



Health Committee

Oral evidence: [Impact of the Spending Review on health and social care](#), HC 678

Monday 9 May 2016

Ordered by the House of Commons to be published on 9 May 2016.

Written evidence from witnesses:

- [Department of Health \(CSR0042\)](#)
- [Department of Health \(CSR0103\)](#)
- [NHS Improvement](#)

[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Julie Cooper; Dr James Davies; Andrea Jenkyns; Emma Reynolds; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford

Questions 295-394

Witnesses: **Rt Hon Jeremy Hunt MP**, Secretary of State for Health, **David Williams**, Director General of Finance, Department of Health, **Simon Stevens**, Chief Executive, NHS England, and **Bob Alexander**, Executive Director of Resources and Deputy Chief Executive, NHS Improvement, gave evidence.

Q295 Chair: Good afternoon. Thank you very much for coming to this final session of our inquiry into the spending review and the consequences for health and social care. Could we start by asking you to introduce yourselves for those following outside this room, starting with David?

David Williams: Certainly. I am David Williams, the director general, finance and NHS group, at DH.

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

Jeremy Hunt: I am Jeremy Hunt, Health Secretary.

Bob Alexander: I am Bob Alexander, director of resources at NHS Improvement.

Q296 Chair: Thank you. Just to set the scene, we would like to explore this afternoon how clear we are about what is the health and social care need going into the future, what the current efficiency gap is and whether we have a coherent plan for filling that efficiency gap

and the consequences of failure. Could I start by commenting on the £8.4 billion promised in the spending review, which is £7.6 billion if we look at it in 2015-16 prices, and the fact that it appears to have been redefined as spending on NHS England rather than the usual baseline? It appears to us and to some of the witnesses to this inquiry that it is actually £4.5 billion that is new money. Could you perhaps comment on that to start with, Secretary of State?

Jeremy Hunt: Of course. First, can I start by thanking you for very kindly moving the date of this hearing? Some of the potential dates would have been very difficult, so that was greatly appreciated.

The main purpose of the spending review was to help NHS England get cracking on the Five Year Forward View, which is the only way, realistically, that we have a chance to transform services, based on some very fundamental principles of prevention being better than cure. It is a plan that Simon Stevens put together that had widespread support and we were very much guided by him as to how much he thought was necessary to get going on the forward view. Simon's particular priority to me privately and then, through me, to the Chancellor, was to front-load that settlement so that we could be confident that the majority of the money that was needed would come early to enable us to make some of the transformational change that has to happen. That was the process that happened. We ended up in a place where we are able to do that, but I am sure that Simon will be able to speak to that.

Q297 Chair: Part of that was predicated on there being £8 billion coming from the Government. Do you recognise that the figure is actually £4.5 billion in new money?

Jeremy Hunt: I recognise that we are talking about £8 billion that was needed for NHS England to deliver the forward view and that in order to deliver that we have had to make some difficult efficiency savings in the rest of the health budget. I do recognise that we did not protect the entire health budget, but our determinant as to whether this was sufficient was what NHS England felt it needed in order to put in place the forward view. Yes, we are making some very challenging efficiency savings in the non-NHS England part of the health budget, but I think it is right that we do so for the simple reason that we are asking—as you are going to be asking us about later this afternoon—NHS providers inside the NHS budget to make very challenging efficiency assumptions, the £22 billion, so it is reasonable that we should ask other parts of the health budget to make those savings.

Q298 Chair: But that then has knock-on consequences for being able to deliver the forward view, such as cuts to Public Health England and Health Education England and, of course, the capital budget. Could you perhaps set out where you see the efficiency gap to be now? Do we still project it to be £22 billion or has that changed as a result of some of the spending review settlements, and could you perhaps then comment about the capital budget changes—the shifts from capital to revenue?

Jeremy Hunt: First, I fully accept that we had to make some challenging decisions on the capital budgets. What I would say about the other savings to the DH budget that sit outside the NHS England mandate is that, just as with NHS providers and the efficiency savings in the £22 billion, we are looking for savings that do not impact on but in fact improve patient care by rethinking service design and the way we spend every pound that goes into the NHS. Exactly the same approach is being taken in the efficiency savings for the

non-NHS England part of the budget, so we are looking for smart efficiencies, not efficiencies that impact on patient care.

With respect to the total sum and the make-up of the £22 billion, Simon Stevens has published some figures today that he might want to elaborate on in more detail as to what the make-up of that is.

Q299 Chair: It would certainly be helpful to know where you see the efficiency gap to be now. Perhaps you could update us on your thoughts about that, Simon.

Simon Stevens: Absolutely, thank you. As a reminder, the so-called £30 billion gap that would open up by 2020 was based on the assumption that demand continued to grow at its historical rate adjusted for the growing population, the ageing population and the new treatments that were likely to come on offer. If you compared that with the situation where you have no extra money and no efficiency, that left us this £30 billion gap, or pressure, by 2020. It is worth noting that most of that gap is not, as it were, money that has to be saved; it is rates of spending growth or demand that we want to try to put a kink in the curve but which that increases. We refreshed the modelling in the spending review, and the basis on which we did that is in the recap briefing that we have provided to the Committee and publish this afternoon. That confirmed that in the zone of £22 billion, plus or minus, it was the right amount to be thinking about.

How that breaks down is that about £6.7 billion of it will be delivered nationally through a range of measures that the NHS nationally, the Department of Health and wider Government will be able to take, and that leaves us £14.9 billion to secure locally. Of that, £1 billion we already have in hand, so that leaves us just under £14 billion, of which £8.6 billion will come from the 2% provider tariff efficiencies and the rest from service change and the process that is now under way through the local planning processes—the sustainability and transformation plans that are being developed in 44 geographical footprints across the country. In a nutshell, although £22 billion is the number that everybody focuses on, in fact it is under £9 billion that is to come from conventional provider efficiencies and it is under £15 billion that is to come from the local health service as against the national action that we are taking.

Q300 Chair: Could you say a little more about how that is going to be achieved and whether it is achievable?

Simon Stevens: Yes. The 2% provider efficiencies represent a change in what has happened over the last several years when we have seen costs growing faster than provider income, and I think the evidence you had from the Health Foundation suggested that implied there had been a productivity decrease over the last several years for reasons that we know about and can discuss. We need to do 180 degrees on that. That is essential to being able to put the health service on the trajectory on which we need it to be over the next three or four years, but Monitor and NHS Improvement have produced the detailed working as to why a 2% efficiency requirement is stretching but not unreasonable to think about for providers over the next four or five years. Again, that was published back in February, but we have shared that this afternoon.

Over and above that, the process that is happening locally is that in every part of the country—44 different geographies—local authorities, provider trusts, CCGs and the

community sector are coming together and saying, “We can see where we need to get to by 2020—what some of the big changes are that, frankly, we have known about for a while but we have tended to kick the can down the road. Now we have to confront those and make those choices.” They are going to let us know at about the summer break—end of June/early July—what they think that means for their own health and care system. When we have that, we will be able to have an aggregated national look at what these efficiency programmes amount to.

Q301 Chair: Did the Department stay within its spending control limits authorised by Parliament in 2015-16?

Simon Stevens: That will be one for David.

David Williams: We are currently at the point where the final end-year positions from both commissioners and providers are being aggregated and consolidated, so it is too early for me to give you a definitive out-turn for health as a whole. That will come out when we publish our annual report and accounts, which we plan to do this side of the summer break in July.

Q302 Chair: There is some concern that NHS Improvement has said that boards need to pursue “all possible and legitimate savings that can be made from reviewing balance sheets.” Is that just clever accounting that is going to make us break even, if we do?

David Williams: It is not just clever accounting, but, as you will know from the 2014-15 accounts, the overall out-turn at group level is quite tightly managed and we want to make sure that we are making every effort this year as well to deliver within the sums voted out by Parliament.

Q303 Chair: There has been particular concern about the transfers from capital budgets to revenue budgets. What consequences are they going to have to be able, realistically, to put in place some of the new models of care into the future, and future finances?

David Williams: For 2015-16, as we set out I think in the supplementary estimates earlier this year, we have transferred around just under £1 billion of capital spend into revenue. Some of that will be as a result of a better estimation of the requirements of individual projects, some of it will be as a result of natural slippage in capital-intensive projects and some will be as a result of management action to defer spending to later in the spending review period, where it will need to be prioritised against other calls on the capital budget for health as a whole.

Q304 Chair: Simon, are you able to say more about it? Clearly, there are many of the new models of care that we want to put in place over the spending review that will rely on capital spending. How concerned are you that that will not be achievable?

Simon Stevens: Some of it is capital; some is revenue through the sustainability and transformation fund. On the capital point, as David says, yes, prospectively capital has been converted into revenue to support the front-loaded nature of the settlement, which we were clear we needed and that we have, but looking out over the next three to five years, we will have a clearer sense of what the reasonable capital requirements are in order to deliver the kinds of change programmes that the local sustainability and transformation plan groups come up with by the summer. One thing they are looking at is what it would

take to lubricate change in their county, their geography or in their part of the city. Then we will have some tough prioritisation to make, but we will be able to exemplify what the case would be for good capital investment in some of those geographies.

Q305 Chair: Will you be able to set out for this Committee, when you have that information, what, if you like, the growing backlog of work is that needs to be done that has been deferred?

Simon Stevens: There are two separate pieces there. One is, as you say, backlog maintenance, which I think probably NHS Improvement and trusts report on anyway. The other is: where there is an opportunity to invest in a new facility or a new way of delivering care, what is the kind of improvement or saving that you get on the back of that? We have two different types of capital requirement going on around the NHS right now. One set of issues deals with the fact that some facilities are old and will at some point need replacing, and in some cases will need replacing sooner rather than later. Another set of issues is that we can see that in some places, if you could invest in a new way of delivering services, you would save a lot on your running costs. We want to distil both types of proposition and see what that looks like for the NHS as a whole come the summer.

Q306 Chair: Are you confident that the capital budget is going to be sufficient?

Simon Stevens: I cannot answer that question until we have seen the answers to the sorts of questions that I have just described.

Q307 Emma Reynolds: I have a quick additional question on productivity. You will want to increase productivity if you are going to achieve efficiency savings. Is there not a risk or a concern that by deferring spending on capital—because the evidence seems to suggest that if you have a higher capital-to-labour ratio you get better productivity—productivity might go backwards, when you need to improve it in the short term?

Simon Stevens: In some cases, yes, and you can clearly see people on multiple sites in old facilities with heavy running costs as a consequence. Recently, I was visiting United Lincolnshire Hospitals Trust, for example, where in Lincoln County Hospital, Boston and Grantham there are clearly capital needs, as there are in other places, and if they got that it would help them run a more efficient show. On the other hand, you also hear places saying their costs are higher because they have a shiny new hospital and it is costing them more because—you know what—new hospitals cost more than old hospitals cost, otherwise there would not be any old hospitals in the NHS. We have to parse through these arguments quite forensically.

Q308 Helen Whately: I will come back to talk about the gap and so will put it aside for a moment. You were talking about the total CSR settlement. Could you talk about how you can be confident that is sufficient not only to maintain and improve the services as they are but to do some of the things that are more recent ambitions, including parity of esteem for mental health and seven-day services?

Simon Stevens: Sure. We set out five criteria that we would use to think about whether the SR settlement would be workable for the NHS, and one was that the pacing of the new things had to correspond to the profile of the money available to fund them. For a number

of these, whereas there are things that, if money were no object, we would love to do them instantly, frankly, we are going to have to phase ourselves over three, four or five years. In a number of the headline objectives, which also links to workforce growth, by the way, in some areas, including mental health and primary care, they are looking at 2020 and quite a lot of the improvement will have to occur at the back end, not the front end, of that period.

If you take the specifics that you talked about with mental health, we asked the independent mental health taskforce to come up with their best-buy list that is affordable and deliverable, given the likely growth in workforce and the other pressures there are going to be on the NHS budget. That is what they have done, with a package worth about £1 billion of extra spending in 2020.

The test will not be some kind of abstract theological debate about parity—important though that is as an aspiration and ambition—but very tangible. With regard to women with severe mental health problems at the time of pregnancy, at the moment there are 40,000-odd people in that situation, of which only about 10,000 are getting care. Are we going to help the other 30,000? For the 280,000 people with severe mental illness who are not getting their physical health needs met, are we getting that attended to? For the extra 10 percentage points of people who should have access to talking therapies, are they going to be able to get those? Those building blocks are costed and scheduled over the course of the next five years. We will have our feet held to the fire by Paul Farmer, the chief executive of Mind and the mental health taskforce, and I have appointed Claire Murdoch, the chief executive of one of the largest combined mental health providers, to help drive the implementation of that.

Q309 Helen Whately: Thank you. That will involve some shift of budget, for instance, into mental health. We also heard the recent, I think welcome, announcement of an increase of £2.4 billion for primary care. Where is the money going to come from? How is that going to be allocated? Where is it going to come from in order to go to those things?

Simon Stevens: It is coming from the overall funding increase available to the national health service over the next five years, and obviously our total NHS England spending will grow from £100 billion or so to £119 billion in cash terms over that period.

Q310 Helen Whately: Thank you. Just to come back to the question about the efficiency ambition—it was very helpful that you set out some categories as to where that is going to come from—could you give some insight into this? You said £6.7 billion will come nationally. Could you give a little insight into that figure?

Simon Stevens: Sure. This will be a combination. There are various things, some of which I would defer to Jeremy or wait till the Queen's Speech in terms of income recovery, some of which are efficiencies in the payments that the NHS makes to third party private providers, some of which is controlling the rate of increase in our national pay bill, and some of which is reducing the central running costs of the Department of Health and its arm's length bodies.

Q311 Helen Whately: Thank you. For the hospitals amount, which you said was £8.6 billion—there was a 2% tariff efficiency—could you explain, given the track record of hospitals in recent years struggling to achieve their efficiency target of 4%, what will make you confident that they will be able to achieve this tariff efficiency?

Simon Stevens: I am sure Bob would want to come in here as well, but the fact is that there are two ways of thinking of this. One is to say that, because we have struggled over the last several years, that leads one to believe we are going to continue to struggle. The alternative, glass half-full version—in fact my glass is just about half full—is that, precisely because there is that efficiency opportunity still available to us, now is the time to take it. I think that when people's backs are against the wall, as indeed they are, they are willing to focus forensically on some of the available efficiencies, not just the clever stuff but some of the blocking and tackling available right now. We have talked before about, and your witnesses earlier in the inquiry I think have discussed, the fact that we have had a big spiral in our temporary staffing costs and we are going to have to make the pivot on that in 2016-17 if costs have gone up from £2.5 billion a year in 2013-14 to perhaps £3.7 billion in 2015-16. NHS Improvement—and Bob will want to comment on this as well, I am sure—has set trusts individual targets and a set of mechanisms to wind that cost growth back.

Jeremy Hunt: Can I say something before Bob comes in because I think this is the \$6 million question about cost reduction? What is going to be different this time? It also relates to Ms Reynolds's question about staff productivity, because the two are inextricably linked. As to the things that are different, first, we do now have the Carter programme of efficiencies for NHS providers really motoring; there is lots more work to do, but there are some very encouraging signs. For example, as of this year, for the first time, 92 trusts are sharing full data about the 100 products that they purchase the most, so they can see complete transparency on who is spending what. One provider saved £40,000 on the day they started using that system because they were about to spend £40,000 more than one of their peer hospitals was spending on the same product. That is happening in a real way, not just in a top-down way. This is a programme that is being agreed with trusts at a local level in terms of the kinds of efficiencies that they can make.

As to Ms Reynolds's question about staff productivity, we believe we are starting to turn the tide on the exploding agency bill. It was understandable, and, with the benefit of hindsight over the period I have been Health Secretary, we can see why it exploded. The big issue that everyone was dealing with was Mid Staffs, and, quite understandably, everyone wanted to make sure that wards were safely staffed as quickly as possible for patient-safety reasons. The unintended consequence of that was a mushrooming of that agency bill. The latest figures that I have seen suggest that the agency bill is beginning to level out. We have saved £290 million since October compared with the trajectory of agency spend at that time. Two thirds of trusts are saying that they are making savings as a result of it and nurse agency costs are 10% lower than they were in October, so we are starting to see an impact. That, of course, will have the most direct numerical impact on staff productivity figures.

There are two other important things. The change we have to see now is for NHS trusts to take a strategic approach to cost reduction and not a hand-to-mouth approach. In the past, budgets were set annually. Decisions were taken in terms of what was going to save me money in the next 12 months. What can I afford to do in the next 12 months? One thing Simon Stevens has agreed with Jim Mackey of NHS Improvement is that towards the end of this year we are going to start on a process of giving people three-year budgets so that they can start to know how much income, how much business, they are going to get, if you like, over a much longer time period and then start to make smart decisions that improve

patient care—those are the important words—rather than impact on patient care. It is strategic reductions; it has to be stuff that benefits patients.

The final point, which we have not touched on today but which is significant—and, Dr Wollaston, you were talking about capital budgets—is that within the capital budgets allocated in the spending review there is a £4 billion investment in IT that we have been very careful to protect going forward because a lot of the staff productivity issues revolve around things like how much time a nurse spends filling out forms when someone is admitted to hospital or when someone is discharged. My concern with the structure we have at the moment is that hospitals have a disincentive to invest in smart IT programmes that are going to save staff time because they will not see the payback for two to three years and they are focusing on next year's numbers. We are trying to create a much more strategic long-term approach.

Q312 Chair: Can I pick up on one point? You said that the Carter programme was really motoring. Is it really motoring everywhere and is it on target to meet the efficiencies it was due to?

Jeremy Hunt: You know as well as me that things do not tend to happen in a uniform way across the NHS, which is a huge organisation, so the truth is that there will be places where it is progressing better and places where it is not progressing as well, and we see from the new CQC inspection regime totally unacceptable variations in the quality of management across the system. What are we doing to help that? NHS Improvement was set up not simply to be a merger of the TDA and Monitor but to represent a change in culture in the NHS, where we give much more proactive support to organisations that are trying to move things such as their efficiency. We are putting together a programme that supports trusts that are struggling to meet their Carter efficiency programme so that they will get better help from the centre.

Q313 Chair: Are we on target to meet the efficiencies that were projected by Lord Carter?

Jeremy Hunt: I cannot answer that question today because we are collecting monthly data as of the start of this year, trust by trust, which will enable us to track progress in meeting those Carter objectives. There is a time delay on the data you collect, as inevitably there is usually a six-week lag. That is something on which I hope we can provide information to the Committee. On the big picture, the biggest single block of efficiency saving that we need this year is the reduction in agency spend, where the objective is to get it back down to the level of a couple of years ago, which would be reducing it from around £3.7 billion to around £2.5 billion. We are on track to do that on the current trajectories, so there is some ground for moderate encouragement.

Q314 Helen Whately: So there is encouragement, for instance, that the Carter plans are going well, but that will only go some of the way. Reverting slightly to my question, where there is a track record of hospitals overspending, what steps are being taken to make sure that, even with the programmes in place, that does not happen again? What is going to make it different this time round, so that we do not see this continuing situation of so much of NHS funding being sucked into hospitals and not going to other parts of the system, like primary care?

Jeremy Hunt: I want to bring Bob in because that is something that NHS Improvement is very focused on.

Bob Alexander: There are three things, I think, and I am sure Simon will agree with me here. The first is a much better start point of understanding between commissioners and providers about plans for the year, and we are going through that process and finalising that now; secondly, the very focused approach to agency control that the Secretary of State and Simon set out before; thirdly, the opportunities presented by the Carter review and how we can put that into some formal programme to take it beyond the 30-odd trusts that work with Lord Carter on coming up with his areas of work, and a recognition that this is a programme over time. This is a programme that addresses the financial challenge of the service over the period of the five-year review.

Q315 Helen Whately: I have a final question, which is going to bring in social care, although only briefly because I know Maggie is going to ask some more questions on that. We have been very much talking about the NHS. My experience locally in east and mid Kent is that we see increasing delayed transfers of care and patients in hospital who we think do not need to be there and some could be in other settings, with the connection to the situation of social care budgets being very tight. We also know that that is a national picture. To what extent do these forecasts of how the NHS will manage within the funding settlement and close the gap take into account the situation with social care? Is social care funding, performance and transparency sufficient to make this all work for the NHS or does something need to change?

Jeremy Hunt: Do you want me to kick off and then maybe Simon can come in on that? The first point to recognise is that it is very tough in social care and they have to make some very challenging efficiencies. The second point is that we are not an island in the NHS. I do not think anyone anywhere buys the idea that perhaps existed in some parts of the NHS that we could operate independently with our budgets and that what happened in the social care system was a problem for the social care system and not for us. We are directly affected by what happens in the social care system: our success is their success and our failure is their failure. That is widely understood. We have made provision in the spending review to alleviate pressure in the social care system with the introduction of the precept for social care, up to 2% that councils are able to raise, which could potentially bring an extra £2 billion into the system. Then, later in the spending review, we are also increasing the Better Care Fund by £1.5 billion, so there is some help there. In order to make the system work, we will need to go further and find efficiencies from the integration of the health and care social system, and we are starting to see some interesting things happen, particularly in Greater Manchester where local authorities and the local NHS are beginning to work together in ways that have never happened before. We are going to need to do all of that and it is going to be vital that we are successful. Do you want to add anything do that?

Simon Stevens: Exactly. It is unfinished business in terms of what the future for social care looks like—we said that publicly—but practically, exactly as the Secretary of State has said, people around the country are now getting in rooms together and saying, “Under these circumstances, what things do we need to do in the way of mutual aid between health and social care?” To take your example, I was together last week with the chief executive of your local trusts and with one of your elected leaders from Kent County

Council talking about how the county council and the NHS locally would come together in a more joined-up way to try to square the circle.

Helen Whately: Thank you. I will not ask anything further on that.

Q316 Paula Sherriff: I will be fairly brief this afternoon as a number of the issues I wanted to cover have already been addressed. Thank you for providing further clarity on where the £22 billion savings are actually coming from, although there is still further evidence to be provided on the £6.7 billion nationally; but for now I want to look at the £8.6 provider efficiencies of 2%.

I will refer briefly to one of my own local health trusts. It is failing all its targets at the moment and, by the trust's own admission, is in crisis, with tempers fraying on the wards. Many wards are found to have half the safe staffing level. Last week, I met a cohort of staff privately and indeed did a patient safety walkabout last Friday in the hospital. It is absolutely crystal clear that patient safety is being compromised. I am absolutely unequivocal about that, and indeed the Health Secretary may well hear more from me later this week on that same issue. Is it fair, achievable or appropriate to impose an arbitrary 2% savings efficiency on that hospital trust in those circumstances, and indeed others like it?

Jeremy Hunt: Shall I start? Certainly, please share with me any information you have about particular concerns at your trust and we will take them very seriously. I do not want to pretend that there are not real challenges on the frontline. In a way, there is a sort of triple whammy of increasing demand for NHS services from an ageing population, much higher expectations on what patient safety should be post-Mid Staffs and financial discipline. When you take those three together, it is a cocktail that is more challenging for people on the NHS frontline than they have ever known in their lifetimes. There are heroic and wonderful efforts going on across the NHS now to keep patients safe. The answer is that we have increased the NHS budget significantly but, given those other pressures, it is not enough to mean that we can deliver safe care for patients without making efficiency savings.

The only point I would make—and I appreciate that this is not always a great comfort for people who are feeling very stressed because of their day-to-day work—is that if you look at the hospitals that are delivering the safest care across the world, in England and outside England, you find that they are also usually the most efficient and the ones with the happiest staff. There is a certain mentality, for completely understandable reasons, about this. The NHS's budget has, I think, never been cut in its history, certainly not at any time that I can remember; it has gone up constantly, so, as a system, we are not used to having to make these incredibly challenging efficiency savings, or at least we were not until about 2010. But it is possible to reduce cost and improve the quality of care and the working environment for doctors and nurses all at the same time, and there are lots of examples. The question that would be legitimately thrown back at me for making that comment is, "Yes, but that takes time." The challenge that people feel is whether they have enough time to make these changes. I recognise that and that is why the role of NHS Improvement in giving trusts the support they need in what is a very challenging period is absolutely vital.

Q317 Paula Sherriff: That is why I specifically asked: is an arbitrary 2% savings efficiency on every trust the right methodology, given that with some trusts you have to take into

account CQC reports, surely, plus challenges and pressures on those individual trusts? The Mid Yorkshire hospitals trust has the third busiest A&E department in the entire country, so clearly, given that we are in Yorkshire and away from London, it is quite a significant challenge on it. I understand that in the last month 937 patients missed the 15-minute ambulance transfer time. That is not good. I think we can all agree that that is not the sort of patient experience that any of us seeks to deliver. Is the arbitrary 2% right?

Jeremy Hunt: I entirely recognise those challenges, but the only thing I would reassure you of is that it was not an arbitrary 2%. When we were having the discussions about the spending review in the run-up to the final settlement, we did not ask ourselves how much we need them to save. The efficiency targets had previously been set at 4%, and we recognised that that was too high and had lots of discussions with representatives from the provider sector as to what they felt was a fair efficiency ask, given the pressures they were facing. The answer came back that 2% felt fair to them; indeed, they welcomed it when we announced the spending review. That was the context, but that is not to say that it is not going to be very challenging to deliver it and we have to play our part in Government to help them do it. One thing I have learned in my time as Health Secretary is that the model of sink or swim, or whatever you might call some of the extreme advocates of the foundation trust model, which is basically to create the conditions for a hospital trust to be as independent as possible and then completely leave it alone, is not sufficient in the current challenges. Even the best foundation trusts want support and help from NHS Improvement, NHS England and the Department of Health if they are going to make those challenges.

Q318 Paula Sherriff: I have two further brief questions. At what cost are these 2% efficiency savings on the providers going to be met? How will the monitoring work in terms of whether that affects quality? Does that mean 75% of the wards in my local hospital will be at half the minimum safe staffing levels? How is that going to be addressed?

Jeremy Hunt: I hope not, and the reason that I say that with some confidence is the new CQC inspection regime, which I introduced in the wake of Mid Staffs, which is, I think, a very independent and public way of making sure that standards of safety do not go down. We have now a system over which I have absolutely no control. The chief inspector of hospitals legally has the right to form a totally independent view of safety in our hospitals. That was not the case before. That independence means that you should have confidence that there is someone who knows what they are looking at, who will be looking at what is going on in all our trusts to try to make sure that decisions are not taken that mean the patients are not safe.

Q319 Paula Sherriff: More broadly, in terms of the savings, both nationally and perhaps more locally, how are those savings going to be monitored and at what frequency? If it is annual, are we going to find out at the end of the financial year that we are several million down on what was predicted, and where would those savings come from in that event?

Jeremy Hunt: One of the things that we have decided is that, where there are really important efficiency savings that need to be met, we need to be monitoring on a monthly basis what progress we are making. It clearly does not work to have a system where the figures are reported quarterly and then you do not see those figures until substantially after the end of the quarter. Where improvements are needed in procurement, rostering and use

of agency staff, we have now increased the frequency of collecting data in those areas so that we can see whether or not we are on track.

Simon Stevens: Maybe I could add in a couple of other complementary thoughts. First, you had Professor Tim Briggs here before you previously talking about the efficiency programme he is driving in orthopaedics. The extraordinary thing—I was talking to him recently—about some of the visits he has made to different hospitals within the same trust is where he described how, frankly, even across a county, the spreading of how to get orthopaedics right does not occur within the same organisation, with different groups of orthopaedic surgeons in that case each doing their own thing. I was talking to a trust chief executive—I know you were up in Salford recently—describing how the 12 trusts that comprise the Greater Manchester arrangement are now coming together to finally realise they have to share their pathology services and some of their back-office services, which this trust chief executive said they had kind of known in their heart of hearts for years but just had not quite got round to, not least because, for some trusts, it would probably put their costs up and they had not figured out a way of sharing out the gains between them. The reality is, in aggregate terms, that the NHS is an incredibly efficient health service, but anywhere you look you can see variation and improvement possibility and that is what we have to get at. The truth is that if we do not, then, as Ms Whately said earlier, it will just have a crowd-out on other important things that we need to do in the national health service, be it mental health services or primary care. We cannot just let hospital spending be the thing that finds its own level and then everybody else gets squeezed on the back of it. That cannot carry on.

Q320 Paula Sherriff: Equally, we cannot compromise patient safety in these circumstances—

Simon Stevens: Sure. I agree, so we have to look at these other sources—

Paula Sherriff: —to achieve arbitrary spending targets.

Simon Stevens: Yes. The 2% is not arbitrary. It was based on a very detailed set of reviews that NHS Improvement published in February explaining why, on average, 1.4% had been the trend rate of efficiency and then there was a catch-up opportunity for those places that were below that. Even more importantly, it is worth saying that, although we talk about the 2% tariff efficiency in 2016-17, we have increased prices for inflation by 3.1% on top of that, so for the first time in quite a long time the tariff is going up in 2016-17; it is not being cut. Over and above that, we have also put in this £1.8 billion of extra support through the Sustainability and Transformation Fund, which Bob and Jim are able to target based on the challenges facing a particular hospital. In having the conversation with the leadership of your hospital about what is a reasonable improvement goal for them, both financially and in terms of their A&E performance and their waiting times, this year they are able to do that on a tailor-made basis rather than as a one-size-fits-all across the sector as a whole.

Paula Sherriff: I will watch with interest; thank you.

Q321 Andrea Jenkyns: I would like to come in on the same point. I am a great advocate of patient safety, as those who know me are aware, but it is important that we put a balanced view, especially regarding this particular trust. Regarding this 2% in efficiency savings and

the issues that they are dealing with, it is not predominantly about the savings. They have had recruitment issues, as we know; they have also had issues of taking on too many agency staff. We also had meetings only a couple of weeks ago with the health team and Ben Gummer. The Government have been very supportive in that, so we need to make sure that what gets put out there is very balanced.

My sister has worked in the NHS for 20-odd years and I have worked for a company that provided services to the NHS in previous years. There is a hell of a lot of problems with efficiencies. It is only as good as the leadership of their trust really. Personally, I think this 2% is right. How long are we going to give trusts and allow them to just get away with not taking control of their costs and their spending? I would like to know what more can be done for those trusts that are not taking care of their budgets to penalise them and pat on the back the ones that are doing things properly. We do not have a never-ending pot of money and never will have, so what more can be done, please?

Bob Alexander: Two things come appropriately to mind. The first is, through the laying of plans, being clear about the prioritisation, the risk associated with individual organisations to their financial improvement and supporting them in two ways. That is both targeted intervention of skills and capabilities that perhaps they do not have yet and need to acquire and/or arranging what I call buddy sessions, where we bring together leaderships of organisations that are better along the path of improvement than others and trying to bring that together in a planned and supportive way to drive greater improvement across the provider cohort.

Q322 Dr Whitford: To start with you, Bob, looking at the payment system itself, Jim Mackey described it as not fit for purpose. Do you not think there is an underlying disincentive in the tariff in that a tariff rewards hospital activity and we are trying to get away from hospital activity? Do you not think that, as opposed to just tweaking it, we require something more fundamental?

Bob Alexander: The tariff function within NHSI is working with colleagues in Simon's organisation to determine changes that need to be made to payment mechanisms to enable the sorts of changes that the Five Year Forward View articulated and supported. That piece of work needs to go as an enabler of change, not as a leader of change, I think. You need to balance that, and we have started it with some of the things that we did immediately for 2016-17, by calling a halt to tariff changes, the consequences of which were not clear to see. We want to move payment mechanisms; we want to improve them; we want to make them more fit for purpose across the range of service. But the most important thing is to be clear that we understand the consequence of those changes such that when they are implemented they have the desired effect rather than effects that maybe particular organisations or particular services recognise.

Q323 Dr Whitford: How do you plan to do that?

Bob Alexander: We plan to do that by working with our commissioning colleagues, because it is a joint responsibility, to make sure that we are clear, as we move pricing mechanisms, as we move propositions, that we can, with evidence, understand what that would mean for the organisations and appropriately build in a trajectory of change so that we do not destabilise while we enable the necessary changes at the speed with which they need to be made to support the outcomes of the Five Year Forward View.

Jeremy Hunt: I want to help briefly before Simon speaks because you are right. We have to move to a system of capitation payments, population health management, delivered by accountable care organisations. It is interesting that Scotland has gone down a different route, which in some ways is closer to that, although Scotland also, as I am sure you will acknowledge, has its own problems of resources still being sucked into the acute sector. Even when you break down some of these barriers, it is still a challenge. But that is the plan and that is why we have the—

Q324 Dr Whitford: Is that not where the health service started, with health authorities and health boards—area-based—but people do recognise, in a way, that we have to find our way back to that?

Jeremy Hunt: Whether you are saying we find a way back to it or whether we are talking about finding a way forward to the kind of budgetary arrangements that you would have in Valencia or Kaiser Permanente, there is a very important need for a focus on integration and basing budgetary decisions on prevention rather than cure. We have the 44 sustainability and transformation areas that NHS England has announced, which are precisely designed to enable that to happen. Just to be very direct, things like suspending the tariff in particular areas for particular arrangements is very much on the table and that is why we are asking areas to look at three-year budgets during the course of this year. The spending review was only announced in November and we needed to give people some stability for 2016-17; but, going forward until the end of the Parliament, we absolutely need to make sure that the incentives are right in the way that the tariff system works, and that will, I am sure, involve significant reform.

Q325 Dr Whitford: Do you see it moving more towards population-based, place-based, network-based funding, rather than this tariff mechanism?

Jeremy Hunt: Absolutely, but Simon might want to add to that.

Simon Stevens: I agree with that completely, but there are some nuances here. After having had the privilege of spending time with you this afternoon, I am wandering over the road to spend three hours with the Public Accounts Committee on the subject of specialised services, and no doubt one point they will be making on the back of an NAO report is: could we not move to more tariff-based reimbursement for specialised services rather than locally negotiated prices where there is a big spread based on historic practice? Indeed, the move towards the new tariff-based system—HRG4+—would give us 2,100 price points compared with the 1,657 we currently have, so there are pushes and pulls here. If you are south-east London, you are in a different position than if you are Devon. If you are Devon, you more or less consume your own smoke: the people of Devon, for the most part, are using the services that are available in Devon and so a population-based control total for Devon is relatively straightforward. Indeed, that is what we have facilitated during the course of the last year, and, as part of the Devon success regime, they will be taking that forward this year and beyond. But if you are south-east London, with three teaching hospitals with lots of cross-boundary flows from Kent, Sussex and Surrey, it is much harder just to say, “Here is the sealed system for south-east London.” That tells us, I think, that, first of all, we have to evolve the new payment models based on the different populations and geographies rather than just some national volte face to a new status quo.

Secondly, we know, not just from this country but internationally, as Bob said, that payment reform is either an inhibitor or an enabler, but it is not the clinical change that will make any difference to patients per se. The clinical difference it will make to patients is whether teams of staff are working with patients in different ways that create holistic care instead of the fragmentation we currently have. If you just do the financial re-engineering ahead of having figured out what the new team-based care processes need to look like, the thing can quite quickly fall over. We saw that in Cambridgeshire recently with the so-called UnitingCare proposition, where they had done the financial re-engineering and not the care redesign sitting underneath it, which is part of what the whole vanguard process is supposed to do, and you did not get the efficiency dividend that supposedly it could produce. So there are those two caveats, I think: first, you have to evolve in different ways in different parts of the country; secondly, you have to think about the underlying care changes, not just the financial veneer.

Q326 Dr Whitford: I have come across a case of outreach service, consultants going out into the community, setting up support services to avoid patients coming in, and, of course, because that consultant is paid by the trust, eventually it was pulled because it was resulting in lower income for the hospital. It is this negative feedback that we absolutely need to get rid of.

Simon Stevens: Exactly; that is right.

Q327 Dr Whitford: Is it not also the case that the tariffs are set in relation to the average costs? So, in actual fact, if a trust works or, indeed, all trusts work really hard and get their costs down, the tariff for the next year will be lower?

Simon Stevens: No, because costs are not re-based year by year, and there is the opposite issue as well, which is that if we do not make the efficiencies then you could argue they just get re-baked into the inflated prices that the tariff assumes is the efficient cost of production.

Q328 Dr Whitford: So the tariff does not relate to the average cost.

Simon Stevens: It is on a very lagged basis.

Q329 Dr Whitford: Okay, but it is affected. The final thing is this. Andrea was asking about what the punishment is for trusts that do not perform, but there are fines in systems there for people who are not meeting their targets. Is that helpful if you are talking about a trust that is maybe already on its knees?

Simon Stevens: That is not the approach we are taking this year. This year, rather than an absolute threshold regardless of how you go into the year, instead, individual trusts will agree with NHS Improvement and NHS England, relative to their starting point, what it would be reasonable to expect in the way of improvement during the course of the year, and as long as they are on course for improvement they will not get dinged. That is if they reach an agreement with NHS Improvement on their performance trajectory; if they do not, they default to the standard system and that is their choice.

Dr Whitford: Thank you.

Q330 Maggie Throup: I want to explore the impact of the CSR on social care and integration of care. We have already touched on the 2% precept, and, Secretary of State, you said that it was likely to raise £2 billion. We have heard from a number of witnesses that the benefit of a 2% precept would be wiped out by the introduction of the national living wage. Once this cost has been met, will there be sufficient funding left for those who require social care support?

Jeremy Hunt: I will kick off on that one. First, we should recognise that, if we want to transform the social care system, the national living wage is very important because we need to attract staff into these very important roles. There are indeed now, at least prior to the NLW, people who are on the minimum wage who I think in many ways are undervalued for the work they are doing. One of the big strategic choices that we make as a society over the next few decades is whether we value people in the very important caring roles for the growing ageing population. It was a very important reform to make. We have, in our funding for the social care system, taken account of the introduction of the national living wage. It is not something that we ignored when we were introducing the precept, and the overall package of support local authorities are going to get for the social care system is a combination of their local government settlement, the new precept, what will come to them through the Better Care Fund, both now and when that increases in the future, and the efficiencies that we need them to make through health and social care integration. I do not pretend that it is not, as with the NHS, a very challenging cocktail of things that they need to get right, but I know that local authorities are interested in talking about integration in a way that has never happened before and there is a real enthusiasm both for local NHS and local authorities to do this. We have to support them as much as we can.

Q331 Maggie Throup: Thank you. I completely agree about the living wage. I have seen at first hand the sort of care that carers give; they are worth every penny and we should not undervalue them. How concerned are you about the potential of social care providers withdrawing from the market and then having a big impact? What steps are you taking to monitor that situation?

Jeremy Hunt: It is a very concerning situation at the moment and there are a number of social care providers that have made public comments about their interest in remaining involved in the market. There are probably three different currents that are going on here. The first is that we are expecting higher quality than we have expected before and we should not apologise for that. At the same time as we had the problems at Mid Staffs, we also had a number of very high-profile examples of abuse in care homes that shocked a lot of people. We need to be uncompromising about the fact that we are expecting the highest standards of care for people who, for example, have dementia. It is an incredibly difficult situation because sometimes they are people who have no family, no visitors and no capacity to express to anyone else if they are treated badly. These are perhaps the most vulnerable people you could imagine and so we need to make sure that we have a system where we are uncompromising. If there are people who are exiting the market because they do not like the much greater scrutiny over standards of care, it is their choice, but this is the right thing for us as a society.

At the same time, I would also say that, in many parts of the world, businesses—because many of these organisations are private businesses—are looking at the ageing population

as one of the biggest commercial opportunities as this is an area that all of us are going to spend much more money on as time goes on, both for our own care and those of our loved ones. It is important not to take a short-sighted approach as to the opportunities in that market, but there are some things that are being ironed out, which I recognise create uncertainty at the moment. There is the cross-subsidy that happens in many care homes of public sector-paid places with privately paid care home placements. There are the overall challenges that councils are facing with the social care budget. I recognise that is creating some uncertainty, but I would say that this is a sector of the economy, going forward, where we are going to be spending more and more money, both publicly and privately, and so it is one where people need to take a long-term view.

Q332 Maggie Throup: Thank you. You mentioned earlier that the NHS is not an island, and social care is not an island either. What assessment have you made of the effects of social care funding restraints, which you have just mentioned, particularly within local authorities, on the operations and finances of the NHS during the review period, because one has an impact on the other?

Jeremy Hunt: Yes. There is a very direct operational impact if people are left in hospital for longer than they should be, when they are medically fit for discharge, because of the processes necessary to admit them either into the social care system or into another part of the NHS. So there is a link to A&E performance, which is itself under a great deal of pressure. That is another reason why we need to break down these budgetary barriers between the NHS and the social care system. That is one thing that we need to recognise.

We also need to recognise that the social care system and the NHS, if we are going to achieve these challenging efficiency savings that we have talked about earlier, are both targeting the same set of individuals. The most vulnerable clients in the social care system are going to be in full-time residential care and they will remain in full-time residential care. The people who are most at risk if councils get these decisions wrong are the people who are living independently but perhaps need a lot of support and perhaps are quite vulnerable, the sort of people who might have a fall and need help. We need to make sure the social care system is there for those people, otherwise they are going to end up in A&E departments and possibly having a protracted length of stay in hospital. There is absolutely an impact on the NHS, which is why I think we are having much more serious discussions between CCGs and local authorities than we have had in the past.

Q333 Maggie Throup: You have talked about integration and some of the new models of care that are testing this out. Yet we have also heard that the Better Care Fund has been used to equalise the precept in different areas despite putting more money into it, and the sustainability and transformation fund is being used to ease the provider deficit. Is there really sufficient funding that is flowing into social care to fund these new models and to fund the integration?

Jeremy Hunt: As to the equalising of the precept, this is something that is primarily about the increases in the Better Care Fund. One of the things you have to recognise when you introduce a new system like the precept is that the council tax base in somewhere like Surrey is going to be much bigger than the council tax base in somewhere like Blackpool, and yet the social care needs in Blackpool are likely to be as big as the social care needs in Surrey. So it is fair, I think, if you are saying you have the chance to raise more money from your own council tax base, that you reflect that differential in the Better Care Fund

allocations. Is it going to be enough? This is a bit of a recurrent theme this afternoon. The answer is that it is not going to be enough if we do not make the challenging efficiency savings that we all know we need to make. Before we beat our chests in despair at the prospect of these challenging efficiency savings, it is worth pointing out that at the start of the last Parliament we had the Nicholson challenge, which was about making around £20 billion of savings, and I believe the NAO analysis of our success in that was that we broadly did manage to make most of that £20 billion—not quite all of it, but most of it. I think the NHS can do these things, but we will not be able to do it by repeating the same tricks. We were able to take certain measures last time; we will have to do new, inventive and different things this time.

Q334 Maggie Throup: Finally, are you forecasting any financial savings from integration of health and social care, including the devolution that we are seeing, particularly in Manchester, during the CSR period? If not in this period, are you predicting it in the future?

Jeremy Hunt: We do believe there are savings. We are not putting a cash amount to it except for the fact that, across all our plans, we recognise that we will only make the numbers add up if we reduce demand for services by getting care to people earlier. That is going to be something whereby we will reduce the long-term pressures on the social care system, the number of people requiring full-time residential care, but also in the NHS with things like the transformation of general practice and mental health care. Part of the benefit of those programmes is that you slow people's descent into needing, for example, full-time residential care, which is why what the NHS does can have a big impact.

Q335 Julie Cooper: You have recognised that there is a problem with the funding in social care, and I welcome that and the precept, but, as you have already mentioned, different authorities have a lower council tax base. In my part of the world, the 2% precept will apply, but even setting aside the minimum wage—which, by the way, I support for quality staff for all the reasons that have been described already—it goes nowhere near touching the funding that has gone out of social care. I am concerned there is a massive crisis situation that is overlapping and going right into the hospital system, and it is not just a mild inconvenience. Patients are really suffering in there because the discharge rate is so much slower than we would all want to see, causing misery for the patient and the family but also the backlog into A&E. I spent time recently—long hours—seeing patients who could not be admitted, having been seen and waiting for an acute bed because that acute bed was currently being occupied by, often, an elderly person who really wanted to go home and had been medically discharged but the social care package funding for them was just not there. The worst scenario I saw was one lady who spent 10 weeks extra in hospital. I am concerned to know what other action you anticipate taking, because this is a crisis situation that the 2% precept is not going to touch.

Jeremy Hunt: I reiterate that the 2% alone will not be enough. It will need to be combined with imaginative thinking and efficiency improvements at a local level that improve patient care rather than detract from it. I fully accept that people are working very hard to try to mitigate those problems. Also, the variation in the efficiency of the way care is delivered is much higher than it should be. If you take home visits, for example, there is the issue of whether someone who does home visits can go directly from home to their first visit and on to the second, third and fourth, or is having to go to base first or to base at the end of the day, and whether they are able to access a proper electronic health record of

a patient or just their own organisation's electronic health records. If they are able to see what the GP record is, that is a very big advantage in the quality of care that they are able to deliver. There is also the integration with what NHS community services are doing; what the district nurses are doing as well is really important.

The straight answer to your question is that it probably will not be possible to bridge the gap if we carry on with current working practices. We need to re-think how we deliver health and social care in a more integrated way, where what GPs and community care do is hand in glove with what the social care system is doing and that we have a holistic approach to patient care.

Q336 Emma Reynolds: I want to come on to social care before public health. Secretary of State, has your Department done an assessment of the cuts to social care in the last Parliament, which were, I think, about 33%? You have said that social care and healthcare need to be more integrated, and I agree with you on that. But I worry that in the last Parliament it was seen as a local government issue, where there were 33% cuts, which is a huge cut, and we know that many poor, elderly people, but also people who are not the poorest, were not able to receive the care they needed, went without care or had difficulty accessing it. Has your Department done an assessment of the impact of those cuts, and has your Department done an impact assessment on the NHS as well, given the problem with delayed transfer?

Jeremy Hunt: We are very conscious of the impact in all those areas. In terms of the impact on the NHS, we are very conscious of the fact that dealing with the challenges in A&E departments is not going to happen unless we have proper hand-in-glove working with the social care system. With respect to what happened as a result of the local government cuts in the last Parliament, the answer is that it just varies between local authorities. All local authorities had to find efficiency savings, but you find authorities like Surrey that actually increased the funding for adult social care and the number of people receiving help from the social care system, and councils like Milton Keynes and Kingston upon Hull that also performed very well in terms of the support they gave for their social care system, but you find other councils where there were less encouraging results. There is a learning process that goes on throughout all this. We are very committed to working closely with local authority partners and tackling that variation.

Q337 Emma Reynolds: But 33%, with respect, goes beyond efficiency savings, does it not? We have heard evidence that this had a real impact on delivery of care. I agree with you on some of the things you have said previously about having to drive efficiency savings, otherwise the budget is going to keep expanding, but I am saying that the degree of cuts to social care in the last Parliament has caused problems from which we are still suffering, and the nature of those cuts, which were a third of the budget, for me goes beyond efficiency savings. Of course, there are always some efficiency savings we can make.

Jeremy Hunt: I do not recognise the 33% figure, so I will happily take that away and look at it in more detail for you.

Q338 Emma Reynolds: That is an LGA figure, yes.

Jeremy Hunt: Although I was not in this job at the start of the last Parliament, I remember that the calculations were made, a bit like we were discussing earlier with the tariff, on the

basis of what the LGA thought were reasonable efficiency improvements to ask for. The one difference between the system we have now and the system we had then is that there is a much higher degree of transparency about the quality of care that is being received by people who depend on the social care system. All social care providers have Ofsted-style, CQC ratings, so we are much more conscious of where the problems are much more quickly than we were before. We believe that there are parts of the country that have withstood the pressure of those cuts in the local government budget much better than others and we need to make sure that lessons are learned across the system.

Q339 Emma Reynolds: I have a quick question on the subject. On the cap on care costs, which was a couple of months after the election—in the Conservative party manifesto it was promised to come into force in April of this year, but it has now been delayed until the end of the Parliament—are you confident that that is something that has been delayed or has it been put off entirely?

Jeremy Hunt: It is absolutely still Government policy. One reason we decided to put that delay in was that the original policy was designed to create an environment where there would be an insurance market that would develop so that people who wanted to protect themselves against paying the first £72,000 before you reach the cap would be able to do so. We saw no signs of that insurance market being developed and so we need to rethink. Our intention was not that everyone should have to pay £72,000 for their care. Our intention was that no one would have to pay anything because everyone would make provision through insurance-style arrangements for that early amount and then anything above the level of the cap would be paid for by the state. We need to think about that.

The broader point that I would make is that the long-term funding over the next few decades of our own social care is something that we need to give a lot more thought to as a society. We decided after the war that it was incredibly important for us to be a society where the norm was for people to save for their pensions, and then we made some provision for people who were not able to save as much as they perhaps needed to. I think we need to go through that same process of thinking for people's social care costs, given that we are all going to live for much longer, and the final few years of our lives are likely to need expensive social care. That period of delay gives us a chance to have that thinking.

Q340 Chair: Can I come back to one of the points you made earlier, Secretary of State, about the opportunities in that market for providers of social care? Is not the main issue that it is not financially viable for many of them to do so? Certainly in many areas, it is simply not viable for them, on the package of financial provision, to provide care in people's homes, particularly in rural areas, so it is impossible to get carers. Is that something that concerns you?

Jeremy Hunt: Of course it concerns me when people say that, but all I was saying was that I hope people will take a strategic view of the marketplace and not one that is based purely on some of the short-term adjustments that are happening. There is a longer-term change, which I think people welcome because it is what they would all prefer, which is a change towards supporting people to live at home independently rather than automatically moving into residential care.

Q341 Chair: I agree, but the trouble is that the financial package available for carers to go out and carry out domiciliary care simply is not viable. Would you recognise that? A very

frequent complaint that I hear as a constituency MP, and particularly for some very vulnerable groups, such as people with dementia, who have problems with wandering, is that their families simply cannot find anywhere that will look after their loved ones on the package of financial care that is available.

Jeremy Hunt: I recognise if we stick with existing models, if we do not make imaginative efficiency changes in the way that care is delivered, if we do not integrate better with the NHS—in other words, if we take the view that we are going to follow exactly the same model of care that we followed in the past at the same levels of efficiency—that it is going to be extremely challenging indeed. That is why on the NHS side we have to work very closely with social care providers because it is so much in our interests that that market does continue to succeed.

Q342 Chair: Indeed. I think we all recognise we want to have people looked after at home, but they cannot be looked after at home because, financially, it is not viable for people to provide that care. Is that a scenario that you recognise?

Jeremy Hunt: The scenario I recognise is that it is going to be very difficult—increasingly difficult—if the people providing and commissioning those services do so on exactly the same basis that they have always done. This is a moment when we have to be very imaginative in joint working with the NHS. I am not saying that there are no financial pressures and that it is not very challenging; I accept that fully. But the response to that needs to be to look for imaginative improvements in the way service is delivered; closer working with the NHS; some of the big devo deals that are happening in parts of country, which are making that possible; and sharing of electronic health records. There are lots of things. The evidence is that there are parts of the country that are managing, despite the budgetary pressures, to sustain and improve social care services, and we have to learn what we can from them.

Q343 Chair: Do you have a current cost for delayed discharges to the NHS? What would you estimate that to be at the moment?

Jeremy Hunt: I do not have a current cost. I have a figure in my mind that it is around 5,000 beds on any given day, and I am aware of that pressure on hospitals.

Q344 Chair: But it has not been costed. Bob, do you have a cost?

Bob Alexander: I do not have that, I am afraid, Chair. I could undertake to work with colleagues and give a response back to the Committee.

Q345 Chair: Thank you. We often talk about the savings that can be achieved from integration, but some of the witnesses to this Committee say that it does not save you any money; it allows you to identify unmet need but does not deliver any savings. Where do you feel that leaves the assumptions in the Five Year Forward View? Are you confident about, and do you have a figure in mind for what we can deliver from, integration?

Simon Stevens: If we go back to where we began the conversation about the nature of the so-called £22 billion savings, it is not that we have to take the number of emergency admissions that are happening today and then cut them by X, although in some places they are successfully doing that through the vanguards; it is more that we just need to see the rate of increase slow a bit compared with what it otherwise would have been to produce

the £30 billion gap in 2020. The experience of some of the early vanguards is quite promising in that regard. They are seeing lower rates of emergency admissions growth, and when you look at the spread of emergency bed days per thousand people living in an area across the country, you see an enormous dispersion. The opportunity is clearly greater in some parts of the country than in others. In fact, up in the north-west, Greater Manchester has some of the highest in-patient bed days per resident population for emergencies, even when you adjust for the age and the deprivation of the population. I think it is no surprise that when you had Sir Howard Bernstein and colleagues before you that you saw they are pretty enthusiastically thinking that the combination of bringing together health and social care is going to help them manage those future pressures.

Chair: Thank you. We have more about prevention now from Emma.

Q346 Emma Reynolds: I want to ask a set of questions about public health. Mr Stevens, you came before the Committee in July last year and said that further cuts to funding for public health “would not be a smart approach.” Is that still your view?

Simon Stevens: Overall, it is not helpful, which is why it was important that the public health programme that NHS England oversees was protected through the spending review, which was achieved through immunisation, screening programmes and so on. There are obviously pressures showing up in the local authority part of the public health programme. There are things that Government nationally can do, notwithstanding that, to help overcome some of those, including changed regulatory frameworks on things like childhood obesity. Seeing this in the round, there are some elements of the package that are pleasing, some that are going to be challenging and some where more action can be taken without a price tag being associated with it, such as the childhood obesity strategy.

Q347 Emma Reynolds: Secretary of State, you said at the beginning of this session that prevention was better than cure and you mentioned the emphasis on that in the Five Year Forward View. We had written and oral evidence from a number of organisations that are worried about the false economy we might be at risk of producing with the £200 million in-year cuts to public health in the last financial year and those cuts also announced in the CSR. Could you give us some more detail on where we are on that? For example, the Local Government Association in its evidence fears that these cuts “will lead to increased pressures on the NHS” and that this will move us away from prevention if we are not careful. Could you give us your assessment of that?

Jeremy Hunt: First, I agree with the theory behind this, which is that it is indeed a false economy to make a cut in public health provision that leads to people using hospital services more often. In fact, public health expenditure is something that we have always been very good at in this country and having an NHS has been something on which we have been able to lead the world. If you look at the progress we have made on public health over the last five years, where we have had pressure on public finances, we have continued to make extremely good progress. Teenage smoking levels have been reduced to their lowest ever; teenage pregnancies are down; and teenage drug use is down.

We have made some very important progress, but we took the decision during the last Parliament that we would devolve significant elements of public health spending to local authorities and we did so for a number of reasons. One is that local authorities are very good—sometimes better than the NHS—at procuring services efficiently, as they have

more experience in doing that, and also that there were some synergies between the work they could do in public health with other work, such as their work in schools.

You are correct to talk about the budgets being cut. It is an average of 3.9% per annum over the spending review period, and we are looking to local authorities to make sure that these are efficiency savings, not the kind of false economies that you are talking about. We have in place a very robust system of being able to monitor transparently the public health services delivered local authority by local authority. The baseline figures for that suggest that there is in fact a big variation in cities like Sheffield and Leeds, which have relatively similar demographics. You see significant differences in key public health indicators, so there is a lot that people can learn from looking at the performance of their neighbours.

Q348 Emma Reynolds: Do you recognise that imposing in-year cuts was very difficult for local authorities? My local authority in Wolverhampton explained they have already put out to tender many of these services. It is not easy at all to effect in-year cuts to public health budgets in that way.

Jeremy Hunt: I recognise that that is challenging. We have just spent some time in the early part of the session talking about the challenges of the efficiencies that the rest of the NHS is going to have to make, so I think it is reasonable that the public authorities should also make some efficiency savings, but I want them to be smart savings—not short-sighted ones.

Q349 Emma Reynolds: You are confident that the 3.9% per annum will only be efficiency savings rather than the false economies that you recognise are a problem.

Jeremy Hunt: The proof of the pudding is in the eating here. In these situations we tend to get variation in performance, but we have been very encouraged by the commitment to public health shown by local authorities. There is a huge amount of enthusiasm about the fact that they are managing public health budgets. We need to make sure where it is going wrong that we bring this issue up through health and wellbeing boards as quickly as possible.

Q350 Emma Reynolds: In the Five Year Forward View, not only was there an emphasis on prevention but there was this phrase that there is going to be “a radical upgrade in prevention and public health.” How can local authorities deliver that if they are working on efficiency savings of 3.9%? How does that go hand in hand with a radical upgrade?

Simon Stevens: I do not want to be Panglossian about it, because there clearly are exactly the pressures you are getting at, but the fact is there are a lot of things that local authorities can do using their power as the local democratic agency, particularly if you think about some of the actions that have been taken on obesity, the licensing or regulatory powers of local authorities and the ability to have an impact on school health, that are not just about the conventional NHS approach to providing services per se. If you think a little more broadly about the conversation we were having on social care, say, there are some quite extraordinary things that we are now going to be seeing the benefit of from the preventive and population health improvements that have happened over the course of the last decade. Within the last fortnight or so, we have seen research from Cambridge that has showed that as a result of improved cardiovascular health we now have 210,000 people a year with a dementia diagnosis compared with 250,000 if we had not had those population

health improvements. That is 40,000 people a year who are not, as a result, now with dementia and needing services from social care and the NHS. The root cause of that has been improved eating, smoking less and benefiting from drugs such as statins. The spillover benefits are much wider than just the kind of conventional public health services that we tend to think about.

Q351 Emma Reynolds: I recognise that, but I have one more question on public health. The ADSS reported in recent months that 40% of local authorities, according to its research, were dropping tobacco cessation services. How does that fit in with efficiency savings? That sounds like an impact on public health to me.

Simon Stevens: It could be, although I think you had Lord Peter Smith before you when you were in Salford. Interestingly, as I was reading the transcripts over the weekend, he picked out smoking cessation services as one of those where they thought that probably they could do a better job more efficiently than the inheritance they would be taking on from the way they had previously been organised. There is also a very big change that is happening in smoking cessation, as we know: what will be the impact of e-cigarettes? Public Health England has said it thinks that that potentially produces a 95% risk reduction. It is clear that smoking cessation is not “mission accomplished”. We need to get the smoking rate down from 18.5% to 13% in order to be able to deliver on the cancer prevention programme that the cancer taskforce has set, but the way in which we do it may be a little different from some of the clinic-based approaches that we have used hitherto. But, again, without being Panglossian about it, people will look at that afresh, as they potentially will other aspects of the locally commissioned public health programme, including health checks.

Q352 Emma Reynolds: This is my last question, which goes to your previous point. Deprivation is one of the main drivers of public health inequalities. To what extent is the Department in discussion with the Department for Communities and Local Government? Certainly, in my own area in Wolverhampton and nearby Birmingham and other urban areas where there are high levels of deprivation, we know there have been consistent moves by this Government to reduce spending and to reduce the grant given to those areas that do have higher spending per head precisely because they have more needs and more deprivation. If this continues, what is the assessment of the Department on the impact on public health inequalities?

Jeremy Hunt: First, can I agree with you about the link between deprivation and risk to public health? That is very well documented and completely fair to say, but I would perhaps take issue with your analysis on the approach that the Department has taken to the allocations for public health. The problem that we had was that when we separated out the public health spending from the PCTs, as existed before, we found huge variations in what had been spent on public health, PCT by PCT, that bore absolutely no relation to deprivation levels. They were basically quite random; it was what a local NHS had chosen to devote resources to in its particular area. There has been quite a difficult process of trying to adjust the levels of spending in different areas so that they reflect local need rather than just historic levels of spend by the NHS. That is, I think, probably what has caused—

Q353 Emma Reynolds: My question was not really about that; I should have made that clear. I welcome the move that public health teams are now in local authorities, and we heard

some very good evidence from public health teams in different local authorities that they much preferred being in the local authority setting for lots of different reasons. My question was about the broader spending by local government, not so much the public health part of local authorities but overall spending by local authorities in deprived areas, which is being hit, which is higher for deprived areas, and I know the Government often talk about this as spending per head. Obviously, it is higher in places like Liverpool, Birmingham and Wolverhampton precisely because there are higher levels of deprivation, but the Government in the last six years—and they are continuing to do this—are moving to decreases in spending per head in these more deprived areas. I am wondering what the conversations are between DCLG and your Department on the impact of the spending decisions, because there is an impact on public health and health inequalities.

Jeremy Hunt: Perhaps it would be helpful if I asked the communities secretary Greg Clark to write to you on that very specific point because I know he would challenge that as being the basis on which allocations are made. All I would say is that, in the parallel discussions that we have had in the Department of Health over the issue of deprivation, the way we have tried to solve it is by making it an independent process at arm's length from Ministers, so it is decided by the NHS England board, and Ministers do not have a say in that decision. It is one where we have had to balance the weighting given to deprivation with the weighting given to the number of older people, in particular population areas, which is also a big determinant of health, as I am sure you would understand. Frankly, transparency about the level of funding given to different areas has revealed that there is variation in the extent to which people are on or off target relative to the needs of their areas. It was difficult to move people closer to target allocations in an environment where overall spending was essentially protected in real terms. Now it is going up significantly. In real terms, we have been able to move people much closer to the targets they need for demographic-weighted amounts.

Q354 Julie Cooper: Turning to the issue of NHS workforce planning and current challenges, can you explain how the CSR funding will help the NHS match available resources to the specific workforce requirements going forward?

Jeremy Hunt: Yes. It is quite a big topic, but the condensed version of it is, first, to acknowledge that this has been a problem over decades—the matching of workforce planning to current need. Essentially, the time delay in training up doctors and nurses means that training, having more undergraduate medical students today, will not affect the NHS in a practical sense for five to seven years, and so getting that process right is something that we urgently need to do. We have tried to strike a better balance in this latest spending review. The number of doctors in training will go up over this Parliament by 11,420; the number of nurses in training will go up by around 40,000, and the potential reforms to bursaries, which I know were hotly debated in Parliament, could lead to a further increase in the number of nurses in training. We are constantly looking at the analysis on this to see if we have got it right and to see if we can do it better, but perhaps the best example of how we got it wrong—and, in fairness, no one could have seen this coming—was that following Mid Staffs we had a huge spike in demand for nursing staff and the result was this mushrooming of the agency bill. That, of course, is incredibly wasteful of the NHS budget and something we need to try to avoid going forward.

Q355 Julie Cooper: Returning to a couple of those, would you acknowledge that the actual use of agency staff as well is having a detrimental effect on the morale of the main core staff? I have heard first hand on hospital wards and in A&E that the staff resent that less-qualified, less-experienced staff are paid at a much higher level than some very experienced senior staff, particularly nursing staff.

Jeremy Hunt: I absolutely agree with that and think it is completely poisonous at ward level if you have a doctor who is being paid £3,500 for one shift or a nurse being paid £2,200 for one shift. It is very unfair if two nurses in the same trust are doing the same work but one of them is choosing to have a part-time contract for three days a week and then works through an agency being sent to the same hospital for another two days a week, boosting their salary, and another nurse has a five-day contract. The strongest critic of this has been Professor Sir Mike Richards, the chief inspector of hospitals. His point about agency staff is that you do not get the continuity of care. It is not that they are not, often, very hard-working individuals, but once you have a team who know each other and know their patients, you can be much more confident you will get continuity of care. That is why, from April—I think I am right, Bob—NHS Improvement issued guidelines that ask all trusts to move towards a system where no one can be paid more working as agency staff or a locum doctor than they would be paid were they working at standard NHS full-time contract rates. Controls have been put in first of all to control the amount paid to agencies but also to control the amount that agencies pay to their own staff. That will take time to work through the system. It is not something we can do overnight because we have to think about patient safety, but that is a very important change.

Q356 Julie Cooper: I accept what you are saying about the long-term planning solutions as well to this, that you do not fix staffing shortages overnight, that you train more nurses and more doctors for the years going forward, and it will be five to 10 years before we feel the benefit. But would you accept that the move to bursaries for nurses is going to have a detrimental effect on recruitment of people who would have been interested in going into a career in nursing and now are thinking again? Some of the health professionals along the way, where we have taken evidence, have said they are worried. At Salford, for example, the nurse lead there said she was worried about the effect that it would have.

Jeremy Hunt: We had a very good debate about this in Parliament last week and the Government's very strong view, which I accept that you will not subscribe to, is that these changes will lead to an increase in the number of nurses going into training, are fairer for nurses going into training and that they will allow greater financial support to nurses who go into training, albeit on a loan basis. I do recognise—and this point was made several times during the debate—that nurse trainees are not identical to other undergraduates, particularly in the sense that you get more mature students going into nursing than you would get into a typical undergraduate degree. We need to monitor it very closely, but the overall lesson of the reforms made to tuition fees at the start of the last Parliament is that this can be a very beneficial way of increasing the number of places and increasing the number of people from poorer backgrounds.

One other point I would make is that, coupled with these changes, we are making some very profound and important changes that open up the nursing market to healthcare professionals without them needing to go through the process of a full-time degree at a university in order to become a nurse. We are, I think, creating a lot of opportunities for

people experienced in healthcare to move into nursing on an accelerated basis. That ought to be something that is very welcome.

Q357 Julie Cooper: I have one final point. Unfortunately, I missed the debate last week around bursaries for nurses, but I fail to see the logic that withdrawing the bursaries is going to make nursing a more attractive career option. I do not see the logic. You were saying that it is going to be beneficial; it is going to increase numbers.

Jeremy Hunt: First, there is an issue about equity: whether we should be paying nurse bursaries to people out of taxes of people who may end up getting a lower salary than nurses themselves get, and, if we are going to have a public subsidy, what is most beneficial to everyone is that that subsidy goes into increasing the number of nurse training places that we have. We are confident, given the experience of what happened in the last Parliament, that it will not be detrimental. At the moment, the system we have means that, I believe, two in three people who apply for a nursing degree course cannot get on it because we do not have enough nurse training places available, and we want to deal with that as a matter of urgency. Given the current financial circumstances, this was the only available way to do it.

Q358 Chair: Can I follow up on that point? You have exercised great caution in shifting away from a tariff system because of the danger of destabilising the system, yet we are making a very sudden change away from nurse bursaries. Do you think there is a case for having a parallel system such as we have in Bolton, teamed up with the Lancashire trust, where you could have bursaries operating alongside an increase in places available through the more conventional student loan route, just so that we do not see the sudden change? There is clear evidence that the workforce is a mature student workforce. Is there any concern on your part that there may be a destabilising effect?

Jeremy Hunt: I understand the logic of your point, but the difficult judgment you have to make is that there is also a very urgent need to increase the number of nurse training places. One reason for the agency staff build-up we talked about extensively earlier in the session is that we do not have a big enough supply of nurses coming on to the market, and I would not want to be coming in front of this Committee in two or three years—

Q359 Chair: No, but could you not have a dual system so that you increase the number of standard courses available with a student loan—the course in Bolton was hugely oversubscribed—to have a dual system where you retain at least some bursaries for those for whom it is a second degree, for example, or a system of grants?

Jeremy Hunt: Our policy response to that is to try to find other ways to make sure we are creating routes for mature people to go into nursing, which is some of the things we have just talked about, but also to make sure that the financial package of support that we offer is sufficiently attractive to mature students so that we do not have those negative effects. In the end, we have to make a judgment, and for me the urgent need is to make sure that we have the right amount of supply of new nurses going into the market, given that there is this time lag before nurses come out qualified and ready to train in the NHS. It is a judgment call, I accept.

Q360 Chair: Could you set out what would be the cost to the NHS of a standard system where somebody takes a loan out and pays tuition fees and the cost of somebody training

through the bursary route? If there is not a huge extra net cost if people are paying tuition fees and taking out a loan, what would be the problem of introducing that in parallel to increase the number of training places you need but cannot afford to fund through the current bursary system?

Jeremy Hunt: Let me write to you with the detailed costings that you asked for with that information, but the point I would make, in terms of money, is that the agency staff bill has gone up for the NHS from £2.5 billion to £3.7 billion, we think, over the last three years. There is a huge cost to the NHS of not training the number of nurses that we need. So our policy priority at this time is to make sure that we—

Q361 Chair: Indeed, and no one argues with that. It is about whether or not you could achieve that by another end as well, by introducing courses alongside. My point is: was withdrawing bursaries a cost-saving measure, because I understand that is going to save a considerable amount from the HEE budget, although not within this Parliament?

Jeremy Hunt: Of course it saves money, but, combined with the other measures we are taking in terms of the support we are putting in place through the new loans system and the new routes into nursing that we are announcing, we are very confident that we will be able to do what we have achieved in other parts of the higher education sector, which is actually end up with a package that increases the number of people from disadvantaged backgrounds going into nursing, and indeed we want to increase the number of people going into nursing full stop.

Q362 Dr Whitford: I want to look at the seven-day services, which was a big manifesto commitment, both in hospital and of GPs. I am sure you have seen both the publication on Friday of the Meacock paper and the comments of Professor Rothwell this morning that suggest we now have almost a two-to-one ratio of papers that do not show a weekend effect as to those that do. Do you not think that the first thing that is required is to gather proper evidence as to whether it exists and what the cause of it might be?

Jeremy Hunt: I think we have that evidence. We have had eight studies now in the last six years.

Q363 Dr Whitford: But there are about 19 studies that say there is not a weekend effect and they tend to be methodologically, like the Meacock paper, more detailed.

Jeremy Hunt: Let us look at the Meacock paper, because the interesting thing about that study is that it concludes that there is a weekend effect. What they say—I have a quote from it here—is that “Hospital staff appear to apply a more stringent admission threshold at weekends to patients seeking emergency care in A&E.” They are stating that they believe that we do not offer the same standard of care at weekends as we offer in the week because you could be sick with the same illness and the same level of acuity and you would be admitted on a weekday but not admitted at a weekend. That is exactly what we want to change. We want to be able to promise everyone they will get the same high-quality care every day of the week.

Q364 Dr Whitford: Speaking to the authors of the paper, they found that there were people who were admitted to get a test but who had a low risk, and if it was on a weekend they would simply be brought back during routine hours for that test, whereas people who were ill

were admitted. We see the same numbers—they have looked at the 12.5 million who came to A&E—and there is no increased death rate among that group; there are actually fractionally fewer deaths of people admitted at weekends, and the main thing is simply this lower denominator of admissions. If we expand, if we say, “We are going to have everything every day,” is there not the danger that in actual fact we will admit more people, so the ratio will look better, but in actual fact exactly the same numbers of people will have died and we will not have prevented any deaths? We will just have made our mortality rate look better.

Jeremy Hunt: We can get into discussions about the different studies, but the most comprehensive study was the Freemantle study that was published last September, which was a huge national—

Q365 Dr Whitford: It is not more comprehensive than Meacock; it is the same dataset, only they included all of the A&E attendances and they drilled further into the paper.

Jeremy Hunt: Yes, and they conclude in that paper that there is a weekend effect. They conclude that the standard of care we give at weekends is different because you have to be more ill to get a decision to admit you. That is a big reason why we believe we should have a seven-day NHS, because we do not believe there should be a difference between the criteria for admission at the weekend and in the week. The broader point I would make about these papers is that there are, I think, internationally 15 studies that show that there is a weekend effect. If you include the Meacock study, that makes it 16 studies. We have now, I think, evidence across emergency surgery, cancer and a whole range of different illnesses and situations.

Q366 Dr Whitford: Yet if you look at the case-matched papers, such as liver transplants and GI bleed, you do not find that at all. Do you not think that really the only way to know a death was avoidable or the treatment of a patient was suboptimal is to review the case?

Jeremy Hunt: I think the people who do these studies will tell you there are different ways of doing it, but I would make this point. I am not an academic, but I think the mistake for a Health Secretary is to look at the overwhelming amount of evidence there is of a weekend effect and decide to get off the hook by disputing the methodologies. It is very clear if you look at the big studies that we have had—

Q367 Dr Whitford: The methodologies are important. This is numerical—that you have different numbers of people admitted on different days because there are not any routine services. You do not have extra deaths in the Meacock paper, which is using the same dataset as Freemantle and, therefore, is it not beholden on the Secretary of State to know what the problem is before you spend billions actually fixing it?

Simon Stevens: Just on the different papers here, my reading of the one you are quoting, which I looked at as well over the weekend—and I am quoting now—is, “The weekend effect was only apparent in the subset of patients who are admitted to hospital,” and “admissions on Sundays, Saturdays and Mondays are associated with higher mortality compared to Wednesday admissions.”

Q368 Dr Philippa Whitford: That is mortality rate not mortality numbers.

Simon Stevens: I am sorry, but I am quoting directly: “...with higher mortality compared to Wednesday admissions.” That is for those who are admitted via A&E. In any event, the

more fundamental point is what the appropriate clinical standard of care for any emergency in-patient on a weekend is. There, we can be guided by the Academy of Medical Royal Colleges, which back in 2012 said that there are at least four things that emergency patients on a weekend, just as on a weekday, should expect. One is that they should get an assessment of their need and their treatment by a senior doctor within 14 hours at the latest; the second is that there needs to be diagnostic back-up available on a weekend, including CT, MRI, ultrasound and pathology.

Q369 Dr Whitford: You think that is not available in most hospitals in England.

Simon Stevens: The third is that there should be consultant-directed treatments available for emergency patients on a weekend, including in critical care, interventional radiology, interventional endoscopy, emergency general surgery. The fourth is that there should be ongoing review for acutely ill patients. Those four things the medical profession is effectively saying represent the appropriate standard of care for patients on a weekend who, all the studies suggest, are sicker. As to what the outcomes are, nevertheless there seems to be wide agreement that patients are sicker. In a sense, the challenge for the health service is to make sure that those four things are in place in every emergency in-patient unit, and, to answer your question, we have asked individual hospitals to self-assess against those. The first quarter of the country should be covered by those by March 2017, rolling out to half by March 2018, and then all of the country by 2020. If we ground it in the standard of care that we would expect for our mum or our daughter, that is a pretty good way to try to take some of the heat out of this discussion.

Q370 Dr Whitford: Is that the definition of seven-day services that you are meaning—

Simon Stevens: It is.

Dr Whitford: —because it has waxed and waned, including talking about “greater convenience”, talking about seeing a GP between eight in the morning and eight at night, seven days a week.

Simon Stevens: In my mind, it is certainly not dermatology outpatients on a Sunday afternoon. The task in front of us is making sure that those four standards of care set by the Academy of Medical Royal Colleges are available to emergency patients in hospital throughout the week.

Q371 Dr Whitford: Do you think that there would have been the same friction with the profession if that is all that had been stuck to as what you were meaning by seven-day services, because that is not what the profession feels that it is being asked to do?

Jeremy Hunt: I have tried very hard, including in the statement I made to Parliament a couple of weeks ago, to be very clear that this is not a policy about seven-day elective care; it is about improving urgent and emergency care so that we are confident that we are giving that same high quality of care. I outlined the standards to Parliament that the Academy of Medical Royal Colleges talks about. When it comes to GP care, we have also been very clear that, yes, we do want people to be able to make routine appointments at the weekend. We think that is an important thing for the NHS to offer people who work during the week and may not be able to take time off work.

Q372 Dr Whitford: Both days eight till eight, or just Saturday mornings?

Jeremy Hunt: We have said we would like them to be able to make appointments until eight in the evening and at weekends, but we are not asking every GP surgery to open at weekends. We think that arrangement is something that can be done through networks of GP surgeries. Indeed, 16 million people already benefit from those networks following the Prime Minister's challenge fund in the last Parliament. In fact, the package that we outlined for general practice a couple of weeks ago shows very clearly how we are able to deliver that with the increases in funding that are going into primary care.

Q373 Dr Whitford: Obviously, that was not particularly in the Five Year Forward View. Is the £2.4 billion going to be on top of what was imagined? Is there extra funding going to go to provide the Five Year Forward View with what is now imagined as seven-day services?

Simon Stevens: The £2.4 billion was a comprehensive package of support for GPs, including core general practice and practices that are under great pressure, of whom we have identified the first 800 or so now, and we are going to work with the RCGP and the General Practitioners Committee this year to broaden that out. It is for technology; it is for 3,000 mental health counsellors who will be embedded in general practice; it is for 1,500 additional pharmacists who will be funded to help primary care. It is a range of things, which is, frankly, all about implementing the strength of out-of-hospital new care models that were envisaged in the forward view, so I think delivering the GP forward view is one and the same as delivering that pillar of the Five Year Forward View.

Q374 Dr Whitford: In the pilot studies that went ahead in the extended general practice, obviously the uptake, other than the Saturday morning, in a lot of places was very low. When Alistair Burt was in front of the Committee he said that that evidence would be taken into account, whereas, obviously, the Prime Minister had initially said it would exist everywhere from eight till eight, seven days a week. Which is it actually going to be?

Jeremy Hunt: We have made a clear manifesto commitment that everyone in England will be able to make routine appointments eight till eight and at weekends. The evidence is quite encouraging that where patients know about the services that are available there is good take-up, but that is not to say that the take-up on a Sunday afternoon is going to be the same as on a Saturday morning. That is why, if you have a networking arrangement, you are not incurring the fixed cost of requiring all 8,000 GP practices to be open at weekends even though there might not be many takers at four o'clock on a Sunday afternoon. But you might have a town like Macclesfield, for example, where there are two GP practices offering Saturday morning appointments but only one that is offering a Sunday afternoon appointment. The technological innovation that makes this viable in a way that has not been possible before is the sharing of electronic health records. Our view is that it very much must be a personalised experience for the patient, which means that, even if they are not seeing their own doctor, they are seeing a doctor who knows about them, has access to their medical record and is able to update their medical record with what happened in that consultation.

Q375 Dr Whitford: Is it not the case, though, that that is going to create more confusion for the patient out of hours in that they are not going to know where to go? At the moment if we need a pharmacy on a Sunday, you have to get the local paper, go to the library or look it up. We already have out-of-hours GP services, so would it not make sense in some way to expand them?

Simon Stevens: Exactly. It would be hard to envisage creating more confusion than already exists because we have this patchwork quilt of GP out-of-hours services, walk-in centres, minor injuries and A&Es of various flavours and so forth. The whole point of this is to streamline and then signal much more explicitly to patients and to the public where you go for your urgent care need, what A&E is and how you access a bookable GP appointment. There are places within a few miles of here, CCGs, that are already doing this very successfully, individual London boroughs with perhaps four hubs that have those arrangements linked to the out-of-hours and the improved 111 services. One thing I think Greater Manchester told you was that they had put in place seven-day access to GP services across Greater Manchester now, not on the never-never five years out. That is an offer they are making to the public across Greater Manchester. If you think about the way the duty chemist arrangement works, this is kind of an enhanced version of that, using the ability to share records, to book appointments and to have a streamlined set of ways into the NHS when it is your child who is ill on a Sunday afternoon, or when you cannot get off work but you should go and see the doctor and it needs to be on the weekend. That is the mechanism that we are going to put in place.

Q376 Dr Whitford: Certainly, when we did our visit and met primary care teams, they said they felt that the new system was undermining out of hours because a doctor will earn more doing one of the Prime Minister's extra GP sessions and they pay an awful lot less in defence. Is there not a danger that, yes, we will start to have the access to GP for routine but actually our out-of-hours GP practice may end up getting dragged down?

Jeremy Hunt: That is why part of the reforms that we are introducing needs to be the proper integration of the 111 service, the out-of-hours service and those routine weekend and evening appointments made by GPs. There may well be a bigger role for the 111 service in signposting people to the appropriate place to go for their needs. One important step that is being made in that process has been the joint commissioning of 111 and out-of-hours services, which is now happening across the country, but we need to make sure that people are properly signposted, because, I agree, at the moment it is much too confusing.

Q377 Dr Whitford: I totally agree with the points about the standards of care across the seven-day emergency service that a patient accesses. Obviously we are not particularly going to agree on what is called the "weekend effect" from research because my impression is that it looks as if we have not answered what the cause is. There are papers suggesting that it is nursing ratios as much as access to consultants. But do you think that it would be cost-effective from the point of view of preventing deaths when, as came out earlier in the discussion, one of the biggest things that causes a shortened life span is deprivation? Could we not be looking at how we spend the money perhaps better than what may be involved, when what we may have is that the core number of people who die does not change that much but we end up changing the denominator of admissions?

Jeremy Hunt: Without getting into a "my academic study versus your academic study" debate, we can agree that there is a weekend effect and that we have higher 30-day mortality rates of people admitted at weekends. What there may be disagreement about is the cause. The Government's view is that we need to look at the clinical standards that the Academy of Medical Royal Colleges recommended in 2012 as the most appropriate way of ensuring that we offer consistent care. That is something that does not just involve

doctor cover; it involves diagnostic tests and some of the other standards involved, the social care system and mental health and so on.

Q378 Dr Whitford: Have you costed what you think it will take to change to meet those standards by 2020?

Jeremy Hunt: Let me ask Simon to do that, but we should be clear that the seven-day service was not just in the Government's manifesto commitments but also in the forward view; but Simon could perhaps talk about the costing.

Simon Stevens: There will be a smart way and an unaffordable way of doing this, so the reason for doing this—a bit as Dr Wollaston was talking about earlier on—on a phased basis is precisely to figure out what is the smart, most cost-effective way of implementing this. The fact that a quarter of the country will be covered by these standards from next March at really very modest incremental cost—indeed, a number of trusts are already providing services to these standards: Wigan, Southampton, James Paget in Norfolk, Torbay, and so forth—shows that it can be done. If you just think you have to pile on a lot more consultant and senior medical staff and other elements, that will clearly have an impact, but the NHS has an incredibly good, if poorly understood, track record of improving the organisation of hospital emergency services, generating patient outcome improvements on the back of it and doing so within an affordable envelope. The two cases I would point to would be the move to major trauma centres and the move to hyper-specialist stroke services. Where those have happened, we have seen huge improvements in survival and relatively modest incremental cost, given the concentration of patient volumes. Similar debates are happening around vascular surgery and emergency surgery around the country as well, and part of the hospital planning process that these 44 geographical footprints are now engaged in is answering the question: what is the smart way to do this for people in our area?

Q379 Dr Whitford: If that has been emerging already, and been emerging through dialogue, which is very much how it has been taken forward in Scotland, do we really need to have all the conflict that we currently have between the Secretary of State and both the senior and junior doctors? It has been done without changing contracts, so could it not simply have been done?

Jeremy Hunt: It has been done in a very few places. We talked before about the financial pressures and the variation in the quality of management across the NHS, and our judgment is that it would not be possible to offer that commitment to everyone, which we made in our manifesto, without some changes in contracts. Where I would agree with you is that there has been too much focus on the junior doctors' contract. It is one thing we need to change in order to have a seven-day NHS, but only one of the things. There are lots of other things we need to do in terms of seven-day diagnostic tests and consultant cover. It has obviously attracted a lot of attention because of the difficulty of reaching an agreed solution with the BMA. I think it is a great shame, because the evidence is that the trusts where we do have a seven-day NHS are not just trusts that are safer for patients but they have higher morale for doctors.

Q380 Dr Whitford: They have obviously managed to do that on the contract as it is because it has not changed.

Jeremy Hunt: In one or two places, but this is something we want to offer consistently across the whole NHS.

Q381 Dr Davies: We are now nearing the end of the session, but I would like to turn to mental health, if I may, and how that relates to the Five Year Forward View and the parity of esteem agenda. Clearly, the mental health taskforce was commissioned to provide a report. How many of the 58 recommendations that they made are agreed with or supported by the Government and the NHS?

Jeremy Hunt: Broadly, we agree with all those recommendations. It is a very ambitious programme. It is an extra £1 billion going to mental health annually, and it is also around 1 million more people being treated annually for mental health conditions. It is a very ambitious programme and something we are very much committed to delivering.

Q382 Dr Davies: The figure of £1 billion has been given. Is that a fully costed figure as per the Government, or is there some flexibility there? Do we know the exact cost?

Simon Stevens: Yes. It was actually £1.325 billion in 2021, of which some of that—£320 million—had already been announced by the Government. In the interests of truth in advertising, we cut the figure to £1 billion, so it was £1 billion of new investment, not a re-announcement of the £320 million that had already been announced, and £1.005 billion is the costed incremental spend in 2020-21.

Q383 Dr Davies: How can we ensure that additional money that is intended to go into mental health does not in fact get sucked into the acute sector, as some providers report has happened in the past?

Simon Stevens: There are two things. First, we have to land 2016-17 in the way that Bob described earlier. We have to make sure that the aggregate provider and commissioner position balances, taking account of the £1.8 billion. If we end up out of whack in 2016-17, that comes at an opportunity cost for other services, which we absolutely do not want, and those in mental health are right to hold the acute services' feet to the fire on that. Secondly, we have to ensure that we are not just putting money in but we are being clear about the services we are getting for the investment. If we were having this conversation about cancer services, say, the currency of the debate would probably not be, "Is it X million or Y million or this relative to that?" It would be, "What are you doing in terms of access to effective cancer services and what is that doing for survival rates and patient experience?" We have to have a similarly precise conversation about mental health. That is what the taskforce allows us to do because we know quite specifically what we have to do on the liaison psychiatry and crisis home response, psychological therapies, eating disorders and so on. We have to measure ourselves against the extent to which we are putting in place those new services that the taskforce has asked us to do over the next five years.

Q384 Dr Davies: Thank you. Can we go back to that £1.325 billion again? Can we be clear? Is that the full cost of all the recommendations being implemented?

Simon Stevens: Yes.

Q385 Helen Whately: I have a broader question and will be brief. I remember at the time of the Five Year Forward View being published there was great excitement around that being a

vision for the future of the NHS, with cross-party consensus and we could see a way forward. You, today, have indicated confidence in the progress on that and the efficiency side of it as well as new models of care, but many witnesses we have had in front of this Committee have not had the same level of confidence, whether they are from the think-tanks or healthcare professions at the frontline. They are much more worried about the direction of travel. Could you comment on what you are doing at the moment or planning to do to increase transparency into the progress along that vision and to build excitement among those clinicians and those at the frontline who are doing and need to do the work to put it into practice?

Simon Stevens: Yes. I agree with that assessment, to tell you the truth. The underlying consensus about how care needs to change is intact, but the reality is we are doing so, in some ways, under more difficult circumstances than would have been apparent 18 months ago, particularly given what has happened to provider finances, the fact that we have to stabilise those this year, and if we do not get that right then we are not going to be able to make the kind of progress that we envisaged on the forward view. It is very important that in 2016-17 the whole of the health service mobilises around both the things we have to sort out this year and the planning process for what change will look like in the 44 different geographies. It is “both and”; it cannot be “either or”. Having over the course of the last 10 days or so met with about half of the geographies in the country, I would say that among the trust chief executives, the commissioning groups, GPs, local authority leaders and chief executives there is a sense that precisely because people’s backs are against the wall they are now willing to talk about some of the more profound changes that are required in the forward view, which in a sense have just always been “something for tomorrow rather than for today.” Now they can see it is now or never.

Jeremy Hunt: I would add to that briefly. One reason for the comment you make, which is a fair comment, is that, when the forward view was announced, the public spotlight was on the amount of extra money the Government were being asked to put in. Then we had an election campaign, which maintained that public spotlight, and then we had a spending review, which maintained that spotlight even more, and it is only really in the period since the spending review that people have started thinking harder about the £22 billion of efficiency savings, which was another very important part of the forward view. We do now have practical plans in place but they are very challenging, so it is inevitable that there is going to be a degree of concern about the challenges in meeting them.

Q386 Dr Whitford: I have a question on the sustainability and transformation fund. We hear that £1.8 billion is going to go on sustainability, as in just keeping on top of the deficits, and may not even cover them. Does that really leave enough for the transformation that was envisaged? The whole Five Year Forward View was, “Bring the money in now and totally change things,” and £300 million is not going to go an awfully long way in totally changing to new models of care.

Simon Stevens: Yes. That £2.1 billion grows to £3.4 billion over the course of the Parliament, but there is no doubt about it: we would have preferred not to have been in a situation where we have to deploy £1.8 billion in the way that we are in 2016-17. The reason we felt that was important was precisely to enable people to re-baseline and focus on sorting themselves out this year. That was the reason why we argued that a front-loaded settlement was necessary in the spending review, and that is what we got.

Q387 Emma Reynolds: I welcome the fact it is front-loaded, and obviously that was called for and part of the consultation that you had before you made that decision. Is there a concern, following up from Philippa's question, that, if you are not able to transform in a way that costs less money at the same time, because the settlement is front-loaded in the later years of the settlement where the increases are very minor, the service might struggle as a result?

Simon Stevens: Yes. It is a U-shaped funding settlement. The bottom of the U-bend is going to be a challenge.

Q388 Dr Whitford: Why is it that shape? Why does it go down and then back up again?

Simon Stevens: By definition, if you are front-loaded then that is one end of the U, and the national health service got a line of sight out to 2020 in our spending review settlement, whereas—I think with the exception of one other Department, and David will correct me if I am wrong—the rest were to 2019-20. We have more certainty, as it were, as to what 2020 looks like as a floor allocation, which we are able to share with other parts of the NHS as they are now doing their multi-year planning, overcoming this kind of annuality problem that you have previously talked about. But a combination of front-loading plus the 2020 position means we do have this U-shaped profile.

Q389 Chair: Could I ask the question in a slightly different way? Is there enough for transformation? You have set out why it has happened, but is there enough?

Simon Stevens: We are going to have to cut our cloth accordingly.

Q390 Chair: But is there enough for transformation to achieve what you wanted to achieve in the Five Year Forward View as originally set out?

Simon Stevens: We have been taking the vanguard programme—50 parts of the country, as you know—and been kicking the tyres on their year 2 investment propositions, their value propositions, so-called. We think what they are signalling does make sense. There are some where we think they are making less substantial progress, so we are going to reallocate money away from some of them to those that are making faster progress, to get more return on the investment. It is true for anything in the national health service that, if the economy does well in the future, the health service will deploy those resources well, but for what we have on offer right now we will get a good return on the investment.

Q391 Chair: With respect, it is great to know there is enough for the vanguards, but we all know this is then about rolling out successful schemes at scale and pace. Is there enough for once you have identified which ones work and which do not? Can we roll out the successful ones at scale and pace given the amount of money we have in the transformation fund?

Simon Stevens: Later this week we are setting out for the 44 geographies what their 2020 allocation looks like and then we are challenging them to answer the question that you have just posed me, Dr Wollaston. In the conversation with 20 or so of them that I had last week, a number of them can see their way to it. Some are still marshalling their forces, so we will be able to answer that question come the summer. I am not going to give you a glib yes or a controversial no. I am going to be led by the evidence.

Q392 Chair: Are you cautiously optimistic—will you go that far—or cautiously pessimistic?

Simon Stevens: You would not do this job if you were not, to a degree, optimistic.

Q393 Chair: Okay. One thing that strikes me, looking at the estimates that we get before this Committee, is that compared with other departmental estimates they give relatively little detail. One reason that mental health often ends up being the poor relation is because nobody is able to track what is spent on mental health without doing FOIs. Can you set out to us that in future years we will have more detail to examine the estimates?

Simon Stevens: Yes. That was one of the recommendations of the mental health taskforce and we have accepted that recommendation. We have published the definitions that the CCGs should be using to record their mental health spending.

I would underline a point that I think Julie Wood from NHS Clinical Commissioners made to you when she was here, which is that we should not make the mistake of thinking that spending in specialist mental health trusts is the same as NHS spending on mental health. The reasons for that are that, first, the investment that the taskforce called for includes a hefty chunk that is in primary mental health services. They have 3,000 more counsellors or therapists. They are going to be embedded alongside GPs; they are not necessarily going to be showing up in mental health provider trusts. Secondly, if you think about the investments we need to make in A&E liaison psychiatry, the full core 24 services, they will probably show up as revenues in an acute trust rather than a mental health trust. If you think about the improvements that we are seeing in some of the treatments that are on offer in psychological therapies, they may or may not show up through mental health trusts. It would be a category mistake to think that there is an identity, if you like, between NHS investment in mental health and what shows up as revenues for mental health trusts, important as they are.

Q394 Chair: Absolutely, but it would be nice to be able to see that detail.

Simon Stevens: Sure.

Chair: Thank you very much. I will let you have a cup of tea before you go on to the PAC. Thank you very much for coming this afternoon.