

Dr Whitford: GPs and hospital doctors. We are short in both.

Emily Thornberry: Do answer about GPs.

Q90 Dr Whitford: How will we get 5,000 extra GPs into the system in five years?

Simon Stevens: I very much hope we can because we certainly need them. The question is, as you say, what are the approaches that Health Education England and others have set out? They have said that there needs to be an increase in the number of people coming out of medical education who choose general practice, and at the moment there are real issues about the so-called fill rate of the vocational training scheme in different parts of the country. London fills its GP training spots with relative ease. In other parts of the country—places like the east midlands, the east of England and the north-east—there are real problems. We have to increase the attractiveness of general practice as a career choice for new medical graduates, and Health Education England have a goal that half of such new doctors will choose general practice, and then a combination of the expanded numbers of training places and some recruitment and retention, which is what they are being tasked with ensuring, gives us, the NHS, access to 5,000 more GPs by 2020. If it could be more than 5,000, we would welcome that, but 5,000 is going to be tough under the circumstances anyway.

There is a fairly concerted effort between NHS England, the Royal College of GPs and the General Practitioners Committee of the BMA, on a 10-point so-called plan with HEE, to both expand the intake but also to support GPs who are currently in the system, so as to deal with the huge pressures and stresses that are bearing down on GPs. Interestingly, again, the conversation, quite understandably, we have had this morning is about the financial pressures in hospitals. All the pressures in GP surgeries tend not to be as noticed, but they are as substantial, and I think we are at a pivot point where we have to do something different in terms of reinventing the clinical model, the practice business model

and the career model, while keeping all that is great about British general practice, list-based personal care with a population orientation, but nevertheless recognising that the kind of pressures and the lifestyle choices that people want to make mean that just having all the work that people can throw at you is not a sustainable model for general practice any more.

Chair: I am conscious that Emily was going to lead on a number of questions about general practice as well.

Q91 Emily Thornberry: Yes. I was going to ask you some questions about general practice. The first way I want to put it is that, if my mum is 75 and has diabetes and high blood pressure, what would she reasonably or—perhaps a better way of saying it is—realistically expect from a GP practice in her area? What would be right for her and for me to think she ought to be getting at the moment from her GP?

Simon Stevens: There are at least three things. One is the ability to readily get to see a GP when she has a condition that requires urgent or immediate attention.

Q92 Emily Thornberry: What would readily mean?

Simon Stevens: Many GP practices have same-day access to a GP in the practice and the ability to book at some further distance if you want to see your named GP. That is the kind of way that GPs are, generally speaking, juxtaposing their appointments systems. That would be the first piece of it.

Q93 Emily Thornberry: She ought to be able to see a GP on that day.

Simon Stevens: That is not a requirement in the GP contract, but for a number of practices it is the way they have organised things. Obviously, as practices are coming together as larger groups, it is sometimes easier for them to provide for urgent appointments that day with a nurse or GP in the practice if that is what she needs, with the ability, for a more routine consultation, to book several days out.

Secondly, however, in the situation where your mum has diabetes, as well as just dealing with circumstances under which she comes to the GP surgery, we would also expect the practice, including practice nurses, to be monitoring her diabetic care during the course of the year, and reaching out to her for routine check-ups where they were required, including eye screening, foot health and so on. Thirdly, to the extent that she ended up with a complication associated with her condition and ended up in hospital, then the GP or the practice will have a responsibility, in the jargon, to case manage the support and home-based care she gets when she needs to come out of hospital. Those would be three pillars, which all explain why it is such a demanding and critically important job.

Q94 Emily Thornberry: After Five Year Forward, what will she realistically get that will be different from her GP?

Simon Stevens: We know that in the case of diabetes there is a huge increase in the number of people expected to have type 2 diabetes over the next five to 10 years. There are between just under 2.5 million and 3 million people right now, on course for 4 million, partly as a result of ageing but actually as a result of the obesity epidemic as well. I am not necessarily talking about your mum now, but if you were a person at risk of diabetes we would want you to have access to a diabetes prevention programme, which together with Public Health England and Diabetes UK we are just beginning to kick off across the country this year; the first 10,000 people are going to be enrolled. Then, more generally, what we want is for everywhere to have the best of what the health service already provides somewhere.

Q95 Emily Thornberry: I am sorry, do you mind if I push you back to being specific there? Many people think about things in terms of themselves or their families. Listening to your vision for where the NHS is going in five years, I was just trying to tie it down to a personal experience. What difference would it make to her in five years' time? What can she look forward to by way of changes to the NHS that might make her care better?

Simon Stevens: Bruce and Jane may want to come in as well, but, in general, we are trying to move to a health service that is more, if I can use this word, anticipatory; in other words, it does not just wait until people get sick and then turn up needing care, but instead identifies the likelihood that you are going to be at risk and works with you to support you to do something about that while also, though, to be clear, building on the very high patient satisfaction that already exists in general practice despite all the pressures. The fact is that 85% of patients rate their care with their practice as very good. The experience, however, of booking appointments or of out-of-hours services is not as high, so it is not 85%; it is 74% for ease of being able to book an appointment and 68% for good experiences of out-of-hours care. That is where there is a focus on support for GPs to think about new ways of offering services and in some cases to come together as networks of practices so that, even if on an evening or a weekend you are not getting access to your own GP, you are able to do so in your local area, town or part of a city in the same way as happens with chemists.

Q96 Emily Thornberry: Would she be able in five years' time to get out-of-hours services when it was not an emergency? Can she look forward to that?

Simon Stevens: Yes, well, this brings us on to seven-day services. I do not know whether, Chair, you are going to get on to that question at any point, but this is a kind of pivot into that conversation to some extent.

Q97 Emily Thornberry: I was just trying to pin down what it was that we were talking about. I am happy to move on because I know we are going to talk about it later.

Simon Stevens: Okay. Bruce may want to comment.

Professor Sir Bruce Keogh: Can I add a small bit? I hesitate to say this with a prominent GP in the room, but if you think of general practice more as primary care, which Jane has alluded to, we are going to see different services delivered to different people by different

people within the context of primary care, so you will effectively get to see someone who knows. One of the important things is very easy contact. The second thing is that for somebody with hypertension and diabetes you would expect them to get, effectively, NICE-approved care. There are nine specific processes for diabetes and what have you. As people get older, that has to be balanced against the risks and benefits of polypharmacy, so there needs to be a pragmatic interpretation of that, and that is one of the skills that GPs can bring. In relatively short order we are going to see much more remote monitoring and the use of technology to help primary care people manage people with long-term conditions. That is going to take us much further, I think, into the space of self-help. People with diabetes are already in that area.

With respect to some of the vanguard centres and the new models of care, you will find that many of the support services will be juxtaposed in a way that they are not at the moment. Simon has already alluded to eye care, foot care, blood tests and social services. They would become much more closely co-located and make life much easier for people.

Q98 Emily Thornberry: That will only be in certain places, though.

Professor Sir Bruce Keogh: Yes.

Q99 Emily Thornberry: It will not be everywhere, will it? It will just depend whether my mum lives near one of those, but she might not get that.

Professor Sir Bruce Keogh: I guess so.

Q100 Emily Thornberry: You talked about it being a no-brainer that the failure in primary care has led to more and more people going into emergency care, and you talked about the importance of moderating the rate of growth of demand and therefore the importance of putting more into primary care. Would you accept, therefore, that the crisis in emergency care is a result of either underinvestment or inadequate access?

Simon Stevens: Those are two of the elements. I think there is a third, which is that the different components of the national health service do not act in a very joined-up way. I forget how things are designed right now in Islington, but in terms of your GP out-of-hours services, your 111 service, the minor injuries, the A and E departments at the Whittington or UCH and the London Ambulance Service, they are not actually connected; the doctors and nurses involved do not have shared access to the summary care records, for the most part, so people often find it pretty confusing. If on a Sunday afternoon your child is looking pecky and you are not quite sure what to do, it is pretty confusing as to how you should interact with the health service. The proposition that Bruce has set out as part of his urgent and emergency care review, which we are now about to get implementing across England over the next 12 months for the first seven places and then rolling out everywhere, is that we will get that joining up. For GP out-of-hours services and the 111 services, we want to ensure that by the year after next they are integrated.

Q101 Emily Thornberry: 111 is really pretty bad, isn't it?

Simon Stevens: No.

Q102 Emily Thornberry: You would not say it was.

Simon Stevens: It has handled 25 million calls since its inception—12 million last year. When you ask people, “What would you have done if you had not called 111?” about a third say they would have gone to the A and E department. In terms of who actually goes to the A and E department having contacted 111, it is something like 8% versus 30%. That said, 111 can be better.

Q103 Emily Thornberry: When I have been to A and E the doctors have said that the impression they get is that 111 does not want to take a risk, so it basically tells people to go to A and E. I have been told to go to A and E immediately. “Make sure you get a taxi; make sure you have someone with you.” I did what I was told, but when I got to A and E they were completely amazed that I had turned up there.

Simon Stevens: Yes, but you asked the question “Is 111 bad?” and I say no, it is not bad but it can be better.

Q104 Emily Thornberry: It is bad.

Simon Stevens: Here is how it can be better. It can be better if it is joined up with the GP out-of-hours service; it can be better if the information available to the skilled call handlers and nurses, paramedics and GPs who are involved is shared, so that if you have had some previous health problem they can see that and you are not having to go through it all. The average 111 call is 14 and a half minutes. It would be good if you did not have to go through all of those steps because the information was readily to hand. It would be better if the options that the 111/out-of-hours combined service had included being able to book you into an outpatient slot with the relevant hospital department the next morning or your GP surgery, or some other clinic, rather than having to be faced with the kind of bifurcated decision of “No further care needed” or “Go to the A and E department.” In the best parts of the country, they have all of that and it is called the directory of services—the DOS—but it is not everywhere. There is a whole load of things that need to improve in the way in which we handle these 12 million calls a year, but that does not mean it is bad. It can be better.

Emily Thornberry: Can I ask two more questions about GPs?

Chair: Emily, we are going to have to move on.

Q105 Emily Thornberry: I will bundle it into one. Do you agree that there ought to be a better way of being able to measure the performance of GP practices? They tell us that they are in crisis. They tell us that 10% of London GPs are considering closing. But it is very

difficult for us to have an overview as to how GPs are doing if we do not have basic data coming in. Don't you agree?

Simon Stevens: Yes, it is hard to argue with that, so the Department of Health have commissioned the Nuffield Trust to produce a better set of quality measures, experience measures of what is happening in general practice, including a better look at GP work load. But frankly, together with the work that the CQC are doing, what that will reveal is that the vast majority of GPs are providing high quality care, highly valued by their patients, but with very substantial increases in work load. QED, we need to expand the investment in primary care, change the model for full use of the multidisciplinary team, including pharmacists, in primary care, and pull out all the stops we can on GP recruitment and retention.

Chair: James, you wanted to follow up with the seven-day NHS.

Q106 Dr Davies: Yes. It falls to me to raise the seven-day NHS. Can you explain the Government's thinking behind this, both as it applies to secondary care and also primary care?

Simon Stevens: Obviously we are here as NHS England, and I think the legitimate reasons for wanting to raise the NHS's game on seven-day services are to solve three distinct problems. Bruce will want to talk more about these, but, to get us kicked off, here are the three different problems we are trying to solve by changes to seven-day services.

First is the now clear-cut excess mortality that exists in hospital settings for patients admitted on a Saturday or a Sunday: 10% plus, I think, on a Saturday and 15% on a Sunday. Bruce will talk more about that. The second problem to be solved is the question that we were just exploring around urgent out-of-hospital access to GP or other non-acute services, where if we do not get it right we see more people flowing into hospital services and getting a worse degree of care co-ordination, at higher cost to the national health service, I might add, because each A and E attendance is probably costing two to three times more than if we had put the same money into GP services.

The third problem we are trying to solve, alongside the hospital in-patient mortality issue and the urgent out-of-hospital issue, is the question of convenient care for people, particularly working people, who often may find it hard to take a morning off Monday to Friday to go and get care that they need but which is not of an urgent care nature. The solutions we need are going to be different for those three separate problems. Part of the issue is that this debate has got conflated, so we have to parse the three problems we are solving and then respond quite pragmatically to those three separate issues.

Professor Sir Bruce Keogh: You asked where all this came from.

Simon Stevens: The guilty man is before you.

Professor Sir Bruce Keogh: It goes back to November 2009 when Dr Foster published some mortality data which had been rebased, and some medical directors were caught by surprise in different hospitals. Then in early 2010 the medical director for the south-east coast of England said, "We have had a look at our hospitals that have high mortality and we think it is higher at the weekends." I was still part of a research group in Birmingham

at that time, and we went off and looked at the hospital episode statistics for the year 2009-10 or 2008-09—I forget now—and it was 14.5 million patients. We developed a risk adjustment algorithm which had quite good statistical predictive power, and we looked to see whether the observation that the mortality at the weekend was indeed translatable to the whole of the NHS. The end result was that there were some interesting findings.

The first was that, if you used Wednesday as control day and took into account, as best you could, administrative data for severity of illness, the day of admission affected your mortality. If you were admitted on a Saturday your mortality was 11% higher, and if you were admitted on a Sunday it was 16% higher. It was interesting that that was true for both elective cases and emergency cases. It was also interesting that we took the opportunity of looking at just over 250 not for profit academic health science centres in the United States and the figures were worse. This was not a problem confined to the NHS, but it was one that we in the NHS were uniquely, I think, positioned to solve. That was happening in one place.

Elsewhere, in Medical Education England, John Collins and John Temple were undertaking a review of undergraduate medical training and they were getting back that junior doctors, particularly within the context of the European working time directive, were feeling under pressure and undersupervised at weekends and were having more and more patients to look after, so they were not happy. That was also endorsed by GMC and BMA surveys and others. There was that going on.

Thirdly, there was a question about increasing demand and, if you like, the opportunity cost in terms of efficiency for our hospitals when, quite frankly, they were winding down on a Friday afternoon and cranking up again on a Monday. Finally, the *Health Service Journal* did a survey of hospital chief executives and said, “Do you think the services are as good at the weekend as they are during the week?” You can predict what the answer to that survey was.

We then took a paper to the NHS England board, having run a forum on seven-day services for the NHS. The plan was that we had engaged with Health Education England who said that, when they were assessing training posts for doctors, they would take a trajectory towards providing good seven-day supervision into account in terms of their recognition process. The CQC would equally take the trajectory towards the provision of seven-day services into account in their ratings, so that if you were not in the right trajectory you would not get a rating of outstanding. Meantime, in 2009, the London Clinical Senate had developed 10 clinical standards which they said should be applicable throughout the week and would define the sort of service that you could expect at the weekend. In essence, those standards said that, first, you have to have good and relevant diagnostic services available seven days a week; then you will have somebody experienced enough to know how to deal with those clinical standards, and it needs to be a senior decision maker; and, finally, they have to have the facilities available to do whatever needs to be done that is defined by the consequences of those diagnostics. Those 10 clinical standards were written into the NHS standard contract over a period of three years; in fact, we pushed that back slightly and we have now tried to identify which specific standards are really the important ones for hitting the mortality.

One of the challenges that Simon asked me to do was to go back and look at more recent figures to see whether the mortality still prevails, and we are in the process of publishing

this—or hoping to. The high-level findings from that are that on a Saturday now the mortality, as Simon said, is 10%, as opposed to 11%. On a Sunday, it is elevated by 15% as opposed to 16%. There is pretty clear evidence that there is a 2% elevation if you are admitted on a Friday and a 5% elevation if you are admitted on a Monday, which points to a kind of weekend effect. On top of that, we have seen in the reporting of high-harm incidents that the proportion is higher at the weekend. The rate of conversion of closed to open operations is 30% higher at the weekend and there are some other findings which again indicate that there are issues at the weekend. Importantly, we also looked at the severity of illness. I can go into the statistics, but a very good risk adjustment model shows that, effectively, if you look at the people who are in the sickest quintile, the proportion who get admitted on Saturdays and Sundays is 25% and 35% higher on a Saturday and a Sunday. The implication is either that these people are sicker and that explains the mortality—but we have taken that into account in the mortality calculations and it does not explain it; it reduces the mortality a bit—or that we are seeing sicker people at the weekend and are simply not prepared for it. My view is that this is an issue that warrants tackling. It is an issue which we in the NHS are uniquely positioned to address over and above other health care systems. It has been widely agreed—we have discussed it with the Academy of Medical Royal Colleges who are fully supportive, and the BMA have been supportive—but when we got into early discussions on this, everybody said, “Look, don’t try and eat this big elephant at once. Focus on urgent and emergency care to start with.” Indeed, there was a debate in the House of Lords that came to the same conclusion. So we linked the seven-day services approach to the urgent and emergency care review, with the aim of making sure that we can offer the best urgent and emergency care to every citizen of this country to the same level seven days a week. I would much rather that that was focused on ambition for our NHS than that it was some kind of stick for the NHS.

Chair: Thank you for setting that out.

Q107 Dr Davies: In other words, you have taken into account factors such as delayed presentation at the weekend, when you talked about the fact that there are more patients who are admitted who are sicker at the weekends and that has been accounted for in your statistics.

Professor Sir Bruce Keogh: No, you cannot, because we do not know the delayed presentation. There is of course the element of young relatives coming back and saying, “Mum or Grandma, you should have gone to the doctor two days ago.” We cannot take that delay into account; we can simply make the observation that people are sicker. Interestingly, that is not across the age spectrum; you see the sicker patients under the age of 20 and on the older age spectrum as well.

Q108 Dr Davies: The concerns raised about this approach, I suppose, relate to cost in part, don’t they, and questions as to how it can be rolled out and in what time scale?

Professor Sir Bruce Keogh: Cost has been a significant issue, and however we have looked at this, it looks as if, in terms of hospitals, it is about 1.5% of the running costs. That is why we have tried to focus on what the real issue is. What is the de minimis offer, if you like, that we can undertake in order to reduce the pure mortality issue, to see

whether we can get the costs down on that particular approach? There are various analyses going on at the moment, as we speak.

Q109 Dr Davies: It is an ongoing process. In terms of primary care, Emily touched on that and the concept that there could be surgeries open at weekends and evenings even on a routine basis rather than on an urgent basis. To what extent does the desire for seven-day working of GP practices indicate problems with the existing out-of-hours services?

Professor Sir Bruce Keogh: That is quite a difficult one to dissect, but, as you know, there are 2,500 practices involved in 57 schemes to try and address the issue of seven-day services. They are approaching them in a multiplicity of different ways, and those ways will vary, as with hospitals, between metropolitan and rural areas. I am kind of with Simon in the sense that we have to have out-of-hours integrated with this whole endeavour, because the more fragmented the system is, the less likely we are to solve the problem.

Q110 Dr Davies: But is the primary aim to avoid people attending A and E, for instance, to deal with urgent cases at the weekend, to perhaps deal with out-of-hours services that may have limited capacity, limited access or limited trust by the patients, or is it to spread the work load over the whole week in terms of elective or routine appointments?

Simon Stevens: You are talking about GPs.

Q111 Dr Davies: GPs, yes.

Simon Stevens: On that let us come back to where we began this part of the discussion, which was the three problems we are trying to solve. Bruce has been talking about the in-patient hospital problem, but for the out-of-hospital problem, yes, there is the urgent care piece but then there is also the routine care. Some figures I have seen suggest that perhaps a fifth of practices already offer some form of appointment on a Saturday morning. There is evidence from some of the first wave of the GP access fund—the Prime Minister’s challenge fund—that expanding that does reduce the attendance rate in A and E departments. A journal article published by Peter Dolton and Vikram Pathania showed that in four schemes in London it has resulted in improved GP access and an 8% reduction in A and E attendances. The reduction was largest on the weekends, and there are equivalent data from some other parts of the country as well. It is about the urgent care system, given what Bruce has described; if people are sicker on a weekend when they turn up at hospital, that is part of why they are having a worse experience. But it does not explain the whole thing, so we need to make sure that those services are available. Over and above that, there is this third question about how to ensure that people who are working during the week are still able to access the health service for planned appointments.

Q112 Dr Davies: Work force has been alluded to in terms of limits to GP recruitment and the retention problems being faced. I know that it has been suggested that GPs currently working in the week will just change their timetable, essentially, and perhaps do more at the weekend or in the evenings rather than in the week, but is that really

achievable in terms of providing a service on weekdays as well—a service that is already under great pressure?

Simon Stevens: Services are under great pressure and the early experience is that for non-urgent appointments the demand is probably greater on some week nights outside regular hours, maybe on a Saturday, less so on a Sunday, and I do not think it is the expectation that every practice will be offering routine appointments seven days a week. I think, rather as duty chemists club together and have a rota, if you cannot get an appointment at your practice, maybe they will arrange it at another neighbouring one on a rota basis. The reality is that we will see what the usage is of these services. In an ideal world the health service would recognise that people have busy lives and cannot always take half a day off to go to an appointment mid-week.

Q113 Dr Davies: Yes, understood.

Jane Cummings: It is also thinking about which is the right work force. There are plenty of examples where there are advanced nurse practitioners working in primary care who run their own clinics, are independent prescribers who manage a lot of long-term conditions and deal with urgent illness. There is something about thinking flexibly about what the options are and also what patients need, and it can often be a different clinical professional other than the GP. They need to work together to deliver the right service. It does not have to be all GP-led.

Q114 Dr Davies: Understood. Presumably you are looking at the fact that if there was additional capacity created, if that is feasible, there would be more demand. Experience has shown that, hasn't it? Simply having, for instance, a four-hour wait in A and E makes it a more desirable place for people to attend. In this day and age when people like instant access to services, I think there is going to be increasing demand, and we have talked about trying to limit an increase in demand in the NHS. I would hope some efforts are being made to look at how the demand might respond to increased access at evenings and weekends and what burdens that places on the NHS and funding.

Simon Stevens: That is absolutely reasonable. Of course, the reality is that one of the big reasons why net public satisfaction with the national health service has gone up from a third to nearly two thirds over the course of 15 years is that the NHS has become more responsive. Waiting times for everything have fallen substantially—in A and E departments, for your cataract operation and for your diagnostics. I do not think anybody wants to go back to a world where the one thing the health service is known for internationally is long waits to get in and then long waits to be treated once you are there. On the other hand, we also need to make sure that we are being smart about the way we use our resources. We recognise the pressures on individual practitioners and we square the circle by not just doing more of the same but by thinking about the full primary care team, the use of technology. For many of the larger GP groups that are coming together, groups like Vitality in Birmingham, a substantial proportion of their patient interactions are now phone-based or Skype. That is a controversial statement and people rightly say that face-to-face consultation is tremendously important for a lot of what general practice does, but it does not have to be the only model of interaction. We need to supplement and

reinvent the clinical model for primary care if we are to have the sustainable services that both GPs and patients want.

Chair: Philippa, did you have a supplementary as well?

Q115 Dr Whitford: Yes, in relation particularly to hospitals. In both of these discussions it strikes me that we start off talking about the 6,000, or the ill people who cannot see a GP and therefore go to A and E, yet somehow we always end up through the signals and on to the track of just having routine everything seven days a week, and obviously we had that announcement with regards to hospitals on Thursday. I am not sure whether you would recognise the description that there are no senior doctors in hospital on evenings and weekends. Certainly I got a lot of comments back. I note that you rank them: saving the 6,000 lives—I do not think that anyone would argue with that—and then the access to the GP. The convenience one surely, in our straitened times and shortage of people, must come third to that. We need to get lives saved and A and E functioning before we think, “Let’s just do everything 24/7.”

Professor Sir Bruce Keogh: Can I make two points in response to that? The first is that the number of lives, which is up to probably 10,000 a year, is a statistical construct which is a statistical excess number. It does not mean avoidable. We need to be absolutely clear about that before it gets misused. I have already alluded to—

Simon Stevens: For the benefit of the Committee and others, explain a little more, Bruce, the distinction between excess and avoidable so that people understand.

Professor Sir Bruce Keogh: The statistics show that more people will die who are admitted on the weekend than who die on a Wednesday. The statistics tell you that they are sicker. They do not tell you the extent to which those deaths could have been prevented. That has to come from a consensus, and that is where the London Clinical Senate laid down their consensus, which led to the 10 clinical standards which set out how we might tackle this. That is the first point and it is one, when I was involved in looking at 14 hospitals with high mortality, on which there was a lot of misunderstanding between statistical excess and avoidability. Avoidability is a very clear concept—that a death should not have happened.

The second point, and I think it is a really important one, is that every Saturday and Sunday there are swathes of consultants going in to see their patients in hospitals, fuelling weekend services on professionalism and good will in a world where “Thank you” is not a common word. It is really important that we recognise the professionalism and contribution that our consultant colleagues are making at the weekends to deal with this. When we started the discussion on seven-day services it was widely received and widely supported by exactly the colleagues who do that. They are seeking some way of formalising the arrangement whereby, first, that is recognised and, secondly, they can be sure that on a regular basis they and their colleagues are offering the best possible services to their patients at the weekend.

Q116 Dr Whitford: But with that consensus is it not the case that it is then undermined by wanting, whether in general practice or hospital, to run routine “Come and check my toenail clinics” on a Sunday, which actually takes away? Is it not the case that about a quarter of the GP pilots have stopped because uptake on a Sunday was not good and it made it harder for them to get enough GPs to cover the urgent GP out-of-hours service? Are you not going to replicate the same thing?

Simon Stevens: Let’s take the separate three problems we are trying to solve. For the weekend offer for routine primary care we have to shape that based on where there is need and where there is uptake. If there is no need or uptake for particular modes or times, obviously that is not going to be where we put all of our eggs, but for the hospital piece I do not think the proposition is that every part of every hospital should be operating on a seven-day basis. The proposition, as Bruce explained, is to forensically focus quite tightly on those aspects of the way a hospital works at weekends that are most likely to have impact on the excess mortality or the avoidable component of the excess mortality. Of the 10 standards, four of them are deemed most likely to have that impact, one being the time to a consultant review, the second being consultant-directed interventions, the third being ongoing consultant cover and the fourth being weekend access to diagnostic testing capability. Those are the things where we are going to get all hospitals between now and the end of September to do a self-assessment as to where they stand against those four clinical standards. We know that many places are already meeting them, but not all, so we will chart a course over the next several years to get everybody in a position where they can meet the four standards that will have that impact on avoidable mortality.

Q117 Dr Whitford: But surely every emergency service within a hospital has senior doctors on call. We have been moving, and I think there is not a conflict in the profession, towards having more of the whole team. The consultant is in there if they are on duty for surgery on a Saturday morning—

Simon Stevens: Yes, but it is not just on call; it is on site.

Q118 Dr Whitford: But they couldn’t get a CT scan. Going in and doing the rounds is part of that, but it is getting the whole team: it is getting a scan, getting access to AHPs, and so on.

Simon Stevens: Precisely, that is right.

Q119 Dr Whitford: Whereas, obviously, it was couched last week as “Senior doctors have signed opt-outs.” That just does not strike me as the way to do what you are talking about.

Simon Stevens: There is a distinction to be made here between what senior doctors are actually doing and what the 2003 consultant contract says. The 2003 consultant contract, which is an indisputable fact, gives the right of opt-out for work other than on a Monday to Friday 7 to 7. If we are going to tackle the issues that Bruce has laid out, we have to approach that. The proposition from NHS Employers is that no consultant should be expected to work more than 13 weekends a year, but nevertheless in some cases, where there is this excess mortality, there will need to be a change in working patterns.

Q120 Dr Whitford: But focusing on the urgent cases is your vision of it.
Simon Stevens: Correct.

Q121 Dr Whitford: Not providing routine clinics and operating lists. I know we need to do as much of that as we can for cost reasons—

Professor Sir Bruce Keogh: To be honest, some of that might follow in the wake. There are many hospitals already providing routine operating and routine clinics on Saturdays. But I think the focus from our point of view in NHS England has to be, “Let’s get the urgent and emergency care set up right first.”

Dr Whitford: I would agree with that. It is just my impression that in the discussion we keep changing track and mixing the two together. Thank you.

Q122 Chair: Further to that point, were you consulted, Mr Stevens, before the announcements about widening this to general practice and making it a more routine part of the service, coming away from that focus that you talked about initially on urgent and emergency priorities?

Simon Stevens: The proposition, I think, was a manifesto commitment of the Government, and obviously it is political parties that write manifestos, but in terms of the way in which that thought is given life in the health service, yes, Bruce and I and others have been talking with the Department of Health about the right way of chunking the problem and then rolling out the solutions. That is why I chunk it in those three categories.

Chair: Thank you.

Q123 Liz McInnes: Can I ask one quick question? It is about the availability of diagnostic testing. What areas of diagnostic testing are not available on an emergency basis? My background is in pathology and I spent over 30 years working in biochemistry for various NHS trusts, and in all my experience in the NHS I never knew my laboratory to close. We always provided out-of-hours care and emergency care, so I am just wondering what—

Simon Stevens: I think it is a fuller imaging service as well as what you are describing. Bruce obviously will come in here, but if you look at the changes to stroke services and the big improvements that we have seen in London, and now in other conurbations as well, with the creation of eight hyper-acute specialist stroke units in London, a lot of that was about having, 24/7, senior clinicians around CT and MRI, I think. Is that right, Bruce?

Professor Sir Bruce Keogh: Yes, that is absolutely right. We have a list of what we think are the important things, but the list does not spring to mind at the moment.

Q124 Chair: I am very conscious that we have been here for over two and a half hours and there are still a number of questions that we would like to cover. It might be a help for everybody if we had a very short comfort break for people to stand up and do something

different. I would also ask whether or not we could carry on for another half an hour after a short break.

Simon Stevens: It would be a delight.

Chair: Thank you, that is great. We will take five minutes to stretch our legs.

Committee suspended.

On resuming—

Chair: Thank you very much. Round two. We are going to start with Liz.

Q125 Liz McInnes: Changing the subject completely to the announcement that public sector pay would be capped at 1% for the next five years, as an ex-NHS employee I understand the pressures that staff have been under with regard to pay freezes and recommendations for 1% pay awards that were not given across the board, and I recall the agenda for change negotiations and the real fight that NHS staff had to get on to pay review bodies to have their pay independently assessed. Now we have had this announcement that pay will be capped at 1%, what is the future role for the pay review bodies? Are they completely redundant for the next five years?

Simon Stevens: I do not think so, because they will have a role, apart from anything else, in thinking about how that extra funding is directed. The living wage will obviously benefit some low income employees, not just in the NHS but across the public sector. The reality, I am afraid, is that that is a question for the Department of Health rather than for NHS England because we do not actually set the remit for the pay review bodies or interact directly with NHS Employers on that.

Q126 Liz McInnes: But do you have a view on it—on the effect it will have on staff morale? NHS staff signed up to an agreement that had a pay review body as part of the agreement and that is effectively being made redundant by Government policy. Do you have a view on that?

Simon Stevens: This is obviously going to continue to be a very challenging time. As we have seen with the issues around paramedic recruitment and retention, the need to convert some of the temporary nurse roles into paid staff, or the higher costs in living in different parts of the country, whatever the overall cap that is set across the NHS work force, we are still going to need, within that, to look quite creatively at what is required in order to recruit and retain in different disciplines in different parts of the country.

Q127 Liz McInnes: But we have talked about trying to improve recruitment and retention to reduce the costs of agency staff. Do you think that will be hampered by this 1% pay cap?

Simon Stevens: We have, I think, 23,500 more doctors, nurses, therapists and other professionally qualified clinicians in the health service in England now than we had five years ago. As Jane said, we need to continue down that path over the coming five years. In

the fullness of time—obviously I am not going to get into a political debate about it this morning—ultimately the health service needs to pay the going rate relative to the private sector in order to recruit and retain the staff we need. That is just an economic fact of life. We said that in the Five Year Forward View. Obviously the expectation for the next four years as set out by the Government is that a further period of pay restraint will contribute towards the headroom we need to maximise the numbers of staff available in the national health service. It is true that at any given point in time there is a trade-off between the cost of employing each person versus the number of people you can employ.

Q128 Dr Davies: How prepared are we for the coming winter?

Simon Stevens: We are preparing hard. The components of that are, rather than dribbling out cash for hospitals and community health services during the course of the year, that funding was put up front into local health service budgets as of April. Secondly, the rate that hospitals were reimbursed through the tariff system for emergency admissions, which was the marginal rate, was more than doubled, for this year—from 30p to 70p on the pound, given your quizzical look, Chair.

The third point is that coming out of last winter the joint working between the NHS and local authorities is, I think, continuing to improve. Having said all that, if there is a very substantial flu outbreak, recognising the continuing pressures in social care, there continue to be moments when the service is under pressure.

Q129 Dr Davies: Do you anticipate there will be further funding still, or is the funding put in place in April—

Simon Stevens: No. Our expectation is that the funding that is available to the national health service in 2015-16 is the funding that has been allocated.

Chair: Thank you.

Q130 Emily Thornberry: Last winter there were not people on trolleys that much in A and E, but there was a long handover for ambulances. I think there was a thing on Channel 4 news about this, and that presumably put patients at risk in A and E. Last winter, at the height of the crisis, there were 300 ambulances a day forced to queue for more than an hour: 40,497 ambulances waited more than an hour, some of them eight or nine hours. How are we going to make sure that does not happen again?

Simon Stevens: We did have a big spike in demand last winter, as you imply, and unfortunately, figures from Public Health England have shown this. The unfortunate proof of that is the number for excess winter mortality last year; far more people died than would have been expected because of the greater number of infectious bugs that were going around last winter than the year before and that in turn manifested itself as pressure on A and E services, ambulance services and GP services.

Q131 Emily Thornberry: If ambulances are queuing outside hospitals trying to discharge their patients, they are not available if someone is really ill in the community if you ring. This is why you have to wait four hours for an ambulance.

Simon Stevens: Correct—absolutely right.

Q132 Emily Thornberry: How are we going to stop that?

Simon Stevens: One of the things that is going to make a difference is some work that Bruce and his colleague Professor Keith Willett have been leading looking at the way in which ambulances are deployed and the interactions that then occur with hospitals. I do not know, Bruce, if you want to say anything about that.

Professor Sir Bruce Keogh: Can I just take a take a step back from ambulances? You used the word “discharge” from hospitals. One of the major problems that hospitals are facing is being able to discharge patients who are ready to be discharged, and that just creates a bottleneck further back down to the front door of the hospital and, as you rightly imply, at particularly stressful times, as Simon has alluded to, actually outside the front door of the hospital. That is all tied in with our plans for the improvement in urgent and emergency care services, which relate also to the provision of seven-day services. There is a widely held belief that at any one time—it will vary from hospital to hospital—about 20% of people in those hospitals do not need to be there. One of the problems we have to tackle, which is going to be a significant problem, is how we ensure that we speed up the discharge of patients from hospital. That becomes one of our major problems, which has an impact on the pre-front door of the hospital. I might not have explained that very well.

Q133 Emily Thornberry: You are hoping to discharge people and therefore there will not be the bottleneck, but what I really want to know about is this. If you are going to have ambulances waiting outside hospitals for more than an hour on a regular basis, it is not even outside the door—it is people dying at home; they are not even able to get their ambulance because they ring for an ambulance and one won’t come. How can we be confident that in the next winter that is not going to happen again?

Professor Sir Bruce Keogh: One thing we are doing is starting now to look at some of the perverse incentives that exist in the ambulance service in terms of sending out, quite often, two or maybe more vehicles to calls. There is some work going on in both the London Ambulance Service and the South Western Ambulance Service to see whether we are categorising those properly. That work will report in due course. That is one particular area of trying to provide more vehicles on the road. I do not know if you want to add anything more, Simon.

Q134 Emily Thornberry: At Truro hospital in Cornwall, there was a delay of eight hours and seven minutes for a man who had palpitations. He was waiting outside the hospital for a whole day. It is not a question of how many ambulances were sent. He was sitting there for eight hours and seven minutes.

Professor Sir Bruce Keogh: I do not know about that case.

Simon Stevens: Clearly there were enormous pressures over the course of last winter and things happened that none of us wants to see happening again. Let us be absolutely clear about that. By way of context, let us also remember that more than nine out of 10 patients in the English NHS, including over the course of last winter, were seen and treated and either admitted then or discharged within four hours, a higher performance than probably in any other industrialised country that measures its A and E or emergency care performance. There are absolutely no grounds for complacency, but there are considerable grounds for just recognising, as a matter of fact, that we start from a high-performing urgent and emergency care system. But even one case of the sort you describe is one too many.

Emily Thornberry: Thank you.

Q135 Maggie Throup: Traditionally, the NHS has existed in silos. I see it as primary care, secondary care and community care, and obviously silos within silos. With the current staffing mix and the demarcation of the silos, and the effect they have, how confident are you that the new models of care proposed in the forward view can actually be delivered?

Simon Stevens: I agree with your description, but there is nothing God-given about it. That is our choice. One of the good things about Agenda for Change², which we were discussing earlier, was that it did, in principle, make it easier. Instead of having the old Whitley council system, where you had lots of different spine points and pay progressions based on one of 300 different types of job category across the national health service, you could do more teamwork, mixing and matching, and in some places that is really happening. But the truth is that it is not happening at the scale and speed we need, and that is true for primary care and for hospital services. In primary care, one of our big opportunities is around the use of clinical pharmacists. We know that perhaps 1,000 or more pharmacists are going to become available from this October, and if you look at the forecast that Health Education England produce they are one of the very few—perhaps the only—category of health professional where apparently we are about to be running a huge national surplus over the next five years. The question is, what do we do with that? In many parts of the country GPs have begun to embed pharmacists in their practice teams, but we want to stimulate more of that. Together with the Royal College of General Practitioners I kicked off a scheme three weeks ago to fund the first 300 clinical pharmacists—250 to 300 clinical pharmacists—in practices across the country to test the impact that that has on the type of services they are able to offer, direct patient services, not just medication reviews and so on, and the impact it has on GP work load. Assuming those go well, that would be a golden example of the kind of changing supplemental skill mix that we are going to need.

Q136 Maggie Throup: Do you see any other change in staffing mix that is needed?

Simon Stevens: Yes. Jane may want to come in here as well. Look at musculoskeletal services and the blend of what orthopaedic nurses do and what therapists do; that is often not as fluid as it could be. Look at the urgent and emergency care work force; there is obviously a rising demand for paramedics, not just in the ambulance service, but in A and E departments

² Agenda for Change: the revised NHS pay and grading system

and in the 111/out-of-hours services. What I have just described is adding some of the established disciplines to teams that exist. The really interesting thing is: are there new types of combination of professional skills, where you create new types of job category altogether? There, frankly, progress has been much slower, because although the pay system enables it—a single job evaluation process and spine—the professional regulatory superstructure stands in the way, in that, if you are a physio that is different from being a nurse and it is different from being a psychologist or a midwife. Jane, how are you going to crack that?

Jane Cummings: It goes back to the point we made earlier. If you look at urgent and emergency care, for example, clearly you need nurses and doctors—experienced nurses and doctors—to be able to deal with the patients that may present, but there is absolutely no reason why physiotherapists should not be in a minor injuries section and able to diagnose and treat many of those minor injuries. We know there are good examples that happen around the country. It is the same with looking at the role, which Simon talked about earlier, of psychologists and activity leaders in mental health or learning disability. As a group of health care professionals, we have to think outside the box in a sense and be more open to looking at the needs of patients and who is then best placed to deal with them rather than doing it in linear professional groupings. I think the vanguards that we have talked about a couple of times this morning will play a big part. When you look at the work that some of the primary and acute systems, or the multi-specialty community providers are looking at, they are really open to thinking differently both about how organisations work together, getting rid of organisational boundaries, and about how staff can move between the different parts of the system in order to follow patients and support them. That is not just about the location and maybe the geography; it is also about the role of individuals. It is really, in a way, thinking about what is needed. Learning disability is a really good example of that. We are transforming the services for learning disability. We are working hand in glove with local authorities, CCGs and specialised commissioning, and providers of different types, looking very differently at how those services will be provided. Yes, by learning disability nurses, and potentially by some psychiatrists with a particular interest in learning disability, but also by psychologists, behavioural therapists and a lot of people trained to be able to provide a whole approach to those patients. That will mean doing things in a different way. The future looks different but actually quite exciting if we can think differently about how we provide that care.

Q137 Maggie Throup: Obviously there has been, as you say, great success with the pharmacists. Are there any lessons that can be learned about why they have been successful that can be transferred to other professions within the NHS?

Simon Stevens: I will give you one, and Jane and Bruce may have others. On the back of what we need to do with cancer, to expand early diagnosis we are going to need a substantial increase in the diagnostic professional work force, and that is going to include endoscopy and scoping. For 15 years at least we have had a small number of nurse endoscopists in this country, but the paradox or puzzle is why that number is only 300—the last estimate I saw was perhaps 300. I was talking to a nurse endoscopist and a consultant gastroenterologist in the City Hospital, Birmingham last Thursday, when we were talking with Harpal Kumar about this, and we need a huge expansion in nurse endoscopists if we are going to be able to tackle early diagnosis, say, for bowel cancer. There is a real economic imperative, a clinical imperative, to get these skill mix changes

right because we know, for example, with bowel cancer that, if you are diagnosed early, nine out of 10 people will survive 10 years. If you are diagnosed late, 19 out of 20 people will be dead. In order to expand that diagnostic access, one of the things we have to do is substantially expand the work force. That is going to require nurses as well as doctors.

Q138 Maggie Throup: Moving on from there, there has been a big emphasis on increasing the number of front-line clinical staff. We have heard that the number has increased over the last few years, but there is also a question—I think Lord Rose brought this up—about the management capability to deliver the forward plan. What is your view on that?

Simon Stevens: Yes, there has been a reduction of, I think, around 18,000 managerial and administrative staff over the same time as there has been a 23,500 increase in clinical front-line health professionals. I do not think it is just about numbers, but I do think it is about the support and, frankly, the public backing that NHS leaders, be they clinical or managerial leaders, get for the incredibly difficult jobs they do. I do not think denigrating the role of NHS managers contributes to that. I think most people can recognise that these are incredibly complex jobs. In fact, the complexity of leading improvement in the national health service, as I think most people would recognise, more than rivals that of selling underwear—referring to Lord Rose’s prior occupation. That is probably a controversial statement that I should now have struck from the record. I think he makes some very good points about the need to mobilise behind a vision for change. We have that vision for improvement in the sense of the forward view, the need for national bodies to back local leaders where change is required and the need to invest in the managers of the future, be they clinical leaders or general managers.

Q139 Maggie Throup: You alluded earlier to the regional variation in being able to attract GPs. You mentioned particularly filling GP training posts. Being an east midlands MP, I am aware of that problem there. Is the regional variation the same across different professions within the NHS or is it specifically GPs?

Simon Stevens: The figures I was quoting were particularly the fill rate for the vocational training scheme in the east midlands. In fact one of the conversations I have been having recently has been with medical schools about how to ensure that medical undergraduates get good experiences of primary care throughout their medical training. In the west midlands, Birmingham university’s medical school does a great job in that regard. It has a very strong primary care faculty and good interest as a result. Nottingham university and others have brilliant medical schools. The question is how we create those same kinds of placements and the same kinds of opportunities in parts of the country that at the moment are finding it harder to attract doctors. It is not just about the medical schools at all—it is other things as well—but they have to be part of the solution.

Q140 Maggie Throup: Obviously if you are not attracting the right GPs in certain geographical areas you have a knock-on effect on support staff as well, so it is of great concern. Are you looking at the professions at all or is it just the GPs?

Simon Stevens: Yes.

Jane Cummings: I can talk a little bit about some of the work around nursing, for example. We know that there are some parts of the country where recruiting nurses to particular areas is more difficult. They may be able to recruit their own, as it were, so people do not move. I have a really good example from a trust on the edge of the east of England. They said it was very difficult for them to bring lots of people in, because once they were there it was just the sea—water—on the other side. What they have done is to concentrate on developing their own staff. It is about being able to recognise that the local community are completely committed to that organisation, so they have done a lot not only to progress different bandings for health care support workers at bands 2, 3 and 4—health care assistant development—but also to work with the local university to enable people to go off and train and then translate that into being registered nurses to go back to that organisation. It is a way of thinking differently, as opposed to the middle of London, for example, where you have nurses who go to London, often for a short time because they want the experience of being in London, but who will rotate around the many organisations, the many trusts that are here. The issue for those organisations is different, because it is about being able to retain the staff they have and reducing the turnover, as opposed to some of the others where turnover is very small and they just cannot recruit externally. Going back to Simon's language, it is really horses for courses. It is thinking differently about the way you manage your staff, depending on the local needs and the local circumstances.

Chair: Thank you. Rachael, you have a supplementary.

Q141 Rachael Maskell: I want to come in on training in the light of the fact that we are going to be delivering services in a very different way in the future. We have referred to the silos of the regulatory framework. Should we not look at regulation alongside training? For instance, in the future if we are delivering more domiciliary care, having multiple professionals coming through the front door of somebody with dementia is first of all confusing but also unsafe for that individual. Would it not be right, looking to the future, to look at how we build the foundation across medical and professional bases for a different form of health professional in the future?

Jane Cummings: Yes. We are looking at that. We have some examples where we have looked particularly at the community work force, partly through the vanguards but also through some of the other work we have done with people like the Queen's Nursing Institute and Southampton University. We have started to look at what one individual can do that is wider than their individual profession so that they can cover more of the areas of care that a particular patient might need or a particular person in their home circumstance might need. If you look at the care assistant role, for example, we have people who may be therapy assistants supporting the work of physios and OTs, as you will know well, and we also have health care assistants who support the work of nurses. Why don't we have some sort of generic support where people can look at doing both? We all have personal examples of that. My dad has support twice a day from people who do quite a lot of different things and they have different experience, but he has the same carers who come in and do everything. That has worked really well for him. We need more of that type of approach.

Q142 Rachael Maskell: I am not just talking about the kind of 1-4 band group but also advanced practitioners in particular clinical specialisms. There is a real skill set crossover and instead of having multiple professionals seeing an individual, surely we should be looking at people who have a skill set that understands that patient through and through.

Jane Cummings: I was referring to all staff; I just used the example of health care assistants.

Q143 Rachael Maskell: We should be looking at the baseline of training and the foundation. Instead of all working together at the end of the process with our roles overlapping each other, we should be looking at the foundations of training and how we build our professional medical training in the future.

Jane Cummings: Yes. One brief example of that is the work we are doing with learning disability, looking at the competencies needed to support patients with a learning disability. Health Education is leading that work. It is about the skills needed to look after that particular patient group rather than which professional grouping should do it—an example exactly picking up your point. We are starting to look at that now.

Chair: I am conscious that we are running very short of time and there is a very important area that we have not covered around mental health. Helen is going to lead on those questions.

Q144 Helen Whately: Thank you very much. In June, the CQC published a report called “Right here, right now” about mental health crisis care, which had some positive content but some concerns were raised in it. For instance, there was one particular bit of data that, of people surveyed, only 37% said that in A and E they felt their concerns were taken seriously, and, similarly, in the 30s, for whether they were treated with warmth and compassion. That report indicated geographic variation as an area of concern. I would be very interested to hear your reflections on that report and about actions being taken for addressing mental health care in a crisis.

Simon Stevens: Yes, the CQC rightly pointed to the need for the whole of the health service to raise its game on mental health, particularly as it relates to physical health, but there is a broader change programme for mental health services that Paul Farmer’s mental health taskforce will chart for us, just as we have done on cancer. On crisis care, as you know, the crisis care concordats that have been agreed in each part of the country provide the coming together of all the different groups, often including the police, to ensure that we have more joined-upness. A consequence of that is that the use of police cells for people at times of mental health crisis is down by more than half—a 56% reduction—since 2011-12. That is a very pleasing demonstration of what is possible when the agencies involved work together backed by targeted investment. We have more work to do around liaison psychiatry—psychiatrists with A and E departments; the estimate is that perhaps about 5% of A and E attendances relate primarily to a mental health condition. Given that we have 23 million A and E attendances, that is obviously a significant number. One of the measures that we were tracking around best practice in A and E departments through the winter was the extent to which, a bit like the conversation we were having on seven-day services for physical health services—consultants and all that—you also have liaison psychiatry available in A and E departments through the week. I think people see

the need for improvement and there are signs that it is occurring, but one of the things that the Farmer taskforce on mental health will do is point to the next steps that are going to be required.

Professor Sir Bruce Keogh: It is also worth saying that, in the urgent and emergency care review that Simon has alluded to and that we are in the process of implementing, we look at everything that we do through three lenses. One is what does it mean for kids? Secondly, what does it mean for the frail older person? Thirdly—this is not in any specific order—what does it mean for people with mental health problems? We are trying to bring the same level of endeavour to all those groups.

Simon Stevens: Yes. We put in £30 million to pump-prime liaison psychiatry services this year, and Theresa May recently announced a £15 million fund to make further investments in health-based places of safety.

Q145 Helen Whately: I am very happy to hear you talking about the priority for liaison psychiatry. That is good to hear. More broadly on mental health, one of the objectives of the Five Year Forward View was to move towards parity of esteem for mental health services. Could you talk about the progress being made in that area?

Simon Stevens: Yes. There are lots of elements as to what this would mean. One is, fundamentally, that we pay the same regard and attention to mental health problems as we do to physical health problems. How do you track whether that is happening? There are issues about the speed at which you are able to get high-quality care when you have a mental health problem and that is why, as you know, we are this year introducing for the first time waiting-time standards in mental health services—a mere 25 years after they were first introduced in physical health services, but better late than never. We are going to need to roll those out to a wider range of mental health services over the course of the next several years, but we are starting with early intervention psychosis services—the severe end of the spectrum—and faster access to evidence-based talking therapies, although we must not use the phrase “talking therapies”, even though it is better than IAPT, because some of this can also be delivered online rather than face to face, so I am told. Anyway, you know what we are talking about—what we are communicating about, I should say. We have to make a start on speedy access to high quality care.

We have to redress some of the historic investment imbalances there have been in mental health services relative to physical health services. NHS England this year asked every CCG to increase its spending on mental health services at least in line with its overall real-terms growth, which is not what happened in years prior. Then we have to ensure that people using mental health services have the same degree of power and clout, and that the same respect is accorded to their needs and preferences as it is in other parts of the health service.

There are two ways, I think, of looking at the history. Certainly in my experience working in mental health services, even as far back as the late '80s, the user movement—the patient voice—in mental health services was stronger than it was in general hospital or physical health services, but the flip side is that many of the circumstances that people who were using mental health services confronted continue to be completely unacceptable. That voice has not translated into change, which is why we have been so clear that the mental

health taskforce has to be co-designed and co-produced with users of mental health services, experts by experience, including the vice-chair of the taskforce, rather than just being something that is done by professionals or by the NHS itself.

Q146 Helen Whately: Thank you. Do you foresee any particular barriers to the progress being made, which you have alluded to, and success in this?

Simon Stevens: Yes. There are all kinds of barriers that we are going to have to overcome. One is that there obviously still continues to be significant public lack of knowledge, and fear and stigma associated with mental health problems, although I detect hugely encouraging signs, even over the last 24 or 36 months, that the national conversation on mental health is changing. That goes for the mental health and wellbeing of adults and also of kids. We have a huge rising pressure on child and adolescent mental health services. People are talking about that; people are sharing, and with that comes the willingness. That is almost a precondition for them calling a spade a spade in terms of the unacceptable nature of the way some services are provided. As a consequence, there are encouraging signs that Parliament has recognised that, and in the Budget just before the election we had increased funding, or targeted funding, for mental health services. Obviously that is not the end of the line, but the terms of national debate are changing and with it the recognition that we have to do better.

Professor Sir Bruce Keogh: The approach among people to mental health is still a bit where cancer was some years ago, where you whispered the word and did not say it. It was more difficult to be open about it. That is changing, as Simon said, particularly with the younger age group, who are more relaxed about talking about mental health problems.

There are professional issues between those people who work in mental health and those people who do not. Part of it relates to the science. Some of the science in physical health is pretty clear-cut and some of it is trickier. Frankly, some of the clinical decisions are trickier in the psychiatric/psychological/neuroscience world because things are less clear-cut. There still remains a professional division between people in physical health and mental health, but the key thing that is starting to bridge that, which used to be a barrier, is increased recognition that mental health and physical health go together. People with mental health problems have reduced life expectancy, which can be translated into things that people who deal with physical health understand, like increased smoking, cardiovascular disease and so on and so forth. Those barriers and those kinds of tribal issues are beginning to wane.

Q147 Helen Whately: I am conscious of the time, but I have one further question. We are talking, I think, particularly about parity or improvements in access; you mentioned waiting-time targets. Do you see there being potential also to start looking more at the outcomes? Actually, it is a bit like the parallels with cancer and other areas, where you start looking at access and then you say, “How are we doing with outcomes?” and going in the same direction for mental health.

Professor Sir Bruce Keogh: There are quite a lot of outcome measures in mental health actually. They perhaps have not been publicised as well, but if we go back to what we call the psychological therapies, the outcome measures there are quite a beacon for the way

things are measured, because they look not only at the outcome for the patient but at the economic benefit and so on. For example, the case that has been made for psychological therapies is quite a textbook case for many other, if you like, intervention endeavours.

Simon Stevens: Yes. Supplementing that, notwithstanding what Bruce said about the evidence base, on things like CBT—cognitive behavioural therapy—and related therapies, there is a strong NICE-approved set of interventions that are demonstrated to have the result, and we track it to a greater extent than we do in physical health. We track the recovery rate from IAPT by patient and by provider in a way that we do not in vascular surgery.

Helen Whately: Thank you.

Chair: The final group of questions concerns one of the most important areas raised after the Francis review, and that was on culture change. Liz has some questions to lead on that.

Q148 Liz McInnes: The duty of candour has been brought in for every provider of health and social care in an attempt to increase openness and transparency and to be able to say in a safe environment what your concerns are as a health service employee. This affects staff across the whole health care sector, and my concern is with how we get the message to staff that it is their duty to report concerns. How do we support them to do that?

Simon Stevens: I am sure Bruce and Jane will want to come in on this as well. What I can tell you, as I am sure you know, is that you can go to leading provider trusts across this country where they have been doing that for quite some time. This is not something that requires or is dependent on a complete change in the national conversation. You can make a difference; you can track it based on what employees in those parts of the health service themselves say about their ability to raise concerns, have them taken seriously and not then be subject to bullying, harassment or discrimination. If you talk to the medical director of the trust that I was at last week—Wrightington, Wigan and Leigh—you will find that they have an open culture where people, as a result of having gone through quite a change as an organisation, can do what you describe. If you go to Frimley Park, I think you can do the same. There are a number of places like that. This is about changing the expectation that we have of leaders and local organisations and, dare I say it, perhaps it will also require change on the part of people who meet in rooms like this sometimes. When an issue arises, what is the reflex response? Is it to say, “Let’s think about how we stop that ever happening again,” respecting the pressures that people are under, or is it to seek to cast blame? We need accountability, but we also need an improvement culture. That can be supported by candour, but it is going to take action from all of us, frankly.

Professor Sir Bruce Keogh: After the Morecambe Bay inquiry I was asked by the Secretary of State to go away and look with colleagues at the codes of practice of doctors and nurses. That led me to a series of thoughts, and I will share some of them with you. The first is that the codes of practice themselves seem to be fine, but the man on the Clapham omnibus might ask why nurses have one code of practice, doctors have another and somebody else has another. Why are there nine regulators of nine different health care professions in the NHS? When you talk to whistleblowers or people who are frustrated in the NHS about improvement, they often feel that they have a good idea but their

organisations are not listening. We need to do some work on how we get organisations to respond.

One of the things that we are doing in terms of the professional codes of practice and how we can put in incentives to encourage people to feel able to speak up—many of them do not speak up because either nothing happens or they are frightened about their careers if they are juniors—is to have a summit in September of all the health care regulators to see how we can turn things around so that it becomes, if you like, advantageous to your professionalism to speak up rather than the reverse, as it is at the moment. That starts to take us into a place where we start to think about—Simon has already alluded to it—the very short life expectancy of chief executives at the top of organisations, two and a half years. Why is that? What is it that is forcing people out and what is it that we are not doing to help them stay in place and either develop their own skills or support their own organisations? That starts to take us into the area of the balance between regulation and encouragement and also the business of recruiting on values. Many other big multinational organisations in this city and in others recruit on values and train for competencies, so we are giving that some thought at the moment and we will try and put together a coherent package. But there is an opportunity, if we get this right, to turn the business of accountability that Simon alluded to, from one of a focus on failure to one of a focus on improvement, and that is where I would like to get to.

Q149 Liz McInnes: The Secretary of State spoke the other day about a no blame culture in the health service. Do you think we will ever achieve that? That is what he aspires to.

Simon Stevens: Matters of degree, I think. It is never going to be a black and white thing, but can we move more in that direction and less in the finger-pointing after the event direction? If we are going to improve, that is what we are going to need.

Q150 Liz McInnes: I am sure you will agree with me that the reason why a lot of staff do not speak out is that they feel that they will somehow be implicated in the problem they are trying to highlight and, in my experience, as an NHS worker, I have seen that happen to NHS staff; they actually become the villain of the piece for speaking up.

Professor Sir Bruce Keogh: But unless we have that aspiration, we certainly will not achieve it.

Liz McInnes: Yes. So it is an aspiration. Thank you.

Q151 Dr Whitford: In Scotland we have the Scottish patient safety initiative, which is involved in trying to break down barriers. We have the huddle that we do at the start of an operating list; we use first-name terms; the case does not start unless the entire team is happy; we have debriefing at the end; and, obviously, we use a Datix system for reporting both errors and near misses and they are reviewed every month. Over time, the more we report and discuss even quite small things, the escalation up to, “That was quite a big thing,” seems

easier. If no one ever talks about issues and suddenly there is one, exactly how do you see the structure coming forward to break that down into little steps?

Simon Stevens: We obviously now have in England, notwithstanding the excellence of Scotland, probably just by virtue of our size, the world's most comprehensive national reporting and learning system for patient safety-related incidents and near misses, run in part by a group at Imperial under Ara Darzi. Ara is becoming a non-executive board member of the new NHS Improvement, so that is why we are vesting that organisation with the responsibility for taking this forward. With our patient safety collaboratives across the country—our 5,000 patient safety fellows—huge progress has been made on this, so these are the beginnings of a sea change in the way people think about health care. Up until now, in most countries, there has been what people working in health care know and what people on the receiving end of health care do not know. That is changing, but as part of the new social contract, we have to give space for improvement as people look frankly at where those opportunities arise.

Q152 Chair: Thank you. We are right at the end of a marathon session. Thank you so much, all three of you, for coming. Before you leave, is there anything you would like to tell us that you have not yet been asked?

Simon Stevens: I have a section of material here that we did not quite get round to. We will save it up in eager anticipation for next time.

Chair: Thank you very much for coming.