HOUSE OF COMMONS

Health Committee

Oral evidence: Establishment and work of NHS Improvement, HC 617

Tuesday 19 January 2016

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Watch the meeting

Members present: Sarah Wollaston (Chair); Mr Ben Bradshaw; Dr James Davies; Andrea Jenkyns; Andrew Percy; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford.

Questions 1-118

Witnesses: **Ed Smith CBE**, Chair, and **Jim Mackey**, Chief Executive, NHS Improvement, gave evidence.

Q1 Chair: Good afternoon and thank you for coming to the Health Committee. Could we start with you both introducing yourselves, perhaps starting with Mr Smith?

Ed Smith: Yes. I am Ed Smith. I am chairman of NHS Improvement.

Jim Mackey: I am Jim Mackey, chief exec of NHS Improvement.

Q2 Mr Bradshaw: Could you both outline your understanding of the genesis and the reasons for this new organisation?

Ed Smith: The genesis is that there is a real desire to see improvement in the system, that we can do regulation and improvement through bringing both the TDA and Monitor together and that we set about an improvement journey around some key aspects of workforce digital delivery, property and financial performance, at the same time maintaining that regulatory oversight of the system together.

Q3 Mr Bradshaw: The original structure was Monitor for FTs on financial regulation and performance in particular, the Department and then whatever the organisation was called before—

Ed Smith: The Trust Development Authority.

Q4 Mr Bradshaw: The Trust Development Authority for non-FTs. Then there was an independent regulator for the whole thing. How is all that going to fit together? I have a slight concern about overlapping competing responsibilities between performance

management and regulation. As far as the public is concerned, it would be much clearer for them if you had clear demarcation between independent regulation on the one hand and performance management on the other.

Ed Smith: We should include the CQC in the oversight and regulatory piece.

Mr Bradshaw: Absolutely.

Ed Smith: Working very closely with the CQC on the inspection regime, on the oversight of quality and resources, and making sure that it is a key part of our own oversight of foundation trusts is also part of it. But in other systems I have worked in I personally see that, sitting together with the regulatory oversight, you can indeed have an improvement journey, provided you are taking cognisance of the inputs on the improvement journey from people like the ombudsman, NHSLA, Healthwatch and other organisations. They then become part of your inputs to what is going on in the sector. They are also part of the regulatory touchpoints that you touch in the sector.

Q5 Mr Bradshaw: You do not see a problem intrinsically in having the same organisation responsible for performance management and for regulation.

Ed Smith: I do not, partly because I think we can manage that quite effectively. I actually think it is better having them together than separate. You have to have safeguards. We will have a director of improvement and we will have a director of regulatory oversight, but we will have an independent board overseeing those things. Where we look as if we might be running into a possible conflict situation, we will deal with it and deal with it then. In the number of things we have to do between both NHS trusts and FTs, there is such a lot of similarity on the improvement and oversight regime that having them together is helpful. In fact, I should say that I have asked permission that we talk about both FTs and non-FTs here, because the legislation requires us to talk about FTs but requires us to go through DH to talk about non-FTs. That is an example.

Q6 Mr Bradshaw: I was going to come on to ask about that.

Ed Smith: With your permission, we can talk about them both.

Q7 Mr Bradshaw: Before we move on to that, are you confident that you have learned the lessons that were highlighted in the Mid Staffs inquiry, where one of the reasons for the delay in addressing the problems at Mid Staffs was because of the failure of Monitor and the then Healthcare Commission to talk to each other?

Ed Smith: Yes. One thing I have done since I arrived only a few months ago is to spend a vast amount of time connecting up what might be termed slightly disconnected parts of the system. One of those has been our relationship with David Behan, Mike Richards and the new chairman Peter Wyman, whom I obviously know. Since his appointment, Jim has spent a lot of time with David Behan and the CQC making sure that that relationship is very close together.

Q8 Mr Bradshaw: Referring to what you just alluded to, is there any point any more in distinguishing between FTs and non-FTs, given you and your new organisation, and the fact that the FT pipeline seems to have dried up?

Ed Smith: Do you want to take that, Jim?

Jim Mackey: Yes. There is a different legal context; so we need to bear that in mind. As Ed has described, we are going to create a single system of oversight, because in a lot of cases, from a performance point of view, there is not much difference. But we have FTs, they will continue to be FTs and we need to recognise that in our approach. It will be slightly different because they have a different legal framework that supports them.

Q9 Mr Bradshaw: How robust is your legal status, given that Monitor was an independent regulator established by Parliament, and the Trust Development Authority was a governmental organisation responsible directly to the Secretary of State? There have been suggestions that you cannot really exist properly without primary legislation, and we are not getting that, by all accounts.

Ed Smith: I think we can and our legal advice is that we can. NHSI will not technically be a legal entity; it will be an organisation, which is a name and a brand, and underneath it will sit the two legal entities of Monitor and the TDA. We have permission and regulations have been changed such that the board directors of Monitor are also board directors of the TDA. They will sit at the NHSI level as a board but effectively operate through the legal structures of Monitor and the TDA. Where we need to have a bit of separation, such as the appointment of chairs of NHS trusts, which is a TDA responsibility, we will create a sub-committee of the board to do that process.

Q10 Mr Bradshaw: You are confident, are you, that the two different legal bases of the two organisations from which you have formed will not give you any difficulties when it comes to your functionality and your ability to be effective on behalf of the public?

Ed Smith: It is certainly the advice we have received and certainly the sense that I have. We are always going to keep it under review. It is clear that trying to aim for primary legislation is impossible. As I said, a bit of secondary legislation, with the change in regulations, has allowed me to become chair of both bodies and has allowed Jim to become chief exec of both bodies. We are working through those components, but, yes, as of now, all the legal advice I have received would indicate that we do not have a difficulty operating under that one umbrella.

Q11 Mr Bradshaw: Will you be able to sack FT chief executives and boards in the same way as you will be able to sack non-FT chief executives and boards?

Ed Smith: When an FT goes into special measures, which has been the case for a while, the autonomy of an FT gets quite significantly shrunk, so there have been cases where we have done that and we will continue to do that, yes.

Q12 Mr Bradshaw: Is it the Care Quality Commission that puts them in special measures, or is it you?

Ed Smith: No; it is the Care Quality Commission that does it and then we react under our powers with that.

Q13 Chair: Can I clarify this? Will you be responsible to Parliament or to the Secretary of State?

Ed Smith: That is a good question. I feel I am responsible to both, but whether I go through the Secretary of State I do not know.

Q14 Chair: You just clarified that you have to ask permission from the Secretary of State to talk to the Select Committee.

Ed Smith: That is just on the TDA aspects.

Q15 Chair: Will that continue on the TDA aspects or not?

Ed Smith: We have a very clear derogation from the Department of Health that we can talk about both sets of organisations, which would seem to me to be absolutely sensible. To do anything else would be to bifurcate the very issue that NHS Improvement is trying to bring together.

Q16 Chair: But there is also an important aspect as to how independently you can carry out your role from the Secretary of State. For example, if we asked you to produce papers and you were responsible to Parliament, we could ask you to do so, whereas if you have to go through the Secretary of State we could not. That is a very important point. It is an issue that has already arisen so far in this Parliament.

Ed Smith: It is a good question.

Q17 Chair: Could you perhaps get back to us on that, because it is important?

Ed Smith: We will, yes. I certainly do not feel I am constrained from talking about NHS trusts when I come in front of the Select Committee.

Q18 Chair: You might not feel constrained, but what if there was a situation in the future where, hypothetically, the Secretary of State found it inconvenient? We found, for example, that there was a delay in producing certain financial reports. Do you remember this issue that we discussed? In future, we would like to think that there would not be any question of your robust independence in being able to produce data as and when you felt fit.

Ed Smith: We will do a note for you on that, Chair, because certainly, in my view, it is very clear that we are accountable to Parliament on both aspects, but it would be a good test, if that got constrained.

Q19 Chair: Yes, but can you categorically reassure us that information will be published when you feel fit?

Ed Smith: On that point, we did publish the second quarter numbers when we felt fit, when they were ready, and the third quarter numbers are going out this week. I have had conversations with the Office for National Statistics and we intend to adopt their voluntary code of publishing national data, which we think is important, basically, to demonstrate our independence on the publishing of key data.

Chair: Great, but you will send us a note on the legal status; thank you.

Q20 Dr Whitford: To clarify, there was Monitor, which was looking at the finances, and the CQC, which was looking at, if you like, clinical quality, but now, with health improvement, some of the quality improvement is under yourselves. Exactly what will that mean on the ground, or will it just be that a CQC report comes to you and then you act?

Jim Mackey: We do not want to duplicate effort or take a slightly different view of the same thing than the CQC has. So we have agreed, in principle—with some work to do—that we will build a framework of assurance that includes CQC ratings on quality and we will just rely upon their work. In return, hopefully, they will take our view on use of resources so they do not duplicate our effort in that regard. We have agreed just this morning with Sir Mike Richards that we will have a session in a couple of weeks' time, with some providers involved as well, and shape how we will do that.

Q21 Dr Whitford: If something in the CQC says, "This aspect needs improvement," is it you who takes that over?

Jim Mackey: We would respond to that, yes. That is effectively the way the regime has worked with the CQC. The responsibility for improving and acting on an action plan has sat with TDA and Monitor once the CQC has reported, and the CQC would then come back and inspect further progress.

Q22 Dr Whitford: There will be clinical involvement and not just the finances.

Jim Mackey: Absolutely.

Q23 Dr Whitford: Reading through all this, it is quite hard for me because it is a different structure.

Jim Mackey: Yes.

Chair: Are there any other points on that?

Q24 Helen Whately: I have one other thing to clarify. Where, for instance, would oversight of governance processes over quality sit in the future structural relationship that we are talking about?

Jim Mackey: Governance would still be part of our considerations. It is part of the CQC view on "well led" as well, so it is in their domain. That will be something else we would look to do jointly, if we can. We have started with quality and use of resources, and, hopefully, we will get to the point of having a joint assessment on that so that I am not in a position to have a view of a provider that has differed at the CQC.

Q25 Mr Bradshaw: Who do both of you answer up to? Do you have a board? Do you answer up to the Secretary of State?

Ed Smith: I am chairman of a board. I am appointing a new board at the NHSI level. The sponsors for our functions are the director general in the Department of Health, and both of us report in to the Secretary of State. In fact we have regular meetings with the whole ministerial team.

Q26 Mr Bradshaw: As far as the public is concerned, what is really important when it comes to any regulatory function is that you are seen as being completely independent from Government. That was the case with the Healthcare Commission and it is the case with the CQC.

Jim Mackey: The law on our regulatory powers has not changed. As Ed has described, we will have a director of regulatory affairs on the board whose responsibility will be to call on regulatory matters. We will build into our system that we will act on their advice. If we are working with an organisation from an improvement point of view, with a regional team, but they cross the line and breach a regulation, that director of regulatory affairs has the ability and the independence to call from a regulatory point of view.

Q27 Mr Bradshaw: But there will be people working in organisations of whom some will have that independent function and work in that way, and there will be others who will be under the direction of the Department to get rid of that hospital or do something about that failing non-FT hospital. How will you ensure that that culture can work within one organisation—the culture that you really need to be an effective regulator, where you need to be fiercely independent, and sometimes very critical of the Government publicly, and of a performance manager, which goes back to the question I was asking earlier? I do not see how these two functions fit in easily in any organisation.

Jim Mackey: There is a matter of emphasis in this. I do not accept that they are mutually exclusive. We can all be mature enough to work with a system that tries to improve first and recognises that there will be a point, if performance does not improve, where there is a regulatory requirement to step in and act upon that. The service is very comfortable with that. We have had a lot of discussion with people in the service about that.

Q28 Mr Bradshaw: I do not care whether the service is comfortable with it. It is about whether the public are comfortable and have confidence in it.

Jim Mackey: Under a director of regulatory affairs, we will have a team that will have sufficient independence to make sure that we comply with the law and regulate where that is required.

Ed Smith: One thing I have not yet concluded on, which may be something we conclude on as we form the next board, is whether I formulate a separate sub-committee of that board simply to deal with some of the regulatory competition aspects, but that is for debate. The advice at the moment is that it is not necessary, but on your point on the way in which it looks, it might be that we put that committee in place because it would be helpful from that perspective.

Q29 Mr Bradshaw: Did you appoint Jim, Ed?

Ed Smith: I was the chair of the panel that appointed Jim, which had a full process, yes, with the chief executive of the civil service, the chair of NHS England and the permanent secretary of the Department of Health. We went through search firms and did all the things that you would expect us to do. So, yes, I did appoint him, and I am delighted that I did, actually.

Q30 Mr Bradshaw: Who appointed you?

Ed Smith: I was appointed by the Secretary of State, as everybody knows, in a relatively abbreviated process because of the personal circumstances in which the organisations found themselves.

Q31 Chair: Thank you. Can I come on now to Monitor and, in future, NHS Improvement's statutory role as a sector regulator for competition and ask where you see yourself on competition and choice? In this predecessor Committee, Andrew Lansley told us on a number of occasions that integration trumped choice when it came to patient care where this was in patients' best interests. Could you set out where you see that position now and whether we are going to see a reduction in the number of times, for example, things have to be put out to tender if that is wasteful, where local systems feel that there is an integrated choice that is in patients' best interests? I am sorry; that is quite a long question.

Ed Smith: Yes. There is a spectrum between being on the end of promoting competition in everything you do but at the other end ensuring that integration of services works. Halfway between that, essentially on a case-by-case basis, is ensuring that there is not harm done to patients and the public, either through a lack of competition or taking competition in isolation from the joined-up nature of health and care services.

Where do I sit? I sit in that middle space. I do not sit in the space of competition being the silver bullet for all aspects of patient choice of care, and, equally, I think there is benefit of testing markets and commissioners putting services out into testing markets. I also think it is important that we get into competitive procurement for services, using both the Government machinery and other machinery that exists for competitive procurement of the supply chain. We have a duty to make sure that competition exists, that it happens, that anticompetitive behaviours do not exist, but we do not have a duty to promote competition at the expense of everything else.

Q32 Chair: Thank you for that. One point that was made during the passage of the Health and Social Care Act was that Monitor might act as an adviser to those systems that were not sure whether or not their arrangements were satisfactory. Do you see that as something you will be able to do?

Ed Smith: We do do that, and we absolutely do that, and I see that as a continuing role for us. It is a helpful role because it is important that trusts do not go and reinvent all of the learnings that we will have from looking at similar situations.

Q33 Chair: Yet the point is often made that we are still wasting too much money within the NHS on transaction costs and putting these processes out to tender. Would you agree with that or do you feel that we have got the balance right at the moment?

Ed Smith: It is important in the short term that we absolutely focus on the key issues. The key issues are getting the money right in the system. The reports from the King's Fund and others have shown in the past that mergers and other forms of integration have not necessarily achieved benefit. I can come back to that later. There are examples of where competition has not worked, but, equally, there are good examples of where competition does work. You have examples in your part of the world, Jim.

Q34 Chair: On that point, in my local area, for example, where they have finally managed to form an integrated care organisation, in Torbay and South Devon, that process was extraordinarily burdensome and wasteful of public money. How are you going to make a difference to help that process speed up?

Jim Mackey: We are reviewing all those processes. Earlier this afternoon we had a session about how, if organisations plan to come together or change form or whatever, we simplify the regulatory process without lowering the bar. Part of that is making an ongoing assessment of organisations' fitness, capability and ability to cope with risk and so on—we are not looking at organisations completely as a standstill and in abstract terms and then starting an assessment process—and being clear what the rules are. A lot of the pain in situations you have described is where the rules have changed over time and maybe organisations set off thinking they are solving A, B and C and then it becomes D, E and F. Part of that is being aligned with the CQC as well. We will create a set of rules. We will create a clearer framework and more simplified ongoing processes with hurdles for organisations to cross before they embark upon those things.

Q35 Chair: Thank you. I have one final point. Where we are seeing, for example, private sector providers raising complaints against commissioners, such as Care UK has done in north-east London, are you going to judge part of your success in how often that is happening to slow this system down—how often people resort to legal challenge?

Jim Mackey: Hopefully, we will help local systems develop good processes and frameworks to make sure they do not end up in a Care UK challenge situation. There will always be a level of challenge where people are disappointed at the end of the process, but we can make sure that there is absolutely thorough and proper process before decisions are made. We would expect to make an improvement in the sector in that regard.

Q36 Chair: Will we be able to see some transparent accounting around how much all these costs are to the NHS?

Jim Mackey: Yes, absolutely.

Ed Smith: One of my key themes, Chair, is to create much greater transparency over the costs of activities, the costs of how we do things and indeed the flow of money through the system from NHS England into CCGs and providers. It is critical that we create that greater level of transparency.

Q37 Chair: We are going to see less waste on all this and more of that money going into patient care.

Ed Smith: On the basis that greater transparency should create less waste, the answer is yes, but let us get to transparency first.

Q38 Dr Whitford: You were talking about integration from the point of view of putting organisations together. There is a lot of integration within the NHS normally—or was—without putting an organisation together. Is it not the case, though, even without becoming one organisation, that because of competition we are not having that integration of a pathway? That is what a patient experience is. It is going to their GP, going through a clinic, an investigation and a treatment. Is that not what has led to Staffordshire talking about

putting in this extra layer of waste, of a prime provider, because the CCG are fed up with having to deal with a whole lot of different providers?

Jim Mackey: We are seeing across the country different responses to try and deal with integration. First, most people agree that integration is a good thing. Secondly, it means different things to different people. Thirdly, it is not necessarily an institutional thing. There is a lot of integration people can do without changing institutional form. I would also say there is sometimes an excuse of the competition, though, where institutions do not want to embrace an integration process for their own protective reasons or whatever.

Q39 Dr Whitford: Do you not think it just adds a difficulty? We had an NHS; we had these things. It sounds to me almost like we are going back round a track to get as close to back where we started.

Jim Mackey: Before we had competition, though, we still had lots of separate institutions. The NHS, throughout its whole history, has had lots of separate institutions within it.

Q40 Dr Whitford: But people were working on pathways and there was not this disincentive of money, being in competition and winning a contract that gets in the way.

Jim Mackey: Those disincentives and the barriers are overplayed. There is a lot of evidence around the country now where people have found solutions to that. Where there is a need to do it and it is not happening, it is often down to local protectionism, where people are trying not to do something because it protects their interests.

Ed Smith: Jim and I agree on many things and we sort of agree on this. It is important to look at it from the patient-flow perspective—really important. One of my tests for the team will be to convince me and the board that patient flow is satisfied even if there are different institutional responses in different parts of the system. It is really important not only from an efficiency point of view, looking at it through that lens, but through a quality-of-patient- experience lens. I will come back to that in terms of data because the more fragmented that becomes, the more difficult the data collection and the data use are.

Q41 Dr Whitford: Is it not also talking about the transparency of accounts? The moment we get to a private provider, even though the money is taxpayer money, we do not get to see what happens to it. We suddenly are in a lead-box situation.

Ed Smith: There is work to do there, but we do agree on most things; I would just always put the patient experience of flow through a pathway quite high on my agenda of looking at the way in which the service works.

Dr Whitford: Absolutely.

Chair: We come on to Andrea now and foundation trusts.

Q42 Andrea Jenkyns: I have a question on foundation trust status. Do you think foundation trusts are becoming meaningless now that so many of them are in deficit, performing poorly or in special measures and subject to enforcement action?

Ed Smith: Foundation trusts have been incredibly useful for quite a long period of time. They have stimulated innovation, efficiency and quality. Where we are now, with a

significant number in difficulty and without their full autonomy, and with a shortage of resources and leadership capability, the question as to whether you continue down that road is a good one. We take the view that we set a pretty high bar for becoming an FT. There is nobody in the acute sector close to that bar, so the reality is that it is pretty unlikely we will see acute trusts moving to foundation trust status until we are out of this financial and quality challenge. Other forms—community trusts and mental health trusts—may get there.

We would rather not focus on the legal form, in a way, and it comes back to Jim's work, which he has started with the team, on creating a single oversight framework regardless of legal form. I do not know if you want to have a minute on that, Jim.

Jim Mackey: We are developing something that looks at the sector and there are a few areas we are going to look at. First, there is quality, taken from the Care Quality Commission. There is delivery on financial aspects, delivery on constitutional standards, and then there is something about leadership and strategic capability. We will develop an earned autonomy system such that, if you are in the best shape possible across those domains, you will have a lot of freedom and ability to make your own decisions, whether you are an FT or not. Also, at the other end of the scale, again whether you are an FT or not, if you are in trouble, you can expect intervention or a lot of oversight from us. You can take that forward, and that might mean in a period of time you have some organisations that are in such good shape that they can be licensed again. They could be an FT, but we are a long way from that in the acute sector. But, also, there is an awful lot going on developing other models, the whole accountable care organisation thing, devolution, integration with local authorities in different ways and the vanguard stuff. That will take us to a place where there are maybe six or seven institutional forms that suit the circumstances there. We will move away from everything being about being an FT to being more about something that suits your local circumstances, but, importantly, being in good shape first.

Q43 Andrea Jenkyns: Thank you. I would like to move on to the patient safety function now, which is something very close to my heart. First, why is NHS Improvement the best place for the NHS patient safety function to be hosted and not the Care Quality Commission or some other body?

Jim Mackey: Safety is an integral part of our improvement activity. There is a risk that people interpret what we do as being largely financial, but we are part of a clinical system. We absolutely need clinical advice and people who can help improve quality and safety in the provider sector. It is absolutely right that we have within our infrastructure experts on safety and the ability for them to network and engage with the service and help keep the service up to date on the latest international quality initiatives.

Q44 Andrea Jenkyns: What aspects of patient safety are you currently focusing on?

Jim Mackey: There is a range of things. A lot of the activities are going into organisations that are in trouble, in special measures, and there are a lot of detailed plans underpinning them. Some of that is about service configuration and sustainability. There are some that have specific outcome problems in certain areas. The team is working on the things that you would expect people to be working on internationally. Infection is still an issue in

some places; there is a lot of good work going on about falls and pressure ulcers. There are all those sorts of things. If you sit in a room with healthcare professionals across the world, they will all talk about the same quality and safety initiatives. A really big thing at the minute is about the management of sepsis, so the team is focused on that; it is a big priority in the NHS as well.

Q45 Andrea Jenkyns: As we have said, given that several trusts are in special measures, do you have any plans for earlier intervention before it gets to that stage?

Jim Mackey: We need a system that identifies trouble before it becomes trouble. The system we have had over the last few years has not been quick enough and looking far enough upstream to see the early signs of distress.

Q46 Andrea Jenkyns: What do you think the barriers have been?

Jim Mackey: It has been a very complex system and a very crowded pitch. There have been lots of different bodies involved. The provider system has become very fragile and stressed over the last few years as the money has got tighter. It is a combination of things. I would not point to any one of them. As I said yesterday to the Public Accounts Committee, periodically there is a time to regroup in the NHS—it is a very large institution—and that is where we are now. It is the time to regroup, simplify, tidy up and recreate systems. A test for us is to make sure that our oversight system is sensitive enough to see where things start to go off track.

Q47 Andrea Jenkyns: You are talking a lot about systems, but what does that mean in reality? What is that going to look like?

Jim Mackey: Data are key, so we are going to need a lot of good data. It is going to need to be transparent, so we should not be relying on just us seeing variation; we want local boards to see variation in trends; we want their neighbours to see that; we want peers to be able to see that; and we want the public, importantly, to be able to see that. We want to try and build a system that is looking at things from lots of angles. Data are key—quality of data and transparency of data. The NHS is a human organisation and relationships are really important. We need to have a view and be able to see whether there are issues with relationships in a certain health community that might cause problems later on.

Q48 Andrea Jenkyns: I would like to come in on that point before we bring Mr Smith in. In the last week I have had somebody contact me over a whistleblowing issue with patient safety and this person has told me they have had so many doors shut in their face. What are you doing to ensure that workers in our health service are protected and not afraid to speak up where there are major patient safety issues?

Ed Smith: You go first on this because I feel very strongly about this issue as well.

Jim Mackey: We have lots of mechanisms for people to report and whistleblow, but people at times still feel unable to do that. We still have a lot to do in creating a culture where people feel able to challenge and speak up where they see something that is wrong.

Q49 Andrea Jenkyns: That is easier said than done. How does that translate into action?

Jim Mackey: Once you have raised an issue, it depends on where you have raised it. In my old institution you would fully expect things to be raised at a local level within the team—occasionally they were escalated to me—and we had established mechanisms to make sure there was a "no blame" approach; people were protected; there were systems to listen to what they were talking about, get underneath the issues and then ensure action was taken. There are mechanisms across the country at different levels to be able to do that.

Q50 Andrea Jenkyns: I wholeheartedly agree with this "no blame" culture if we are trying to get people to be more open, but I think it has to be balanced with making sure there is a place of consequence if there is something not right going on. Have you got the balance right?

Jim Mackey: It is hard to tell. We will not have the balance right all of the time; no single institution will. We need to do our level best to make sure, first, that if there is an issue somebody feels able to raise it. I agree absolutely that the "no blame" thing cannot be a "no consequence" issue. There are times when somebody has just done something silly and there needs to be a consequence. Most of the time that is not the case in the NHS, in my experience.

Ed Smith: On this subject, when I read a report that says 28% of people report bullying and 14% report physical violence, I feel embarrassed to be sitting on top of a system that is doing that. Right at the top of my agenda, with my trust chairs and with other parts of the system, is making sure that we have got this very high on the agenda. There is not an instant solution. Also, you have to be careful about what is the setting of objectives, what is performance management and what is all of that compared with completely the other side, which is a bullying, secretive culture; 14% of people reporting physical violence is a terrifying statistic. It is there. I have already had a discussion with some of my chairs about it and we are going to have a theme around this as they have in another part of my non-executive forest where it is zero tolerance but there are consequences.

Andrea Jenkyns: A place of consequence, yes. Thank you.

Q51 Helen Whately: There is a long history of pan-NHS organisations trying to drive improvement, whether it is the Modernisation Agency, the NHS University or the Institute for Innovation and Improvement; the TDA tried to take on an improvement role as well. But, arguably, with all that turnover, there has not been the greatest impact from those kinds of initiatives. What is this NHS Improvement organisation going to do differently so that it is more successful? How is it going to go about driving improvement in the system?

Ed Smith: Jim has been in the system a long time and I have not. I do not know about the others, but I will tell you what I think we should do. We should embrace the excellence that is out there in pockets but not shared across the organisation. There is some really good stuff going on. You do not build all the capabilities in the centre and become an improvement agency that has all that capability and just sends it out. You create task and finish groups of people who are good on data use, patient safety and cultures that stamp out bullying. You get them round the table. In fact, on the website of the Joint Improvement Team in Scotland, there are 53 pages of examples of things that people do

locally, which could then be picked up and done by other people. We do not have that sort of mood music around the system, of people learning from others. In fact, we have the opposite, which is almost silo based: "What I have is mine and you're not having it."

Q52 Dr Whitford: It is called "once for Scotland". We are getting rid of the "not invented here".

Ed Smith: I am going up to see Jim and Margaret to learn because, quite frankly, some of that stuff you can put into the English system using technology and things. Jim, you take it from there, because I do not think we are going to build large capabilities in the middle. We are going to build some national capability.

Jim Mackey: The effort needs to come from local teams where people at every level feel the desire, the ambition, and have the mechanisms and systems that would enable improvement. We will not build a system that just has a load of national experts who turn up and sprinkle fairy dust on places; that has not worked. You raise a good point, though. In my career in the NHS, there have been a few periods where it looks like we have caught the wave for a while and improvements worked for a short period, but at no point has it ever been sustained. We are doing a bit of analysis on when that has happened to see if we can see some themes as to what created the circumstances where it worked. As Ed said, there is a load of fantastic things going on out there in the service; it is just hard to share, hard to learn from and hard to connect people. Our job is to make that possible rather than us directly physically improving things.

Q53 Helen Whately: Have you thought about how you might incentivise people somehow and change the context so that people do go and see? I have lost track of the number of hospitals and people I spoke to who said, yes, they think somebody might be doing this out there, but they have to work out how to do it. They have not been together to see somewhere else. Somehow, there just was not that oomph, something to make them go elsewhere.

Jim Mackey: That is directly linked to the day-to-day circumstances people find themselves in. It is impossible to do when you are struggling terribly with the money and you cannot find patients beds from A&E. Realistically, those people are not going to find the time to go and visit somewhere and learn from them. In my old organisation, in Northumbria, we used to do visit days. Every month or every two months, two or three organisations would come and see us and look at things that we were doing, and we would reciprocate and go elsewhere and do that; but they tended to be organisations who are either in very good shape themselves and had the time and headroom to do it or had been sent by a regulator to come and see us. Our first job is to create a context where more people are managing to deliver what is required of them day to day so that they have the headroom and the thought space to be able to think about improvement and allow staff to connect with this and learn from each other. That is going to be quite hard to get to from where we are now.

Ed Smith: I have three or four quick things. One, I have established a chairs advisory partnership, which is going to be jointly run with Peter Wyman of the CQC, bringing chairs together to present and discuss items that they can then use, discuss and take out to their organisations. Jim is doing the same with a chief executives group. We are going to

make sure that our NHSI organisation is regionally based; it might come as a surprise that it is not. At the moment Monitor is fully London based. We are firmly of the view that we should have people closer to local health economies in a regional structure, and, indeed, where possible, over time co-located in teams with NHS England. We are shifting the emphasis of the organisation closer to local health economies and then—it sounds soft, but it is hard to do—telling people that a "not invented here" way of doing things is perhaps a bit closed. But you have to get the heads up. When times are like they are, leaders become managers and managers become administrators. We have to get people out of the financial challenges in the short term and get them working up above where they are in the system at the moment.

Q54 Helen Whately: Would you share the view—the Secretary of State last year himself said—that there needs to be a cultural change in the NHS; it needs to become a learning organisation, and NHS Improvement was intended in part to drive that? Do you see now, from where you are sitting, that there is a cultural change and you are going to have to take the steps to do it?

Ed Smith: It is all about people; it really is. When you have a proliferation of targets, of "Do this this month. Do something else next month," you get a culture of disengagement and it becomes difficult to do what you need to do. Everybody thinks that a change of culture is a light-bulb moment where you just flick a switch and the lights come on, but it does not happen. You have to do a lot of things in a consistent way over a five-year period of time. The first thing you have to do is use the money wisely. With the joint planning guidance and with the notes that Jim sent out last week, we make it clear how we have set some short-term targets to help people get out of the short-term issues. We have to get to a different place in terms of how people feel in the system. Reading *The Guardian* over the last two days, I have to say that I sit there and say, "Isn't it wonderful—the stories people tell about their dedication and the work they do on the ground?" Why don't we harness and engage with that more than perhaps it is seen that we do at the moment? It sounds a bit romantic, but it is not romantic; it is really hard to do and we are going to set out on the course of doing it.

Jim Mackey: Absolutely. With all that, we can create circumstances nationally and systems, networks and all those sorts of things, but we need everybody—the NHS employs about a million people—absolutely in the position where they want to improve things; they are hungry; they have ambition for their teams and their patients and so on. That is working well in pockets; we have to make it work well consistently across the board.

Q55 Helen Whately: I have one specific final question on this. One thing I found, working with hospitals—I think it is well recognised—is that there can be gaps in the analytical capability around investigating what has gone wrong and planning for the future, hence the use of management consultants sometimes to plug that gap. Do you have a view on how that should be addressed?

Ed Smith: It is a significant gap. Do you want to take it?

Jim Mackey: Absolutely. Again, there are pockets of real excellence in terms of the use of data. UHB has fantastic data systems and it is good at using them, as are Salford, my old

organisation, and the Royal Free. Lots of people are doing that, but also some organisations have virtually no capacity and capability to do that. One thing we want to try and do is hook people up to try and share each other's resource, to work together. Some of this is quite specialist, so you would not want every organisation to try and recruit the teams that are not possible to recruit to on that scale or use technology on that scale. A lot of that answer is within the NHS rather than with the advisory firms.

Q56 Dr Whitford: Talking about interacting with teams and more health improvement, Monitor was criticised in the past for having a vanishing small number of people with a clinical background within it. We have met you and the head of the CQC, who are all much more from, if you like, the figures or the money side. How exactly will you have a clinical resource both to interpret what you are looking at and to work with teams so that teams accept, "This person understands the hole I am in," as opposed to, "This person has swanned in and is counting the money"?

Jim Mackey: The TDA side of our organisation is largely populated with NHS people. I could not give you the number, but a very significant proportion of them are people who have been nurses, doctors, physios and so on, so they come from a clinical background. We will be making sure that when we develop our systems, especially our regional teams, we have good clinical colleagues within the systems—senior nurses, senior medics and so on—but, importantly, creating networks that harness and engage with the service, with people who are practising day to day. There is one worry for me, and it may be part of why improvement has not worked over time; there is a danger that we think we have all the answers. I have been out of hospital practice for about four months now and I already feel deskilled. We have to have systems that are constantly connecting and staying up to date with what is topical, what is reasonable and where the developments are ongoing. It is our job to be a facilitator of that rather than being the home of all the intelligence and information.

Q57 Dr Whitford: You would share proposals.

Jim Mackey: Yes.

Q58 Maggie Throup: Before I touch on how NHSI will work with the CQC, you almost have a bit of a conflict—quality versus money. Also, you have talked about a single unified framework. There is some concern that this will create more burden than less on the providers. Can you expand on that and convince me that will not be the case?

Jim Mackey: Yes. As I said earlier, there is a real danger that we could do that and that has happened a lot over the years. The steps toward us relying on the CQC for part of that assessment and vice versa—you know, them relying on us—are big, and we will increasingly do things together and with NHS England. Rather than things being assessed or interpreted twice or three times, we will try and simplify that. We have not yet engaged with other colleagues about this, but we have determined on our team that, when we do make a connection with an organisation because it might have an issue, the first step of that process should be that we agree with the other bodies that there is one point of entry and one lead organisation. We get that fed back an awful lot and I have seen it myself where an organisation gets into trouble and has six plans to write immediately; they are all slightly different and all have different timetables and are sometimes contradictory. We

need to take a responsibility to solve that for the organisations because they cannot do it themselves. We will build that over time and build in check mechanisms so that, periodically, we will test with the service that, frankly, they have not lost the plot. These are easy things to set off on or try and do but are quite hard to maintain. It gets back to Ed's points on his chairs network and my chief executives network, and the medics will do the same, et cetera, having constant mechanisms that are telling us whether we are asking for things twice, whether we are doing contradictory things with other regulators, and we will hard-wire into our systems to make sure we resolve that when it occurs. It is quite hard because we have a lot of national bodies; it has become a very messy system.

Ed Smith: There are a couple of things from me. With Malcolm, Peter Wyman and myself, providers, commissioners and technical people, we are very clear that we meet regularly; we have constant communication with—the words I use—instinctive collaboration. The message to Jim in his becoming chief exec is "instinctively collaborate with others in the system."

The other thing I was quite surprised about when I read the NHS providers survey was that 96% of FTs had seen a significant increase in data requests over the last 12 months and 70% of trusts. One thing I would like us to do is have a real data project. They said that many of those requests came from local commissioners, from other parts of the system as well as from us. We need to de-duplicate—a terrible word—data requests. One of my themes, when we get to it, is quite a significant data study, which I did in higher education 10 years ago, to reduce the burden of data requests at different times for the same data from different bodies. We need to harness that and get the data once and use it many times. That will help release capacity.

Q59 Maggie Throup: You have the vision for that.

Ed Smith: Yes. That is the joy of being a chairman.

Q60 Maggie Throup: Do you have the capability lower in the structure to do it?

Jim Mackey: We are not there yet because we do not technically fully exist yet, but we might have a shared analytical resource; it is a shared data collection system between the different bodies. I think that is entirely possible. That is where we will want to go rather than have three, four or five separate points of data collection. You make your own interpretation then within the institution, but there is no need to ask for the same thing several times, is there?

Q61 Maggie Throup: You mentioned about a lead organisation. How will that lead organisation be decided? Will you be fighting over who is in the lead organisation?

Jim Mackey: It does not matter as long as it works. It could be properly shared services that are run in a neutral way, but more likely we will run one thing, the CQC will run another in return, and we will just do deals with each other about what is the most pragmatic way forward without making it overcomplicated. A lot of this is in the mind. We get a lot of comments such as, "Are you going into this with the spirit of genuinely trying to help, collaborate and make things simpler?" We get that time and time again, and I have seen it myself recently. We have created a really complex system. It is time to simplify it.

Q62 Maggie Throup: We have talked about silos in the past and mentioned it today. Are you determined to break down those silos? Will you be able to?

Jim Mackey: Absolutely.

Ed Smith: We are absolutely determined to break them down.

Q63 Maggie Throup: We will bring you back and hold you to account on that one. It is one of my bugbears.

Jim Mackey: In the last couple of months we have had incidents with organisations who have got into trouble. Some of them have been quite high profile and we have agreed in each of those cases between ourselves—the CQC and NHS England—that one of us will lead the processes and will rely upon the others and help, or where there is a need we will do a joint process, rather than having separate or sequential, maybe contradictory, processes with those organisations. When you are in trouble, the last thing you want is some extra person coming to mark your homework.

Q64 Maggie Throup: So far, on the ones where you have worked together, is that working?

Jim Mackey: It is working pretty well, yes. It is early days, but it is working pretty well.

Q65 Maggie Throup: Do you have any evidence that they have come out of those difficulties quicker than they would have done otherwise?

Jim Mackey: It is too early to tell. Hopefully, they will, but it is too early to tell.

Chair: Thank you. Now to trust deficits.

Q66 Dr Whitford: What do you think is the root cause of the fact that nearly 80% of trusts are going to be in deficit or are already in deficit?

Ed Smith: Can I say root causes, because there are many?

Q67 Dr Whitford: Yes. We will maybe go for the top few rather than every single one.

Ed Smith: I will not go through them all. One is clearly on the demand side, and it is pretty straightforward: the increase in population, the increase in illness and sickness and things. Our ability to fix it is creating a significant demand. The data are fairly clear about the increase in demand; it has probably outstripped the funding that has been available. Secondly, the inflow inside an institution and between institutions is not where we would want it to be. Moving people through departments in a hospital and out is causing a difficulty. Delayed transfers of care are creating quite a bit of bed blocking in acute trusts. That is increasing the cost of delivery and the costs inside a trust. The third one is—and this goes back a while—workforce planning. It is easy with hindsight and I do not like to go backwards other than to learn from it, but, with hindsight, we ended up probably in the wrong place with forecast numbers that we needed for nurses, in particular. We then had the Mid Staffs issue and the CQC staffing ratios, and the reflex, quite frankly, to increase

nursing at a time when we had a lot of supply; I do not want to rehearse the point about the extra £1 billion that is in the system because of the agency costs. Again, that is well known and was rehearsed yesterday, but that is a significant piece of cost in the system, which Jim and I have set about dealing with in the short term. The long term is about getting workforce planning properly sorted out. They are the top three or four. Jim, you might want to add to that.

Jim Mackey: No, that is a good summary. It is never just one thing in the NHS; it is multifactorial. When you put all those things together you can understand and rationalise why we are where we are. The important thing is what we are going to do about it.

Q68 Dr Whitford: Does not the fact that the NHS moved from miraculously every year being in the black in 2013 to 2014 to suddenly plummeting into the red show that at least some of the contribution to this is the changes of the Health and Social Care Act, bidding, tendering, competing and not working together?

Jim Mackey: I personally do not think that is the case. The system has, in aggregate, balanced over those years, but the provider deficit has built up in that time. In the early days of the foundation trust system, there was a balance of risk where the risk was tipped more towards commissioners. That was corrected about six or seven years ago and tipped more towards providers. We have just seen that get slightly out of kilter over the last couple of years.

Q69 Mr Bradshaw: Are you saying that the Lansley upheaval—this huge upheaval, the biggest reorganisation ever such that we can see it from outer space, as the former NHS chief executive described it—at a time of maximum spending restraint had no impact on NHS finances?

Jim Mackey: I am not saying that. I am saying that is not the main driver of provider deficits at that time.

Q70 Dr Whitford: It is just that, when you see the figures, we always somehow found £500 million down the back of the sofa at the end of the year and then it was £100 million, £800 million, £1.6 million and we are expecting it to be—

Mr Bradshaw: What about commissioner deficits? I live in a part of the world that did not have any deficits six years ago and it is now one of the most financially challenged in the whole country. All the health professionals in my patch—providers, commissioners and whoever—say that that unnecessary and costly upheaval is part of the problem.

Chair: Shall we deal with one question at a time?

Mr Bradshaw: Yes, but I am just amazed, Chair.

Jim Mackey: The biggest driver at that time was the increase in the efficiency requirement that drove a lot of the provider deficits at that time. I accept that in certain parts of the country the turbulence has been very costly and very distracting. There is nothing we can do about that now. A big part of what we have to do now, as we have said before, is to simplify and try and get people behind—

Q71 Dr Whitford: How would you imagine tackling the three that you have laid out?

Jim Mackey: In the coming year we have a few things going on. The first is that we have a better settlement in the spending review than we had anticipated a few months ago. There is slightly more resource than we had expected to have. Secondly, we have been able to translate that into a better, more reasonable tariff settlement for providers, the key thing being an efficiency requirement of 2% rather than 3 and a bit, as it was last year and in previous years, in a reasonable inflation uplift; so providers have a more reasonable requirement in the next year and in following years.

Q72 Dr Whitford: What do you think the uplift in the tariff is going to be?

Jim Mackey: It is inflation of 3.06% and an efficiency requirement of 2%, so a positive 1.06%. That was a negative figure last year. That is quite a big difference. Providers in the coming year were expecting that to be another negative tariff year, so that is a big change. Separate from that, we have the transformation fund of £1.8 billion, which is being targeted at eliminating provider deficits. That was published and issued to the service last Friday, with control totals, effectively, that work with this theory. If you have a deficit of £10 million, the transformation fund might give you £6 million and you have to squeeze the rest out yourself, which is within reach for most organisations. We believe that will get us more than a pound-for-pound improvement in the coming year.

If you add to that the Carter review, as we discussed yesterday in the Public Accounts Committee, it has identified £5 billion-worth of savings. A lot of people would argue with that, but it is absolutely certainly not nil. There is a huge number in there for organisations to go at, and the actions we have taken on locum and agency control should, if enacted fully in the way we expect, save in excess of £1 billion on an annual basis. When you put all those things together, just as the cause of the deficit is multifactorial, we have created an awful lot of things that should have a seriously positive effect.

Q73 Dr Whitford: There was talk about a headcount reduction. That simply means staff. How will that be balanced against maintaining safe staff when NHS England has one of the lowest ratios in the UK, and a lot of what came out of the Francis report was about there not being enough nurses in the hospital?

Jim Mackey: Nobody has any intention of doing anything that damages safety or quality. What I was referring to in the headcount reduction was this. We have a handful of organisations that we have analysed and seen so far in the last two years that have had a serious increase in headcount and at the same time managed to deteriorate in their results and performance, and clinical outcomes have not improved. We want to work with those organisations with the CQC alongside us and understand what that is about, and then try and re-base things. You could argue in a really simple sense that organisations such as Barts could go back two years, save nearly £70 million by doing so and improve performance and outcomes, because they were in much better shape two years ago before that explosion happened.

Q74 Dr Whitford: You mentioned as one of the causes—and of course there are multiple causes—increased demand, and particularly increased demand into hospital, and a lot of the projects that we hear talked about are how to move that back into the community. Is the tariff not counterproductive in that? I met a consultant who had been doing outreach work; it was quite a specialist area. They had reduced admissions by 40% and it was pulled by the hospital because the hospital lost money on the tariff. Is there not something more intrinsic about the tariff that we need to change?

Jim Mackey: Again, I am on record yesterday as saying that the tariff mechanisms we have now are not fit for what we need to do in the future—or even now. In my former organisation we opened a new emergency hospital last year and the estimates when I left were that it would lose about £8.5 million by seeing more people but admitting fewer patients. That would be lost income to the FT, but we agreed with our commissioners that the money would flow in a different way so that the trust was incentivised to do the right thing. That is all about relationships. It is entirely possible within the current mechanisms to do that.

Q75 Dr Whitford: But can we not avoid the "not invented here" and every single area having to work that out?

Jim Mackey: Absolutely. We need to look at our payment mechanisms and make sure there is a standardisation, where necessary. We support local initiatives. We will create a framework that encourages and supports people to do the things I have just described. That moves away from the kind of widget-counting tariff mechanisms we had a few years ago and will require different instruments. Those instruments might change over time depending on what the issues are.

Ed Smith: I was pleased to see over the last few weeks, and confirmed yesterday, that both Simon Stevens and Jim agree that we need to carry out a review of the whole pricing/payments system. That is, again, one of the big projects that we need to get to, but it won't happen in the next two years—it will happen over a period of time—because replacing the pricing/payment system with something else needs to be done with care. It is on the agenda.

Q76 Dr Whitford: That is part of the burden of where the NHS has gone in the last 15 years that is holding it back rather than taking it forward.

Jim Mackey: I think we are where we are. The system needs to change. Because of the aggregate financial position, individual tariffs no longer have any credibility. We have to rebuild the whole system and then look at the individual mechanisms to make sure that they do what they need to do.

Q77 Dr Whitford: Can I ask you one last thing on the role of PFI within this and whether you see some mechanism for trusts or hospitals to be rescued from PFI?

Jim Mackey: There are already subsidies in place for some PFI schemes that went through a process a few years ago to determine where that was required. There are a handful of places where initial work indicates that bringing them back into public ownership is the right thing and good value for money, but not many—a handful. There is also good evidence now in some sites where there is a process you can go through with a PFI

company to make the scheme much better value for money. We have a task and finish group looking at how we do that. It is one of those things that probably does need a bit of a central specialist team—some of our guys drawn with people from the service. You would not want every individual institution trying to learn this and do it themselves. It is too complex.

Q78 Dr Whitford: But you are planning to try and tackle that.
Jim Mackey: Yes.

Ed Smith: We are, yes. As I went round the system doing lots of listening before Jim arrived, one thing that came up was PFI. So Jim, having arrived, has taken on how we take it forward and deal with it. Again, coming back to Helen's point, the way in which we would deal with it is not by creating a large central body. There are some great people who manage their PFIs really effectively in trusts and it is enjoining them in a task and finish group to help us get the job done.

Q79 Chair: Another factor raised with me is market forces. Is that something you will be looking at in your review?
Jim Mackey: It is mainly an NHS England issue, through the commissioning process, but we will be having a look at that. Also, mainly from a provider point of view, in certain very remote locations there are structural issues that arise because of their distance from a big urban centre. Again, we have some work ongoing to try and understand that impact and make sure it is corrected.

Q80 Chair: Thank you. Another issue you touched on earlier was your data project. Will your data project also make it much easier for those who want to look at the finances within institutions to see where the money goes within the system? A point that is repeatedly made to me is how difficult it is for people to look at the NHS's accounts.
Ed Smith: I certainly hope so. I have said to you, and I have certainly said as I have gone round the system, that we need transparency from top to bottom of the way in which the money flows out of DH into NHS England, through into CCGs, and from CCGs how it then flows into providers. We do not have that full transparent look, both in-year and in-budgets. We should do that. That is another project between NHSE and NHSI, to get that much greater level of transparency, including looking through the CCGs as to where the money that has been allocated to them goes. I have to tread carefully on that, but, again, in the spirit of complete transparency on public money, it is an important aspect of what we do.

Q81 Chair: Would you be looking at a common financial reporting framework?
Jim Mackey: There are already standards for consistency of reporting across the sector. I have to say, as an ex-FD, that I used to look around, as you do, at other organisations; you try and see their board reports to see where they stand financially. The general standards of reporting are not as good as we would like. We will be introducing new standards in the new financial year that are clear on expectation. Public bodies should write board reports and ensure that financial reports are available for the public to see on websites.

Q82 Chair: Sometimes I hear reports of documentation of 300 pages being given to board directors the day before a meeting so that you can't see the wood for the trees.

Jim Mackey: That is a failure of governance; it should not happen. In my old organisation—and Ed is exactly the same—they would not accept that. We need to be clear as to what the expectations are.

Q83 Chair: It is clarity. When we interview you at your next accountability hearing, we will be able to hear about progress on accountability and transparency of data.

Ed Smith: Yes; it will be progress and perhaps progress not as fast as the Committee would like, but it will be progress. I sit in the camp of "300 pages is opacity, not clarity", and the day before is either deliberate or incompetent support of the board. I feel quite strongly about it. My colleagues in the organisations that I chair know that it is five working days before, it is a two-page paper, and if there are appendices it is not 300 pages of appendices. We have to work through the system on that and it will take time.

Q84 Maggie Throup: How will you ensure that the £3.8 billion "front-loading" of the comprehensive spending review settlement is used to establish changes that will help providers cope with the lower settlements they are getting in future years?

Jim Mackey: That is where the transformation fund comes in. It has been described as a "fire break" year, so it gives providers a bit of headspace this year—some time. Access to the fund will be on condition of demonstrating progress on Carter on the locum and agency issue and on a range of other things that will give them productivity gains in future years. This is a year of catching our breath and preparing for the years after that. The CSR indicates efficiency requirements of around 2% for providers during the life of the plan, but the system understands—providers understand—the need to get ahead of the game and create more headroom going forward.

Q85 Maggie Throup: Do you want to add anything?

Ed Smith: No.

Q86 Maggie Throup: You mentioned earlier that you are working with Simon Stevens on the pricing payments. We are 18 months in to the Five Year Forward View already. Are you working with him on the post-Five Year Forward View, especially with regard to the financial side of things?

Ed Smith: The last thing I said before I left the NHS England board last summer was that we need to be starting work now on the second Five Year Forward View. I then left the board, so I will leave it to Jim to see how he is taking it forward.

Jim Mackey: It is an ongoing process; we are working on these things all the time. Again, good organisations will have 10-year financial plans, they will have long-term strategic plans, et cetera, and a lot of that has been squeezed out in recent years. It is not a cliff-edge thing; it is not done when we reach the five-year point. There is a lot of good stuff to learn from in the vanguard sites as well. We need to make sure that is shared properly and adopted, where it is possible, and accelerated.

Chair: Thank you. Was there anything else you wanted to ask about the comprehensive spending review?

Maggie Throup: I have covered that.

Q87 Helen Whately: Before I move on to productivity, can I pick up on the front-loading question and how to make sure that it goes into transformative change and not just plugging the gap? You spoke about the money going to trusts being dependent on them doing certain things. Arguably, some of the things mentioned, yes, are kind of important efficiency programmes, but they are not so much the transformation that was envisaged in the Five Year Forward View, which requires, in my understanding, quite a different level of change in the way organisations behave and use technology.

Jim Mackey: That is dealt with largely in the second stage of the planning process. Ed mentioned earlier the planning guidance. There are two stages: the first stage is an institutional-based, quite simple business plan. The really important bit is the sustainability of transformation plans, which are health economy-wide, things that will happen in the spring. That is the opportunity for people to determine that there is a service change required, there is a need to embrace technology in a different way and there is maybe an integration issue. We are working together with NHS England and the service to make sure that we take that opportunity. This is the year to go for it in that regard. If we do not, we are going to be back here in a couple of years' time with other problems. This is the time.

Q88 Helen Whately: How is the front-loaded money split between the more standard efficiency and keeping things going and driving that change? What are the rough weightings?

Jim Mackey: It is hard to say, to be honest. The bulk of the £1.8 billion is to stabilise, but that gives you the ability to have the headroom and to think of your business case for change. Without the former, you have no chance of doing the latter. Even if we produced money that was purely for transformation, unless we had addressed the leaking roof, people would not have got to it. These things are not mutually exclusive. We have to do them both. You have to run day to day and think of the future, but when you get one seriously out of kilter you will end up doing neither.

Q89 Helen Whately: Rather than all the money still going to the acute sector and the stabilisation of that, are we going to see a shift in some of the funding that has been so much called for over these coming years going to the other parts of the system to enable that to be achieved?

Jim Mackey: There has to be. I was talking to community service providers on Friday who were slightly upset because they will not get anything out of the transformation fund. I used to run community services as well. We need to think about this in a different way so that there is a business case that can be made for community services that saves commissioners money by treating patients in a different setting, or providers by reducing length of stay, or shifting system costs in a different way. We need to help them make that case better. That has been a real barrier for investment in community services. It is quite hard to do but we should not give up on it. There is not a scenario where there will just be

a load of blank-cheque investments. We are in an environment now where everything has to wash its face and, importantly, improve things for patients as well. I am quite optimistic about that: get a bit of headspace and let people really think about the business case. It is probably easier to reduce length of stay and make the case to the acute sector about saving money. Stopping people going to hospital, full stop, is really tricky and could take a long time.

Q90 Helen Whately: On that point, we have just been doing the primary care inquiry, and we heard the primary care sector ask for more money, but I did not find they made a very strong case for how much money for what. So, maybe on your point, there is something about supporting the other parts of the system to make a stronger case for that.

Jim Mackey: Yes. Often there is a case there, but they are just not used to demonstrating it in the right way.

Q91 Helen Whately: I will now come to productivity. It is well known that the health service needs to make a substantial productivity improvement over the coming years in order to avoid needing an extra £22 billion on top of the £8 billion come 2020, but beyond the indications of the Five Year Forward View and the interim Carter report, it is still unclear how that efficiency improvement is going to be made, when it is going to be made, who is going to make it and what the levers are. Can you give us some more visibility on that?

Jim Mackey: The provider bit is, broadly, 2% a year through the life of the plan, as I mentioned earlier on. We are quite clear on that and that will be embedded in the tariff when we know what we are working with. There is a plan for the rest of the efficiencies, which include land sales and other changes, and that is an NHS England and a DH point; so you need to ask them. I have a broad idea how it all works, but I am not an expert and I did not negotiate the spending review, so I would probably suggest you ask them. They will give you a better answer.

Q92 Helen Whately: Albeit that part of the work of NHS Improvement, as an organisation, will be to enable organisations to make those kinds of changes.

Jim Mackey: A lot of the savings outside the 2% are things that do not affect the provider sector; they are things that are in the commissioning system or in other parts of the system. We will work together on it and land sales is an issue where we will definitely work together, but there are other commissioning-specific issues that NHS England will get on with and do.

Q93 Helen Whately: But the Carter report savings would come within the 2%.

Ed Smith: Yes. I brought Pat Carter on to our board. I think that was announced just before Christmas. I am bringing Pat's team across to sit inside our organisation, and we are going to capture and use that and additional supply chain data to drive the supply chain procurement savings—absolutely. I am delighted that Pat has come on to our board because that is where the heart of that efficiency drive should sit, and indeed it was part of your letter on Friday, Jim, about targets and the use of the transformation fund.

Q94 Helen Whately: The Carter interim report has been criticised for its use, for instance, of "reference costs" data, which are known to have not been the most robust. Do you have a view on the feasibility of the savings opportunities suggested in that way?

Jim Mackey: Yes. As I said yesterday, you will not find many people who will say, "We will definitely guarantee £5 billion," but there is nobody who would say it is nil. There is a serious number in there and we need to work with each individual institution, work through the data issues and be clear about what is achievable. That work is ongoing. On the reference costs point, as I said yesterday, reference costs did fall into disrepute a little bit; people did not put as much attention into them because they were not really used for anything. The service understands now that they are going to be used for things, so they will improve dramatically, and hopefully this will build. It is not a fixed point in time where this will be solved. It will continue to evolve over the next few years. We will see the data becoming more accurate, more meaningful and huge productivity gains following.

Q95 Helen Whately: Do you have a view on where particularly those huge productivity gains will come from? What theme or organisations will need to be followed?

Jim Mackey: There is a bit of a different flavour in different organisations, but there are some themes. There is definitely huge procurement opportunity. Even within one institution you can buy the same things at different prices, which is absolutely unbelievable, but it happens. The NHS is big and complex; the use of the estate is seriously inefficient at times, with huge variation. The workforce metrics are really interesting. Some of Pat's work has been where you go into an organisation and a ward thinks they do not have enough staff, and then the productivity work points them to all the waste and duplication and the fact that they might have more staff than they think, certainly different from what they have rostered, and compared with the ward next door there is a huge variation. That has huge value there. Because it has been built through an engagement process with clinicians on the ground, it has been very credible.

Ed Smith: It has credibility.

Q96 Helen Whately: Is that where, this time, it will be different from previous initiatives or attempts to make that kind of change?

Jim Mackey: Pat has put a huge effort into it. It has taken longer than people would have expected or wanted because he has spent a huge amount of time making sure people are behind the methodology and have bought into it properly. That is a big thing in the NHS, where people want to feel like they own it so that it is hard to argue against; it is their data. All those things are important. It is then much harder to resist the change.

Q97 Helen Whately: You say people are behind the methodology despite some of the coverage.

Jim Mackey: Yes. As I said, you will not find anyone today who will guarantee you that their number is absolutely right and they will do it. There is a bit of negotiation to be done.

Ed Smith: It was great that Pat went round 28 hospitals and spent a day or two days with the management team, with the data, showing them, exploring initial denial to acceptability. That has created that credibility in data. You just have to take that approach. You do not just take data, benchmark it and say that's it. It is hard yards on engaging hard-

pressed hospital management who think they are doing the right thing and do not have the data. So I just think it is a—

Jim Mackey: Absolutely. It is the first time in my career there has been that kind of serious and sustained effort. People have set off on that path before and then reverted to just sending the data and seeing what people do with it. They have put themselves out to make it as robust as it can be. Reference costs are not perfect—none of our data is perfect—but it does not wipe the floor with it.

Q98 Andrew Percy: On the agency price cap, a number of staffing agencies in healthcare have raised concerns about this. They have said it could push up costs potentially, lead to staff shortages and require people to use this break-out clause. I had a constituent contact me, whom we will call Julie—primarily because that is her name—saying she is an agency staff member, she has chosen to do this and picks up a lot of the extra costs. She said, if she is not prepared to go and work at short notice, as she is, all over Yorkshire and Lincolnshire, who is going to? The changes and the caps make her feel as if she is not welcome in the NHS and they do not take into account the full costs that employers would have to pick up, which she herself picks up, be that car parking, travel costs—most people pay that, but she travels a lot further, of course—insurance costs, holiday pay, pension and all the rest of it. What do you say in response to those agency staff who have this concern—that the comparison is not fair—and to the agencies, who are saying that this could have the perverse effect of driving up admin costs and leading to staff shortages?

Jim Mackey: On the first point, the number of times when people have needed to break the glass has reduced dramatically after the first couple of weeks and is running at a much lower level than we had expected it to do. The agencies will say that definitely because we are squeezing their margins. That is what we need to do. There is huge variation in the margin in the fee that is charged by agencies. Sometimes they will change it for the same organisation on the same shift with different staff. It is absolutely right that we get a grip of that. As to the member of staff you are talking about, I would rather they work for the NHS and I would rather they work on banks for the NHS at NHS rates as well rather than doing it through an agency. That is what we are trying to encourage. As Ed said, we are going to spend about £1 billion more than we spent last year on this. It has driven a huge supply shortage in its own right because of the way it has distorted the market and it is absolutely right that we try and get a grip of this. Six or seven years ago it was virtually unheard of to use agencies, and staff in the way that you described would very happily work between two or three providers on their bank. That is where we want to get back to.

Q99 Andrew Percy: But of course they would be paid less; it is going to be capped at a level.

Jim Mackey: They will eventually be paid, with the additional measures that we reported last week, at NHS standard terms and conditions.

Q100 Andrew Percy: They do not have all the advantages, do they, though?

Jim Mackey: There is a choice. They can either work for the NHS or they can be independent, but, in my view, we have trained them—the NHS has paid for their training—intending that they work for the NHS, and I would rather they did.

Q101 Andrew Percy: But some people—and my constituent, in particular, because she is a single mother—choose to do this because the shifts can fit better around—

Jim Mackey: So employers need to be flexible.

Q102 Andrew Percy: The point—if I can finish—that she is concerned about is that it is creating a division in the workforce. This change sends out the message that people like her, who are providing, she says to me, first-class valuable care in the NHS, are somehow fleecing the system. She says she has been accused of that by other colleagues. Whichever way round, these are people who are providing NHS care, are they not? They need to feel valued as much as anyone else. That is the point and the frustration. As to the charges, they have been incredible and I would support anything to try and reduce them, but I am concerned at some of the language that is used, as if they are in some way fleecing the system, forgetting the valuable contribution they make to patient care.

Jim Mackey: Employers need to be more flexible in their approach. If people are working through agencies because their employers just cannot get their head around flexibility, that is wrong and we need to help them correct that. I agree with you on the inequity thing. There is nothing more inequitable than substantive staff who have a continuous commitment to that institution seeing people come in, do a shift and get paid three times what they are getting paid and then go away and have no ongoing responsibility for that institution. That is what we are seeking to address in this change.

Andrew Percy: That is not unique to the NHS, is it?

Q103 Mr Bradshaw: What has driven this growth? Something must have driven this growth.

Jim Mackey: It is partly volume growth, people seeking to employ more people, which is largely a response to the inspection regime, safe staffing requirements and so on, and, as that has kicked in there has been a huge related price growth where, frankly, trusts have been held to ransom. If you are the on-call manager having to find an ED doctor at eight o'clock on a Friday night, you will pay whatever you have to pay to get an ED doctor. That has been happening and it has been exploited. There is very clear evidence where that has been exploited with extortionate rates and we need to stop this.

Q104 Mr Bradshaw: Are you confident that the suggestion by the agencies that this could drive people out of the health service altogether abroad and exacerbate the current shortages will not happen or is not happening?

Jim Mackey: We will keep it under review. We have been reviewing it so far. We have seen no evidence of that. They would absolutely say that, would they not? It is entirely understandable they have said that. If we do see signs of that, we will act and address it. There are still break-clause provisions and we should not forget that about half of these staff work for the NHS. They are doing their extra shifts through an agency. This time last year I met with a group of junior doctors who had previously been working for my organisation with us doing their extra shifts and had chosen to do it through agencies because they were getting paid two or three times the rate. We need to stop it.

Q105 Chair: Can you give us any preliminary data on how it is going so far—the kind of savings we are seeing at the moment?

Jim Mackey: On the locum and agency cap, yes. Our estimates were about £150 million to be saved in the last quarter. It is quite hard to quantify. I think it is possible to get about a £1 billion saving from this change, maybe more if we follow it through in the right way. The reason I am a bit cautious about that is that it is a very adaptive market, it is very complex and we need to be careful that we do not create too much of a supply shock that causes us quality problems; so we are being a bit more cautious than we could be. If we just look at the evidence, we spent about £2.4 billion on locum and agency staff two years ago and we are going to spend about £4 billion this year. There is absolutely no reason we cannot get back to the levels of two years ago. There are still some organisations that virtually never use locum agencies. That needs to be the norm again.

Q106 Dr Davies: Can I stay on that issue for another minute and ask about NHS Professionals? Do you think there is scope for them to expand to provide agency staff, which might be more competitive?

Jim Mackey: Absolutely; there could be. A lot of organisations are enhancing their local bank, creating regional banks. Some are thinking again about using NHS Professionals. The point is to let us try and bring this back to the family again and run it ourselves.

Q107 Dr Davies: My main topic is about the seven-day NHS. What exactly does that mean to you and do you think that the NHS, with its current funding as expected, can provide that?

Jim Mackey: What it means to me is not that every single service and professional works seven days. If you think of it from the public's point of view, you probably want access to a GP over a weekend and over holiday periods. If you present with an emergency problem, you want to see senior decision makers and have all the right diagnostics and treatment whether it is a Sunday afternoon or a Wednesday afternoon. Again, in my experience, where we have tried to provide elective services on weekends, there has not been that much public appetite for it. There needs to be a local flavour to this—it will work differently in different places—but, as a minimum, we need a core emergency and diagnostic provision throughout the seven days so that there is absolute consistency.

Q108 Dr Davies: I would agree with you, but when funding comes into this, do you think it is achievable within the current climate?

Jim Mackey: Again, it is hard to tell. Some organisations are very well developed and others are not. You can see quite a big productivity gain if you get this right by shorter length of stay, avoiding admission and more rapid turnaround of patients. It needs to be run sensitively over time. Again, in my experience, over a few years we opened some things on weekends and then closed them again when it was clear it was not required or not going to get the result that we wanted. I would rather we did not plunge in and say, "This is how it has to be everywhere." Providers locally have to work out what is right in their circumstances, with the idea that there is a core provision—a core standard—that is required.

Q109 Dr Davies: Is it your understanding that the additional money coming in will employ additional staff and not just junior doctors and consultants, but nursing staff, for instance, bearing in mind whether they are available to recruit, of course?

Jim Mackey: There will be some financial impact, but it has not yet been quantified right across the NHS. We will be working with providers to make sure we develop in this regard in line with the resources available.

Q110 Dr Whitford: The opening phrase about "What does it mean to you?", having been in this place now for nine months, to me, seems to be the issue. I do not think that the profession—I mean it in the broadest clinical sense of doctors, nurses and AHPs—has any issue with trying to strengthen the seven-day emergency side if someone is unwell, but in speeches we keep hearing it going on another track and we talk about eight till eight GPs for routine work, and the same in the hospitals. I just do not see how the NHS can do that. Is that not a distraction from getting the emergency service right, which everyone would agree about?

Jim Mackey: Yes, we could do with a clear narrative. We had a discussion yesterday that we should be collectively clear, from an NHS leadership point of view, on what we mean by this. Pretty much every conversation I have had ends up with the conversation we have just had. We are talking about the core emergency consistency of provision and then, if there is a local flavour which means you need to provide certain clinics on a weekend or whatever, that is fine; do that. Also, from the GP access point of view, I do not think there is a lot of demand for people to go and see a GP at seven o'clock on a Saturday night. Let us get the provision tailored to what is required. This is not something that is necessarily having to happen in every building; it is something that may be better done on a health community basis or on a broader geography.

Q111 Dr Whitford: Some of the pilots reported that they were struggling to cover the out-of-hours GP service because the GP could be doing a really quiet Sunday practice cover. It is trying to keep this focused on what we need to avoid people having delays in diagnosis; and, as my colleague said, it is not just doctors; it is not even just nurses; it is allied health professionals, social care and diagnostics, but all to do with moving the unwell patient.

Jim Mackey: I agree.

Q112 Chair: Can I come in there, because I know your remit does not cover primary care but the provider sector? Have you done any piece of work that sets out the scale of the cost of trying to provide a routine service, and do you feel there should be a case made for that money going to other priorities?

Jim Mackey: We have not done that yet.

Q113 Chair: It is not just the controversy about routine services; it is about some of the data that is being produced on emergency services. For example, we have seen a much-quoted figure of 20% on acute strokes—the weekend effect, if you like—and I gather that is based on the publication "Mortality following Stroke" of Roberts et al, published in 2015. But the case has been made that this is based on data pre the transformation to acute services, particularly within London. Would you agree with some of the criticism that recent

audits of stroke outcome in London in particular do not show a weekend effect? Is that your assessment of the situation?

Jim Mackey: I have not looked at that data recently, so I could not comment upon it.

Q114 Chair: I wondered whether you had done any work looking at how effective we are going to be in deploying resources. Is that something—

Jim Mackey: No. It will be something we get to, but we have not done it yet.

Q115 Dr Whitford: The Bray paper suggested the issue was that it was nursing that made a difference in survival rather than medical and working out what the problem is.

Jim Mackey: In the stroke system, one of the big drivers in their HASUs—hyper-acute stroke units—is access to nursing and allied health professionals. We often focus on the doctor bit, but it is the broader healthcare team; so I would agree on that.

Dr Whitford: There is a danger when we are talking about headcount reduction and other things that we go back round a track and have some other catastrophic report.

Q116 Chair: Surely the point is that your role is about value for money and productivity. Surely it is very important that you are in a position to feed back advice about what your priorities are to those who are perhaps wanting to design services to be a seven-day service.

Jim Mackey: Absolutely, so we will be looking at the clinical evidence and the changes in clinical outcomes over time as well as changes in the financial outcomes. They have to sit together, absolutely.

Q117 Chair: It is crucial, is it not, to have the evidence to be able to present a case?

Jim Mackey: It is, yes.

Q118 Chair: Can you assure us that that is something that you will be working on?

Jim Mackey: Absolutely, yes.

Chair: Do colleagues have any more questions? No. In that case, thank you very much for coming this afternoon.