Health Committee

Oral evidence: NHS current issues 2016, HC 299
Tuesday 19 July 2016

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Watch the meeting

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

Questions 1-132

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

Q1 Chair: Good afternoon and thank you for coming. It is great to hear from Simon Stevens, chief executive of the NHS, and Professor Sir Bruce Keogh, the national medical director. Thank you very much for coming today. We have a lot of questions to get through and I know that you have to leave us today by 4.45 pm. Perhaps I could start straightaway by returning to the five year forward view and the figure you set out of between £8 billion and £21 billion by 2020 that would be needed. You are also very clear in the five year forward view that, for that to be at the lower end of the range, very many other aspects would have to be in place around service transformation in public health and social care. I do not know whether you have had an opportunity to see our report out today.

Simon Stevens: I have.

Chair: Do you have any thoughts on the figure, which we think is more accurate, about health spending being £4.5 billion, and would you like to make any comments about whether or not there is adequate funding for the five year forward view?

Simon Stevens: As your report very cogently teases out, there are different ways of defining what NHS spending is versus the general spending available to the Department of Health. As we said the last time we were together, and produced the background material with the original calculations, the estimate we made was that between £8 billion and £21 billion would be the funding required, and, as you say, Dr Wollaston, in order to be at the lower end of the range we would need sustained public health services, we would need social care to continue to be funded relative to increasing need, and we would need transformational funding and capital investment. They relate to a broader set of costs than what shows up in the NHS line, but part of your analysis also looked at the impact of changes to the Health Education England budget, particularly around nurse training costs, and you could argue that that was not factored one way or the other into the original demand calculations of the five year forward view.

Q2 Chair: One other area that we referred to in our report, and which is in your *Daily Telegraph* article today, is around public health.

Simon Stevens: Yes.

Q3 Chair: It is interesting to note that our new Prime Minister on the steps of Downing Street in her first speech talked about tackling burning injustices, and at the top of that list was health inequality. In your article, you refer specifically to the issue of the childhood obesity strategy. Do you have any points that you would like to make to the Prime Minister about strategies such as the childhood obesity strategy, for example, or the life chances strategy, and how crucial they are in achieving the savings required in the five year forward view?

Simon Stevens: I know folks have an awful lot on their plates right now, but a well worked-up set of high-impact proposals was more or less ready to roll on childhood obesity, and it would be great if they were forthcoming sooner rather than later.

Q4 Chair: We have had concerns expressed to us as a Committee that some of the measures that were originally going to be in the childhood obesity strategy have been watered down. Is that something that you are aware of, or do you have any concerns about that?

Simon Stevens: No, I am not aware of that. Certainly the version as it stood was a good package. It will be important to ensure that the changes that are being sought around food reformulation, and changes to the promotions and advertising environment, have a regulatory backstop, so that it is not just for industry leaders but creates a level playing field across the sector and people can be certain that, if voluntary endeavour does not produce the results, there will be an enforcement mechanism behind it. That is what is most likely to produce the kinds of shifts in formulation—particularly added sugars, but other things as well—that the expert panel advising Public Health England said would make the difference.

Q5 Chair: Are there any other points referring to funding that you would like to make about the public health budget and the cuts to it that we referred to in our report?

Simon Stevens: Could I make one other point before responding to that invitation? I strongly agree with the points that Jamie Oliver was making recently—that the people who will benefit most from an effective childhood obesity strategy are in fact kids from poorer families. The suggestion that somehow assertive action on childhood obesity will end up discriminating against low-income families is the complete opposite of the real-world impact. It is lower-income children who are most exposed to obesogenic environments and whose health and life prospects are being damaged as a consequence.

Q6 Chair: In other words, if the Prime Minister wants to make progress on narrowing the nine-year life expectancy gap that she refers to, do you feel it is absolutely essential that we go forward and implement the childhood obesity strategy?

Simon Stevens: I do, and I am confident that we will, because the argument has been well made; the reason for action is understood and, as a country, we are ready for this kind of action.

Q7 Chair: Have you had any indication about the reasons for the delay in the publication of the strategy or any indication of when it will come out?

Simon Stevens: Not really, but it is hardly for me to suggest to your good selves. There have been a number of other things happening over the last 15 or 20 days within half a mile of here, so I think it is purely that.

Chair: Yes, fine, okay. We are going to come to Helen now to address in more detail the financial picture.

Q8 Helen Whately: I am going to follow up on Sarah's first question. Given the funding settlements that we have seen for public health and the squeeze on social care and the pressure there, do you still believe that the NHS can manage with funding at the lower end of the scale that you mentioned earlier?

Simon Stevens: Given the new economic context and the decisions that will be facing the new Government, it is not at this point clear precisely what the next three or four years should look like in terms of the public finances; but certainly from the point of view of the NHS, for this year, 2016-17, we asked for a front-loaded SR settlement and we got that, and, although it is going to be a very tough year, that certainly will enable us to make a very big dent in the hospital deficit, which received such focus last year. For 2016-17 and 2017-18, we have the kick-start to the forward view that we need. However, it was a U-shaped funding settlement, and when you get to the U-bend times are considerably tougher. As to what the prospects are for 2018 and beyond, that has to be a conversation for another day, but I have made on several occasions the point that, were there to be any availability of extra funding in the short to medium term, social care would have a strong first call on that.

Q9 Helen Whately: You have indeed said that to us before, although I take from listening to your answer that you do not sound entirely confident that the NHS would be able to deliver the ambitions of the five year forward view with the lower end of the funding scale.

Simon Stevens: I am just reflecting, in a sense, where Dr Wollaston started, which is that there are issues around the availability of capital, around what is happening in social care and around public health; the indisputable fact is that we enter 2016-17 with a tougher set of cost pressures in the hospital sector than was envisaged in October 2014. The national health service can cut our cloth according to the funding settlement that the Government of the day make available, but I certainly do not want to suggest that we are in the land of milk and honey.

Q10 Helen Whately: One thing you will know I have been calling for is a more concrete plan for the delivery of the five year forward view—where efficiency will come from and the shift in spending and activity from acute to out of hospital, for instance. We want to see a plan that we can check progress against. We seem to be moving towards that in the sustainability and transformation plans at a localised level, so all eyes are very much on those STPs. Could you tell us how the sustainability and transformation plans are progressing and how many would you say amount to robust and credible plans that will deliver on the ambitions of the five year forward view?

Simon Stevens: Sure. I have been spending a big part of this month with my colleague Jim Mackey and others having face-to-face discussions with all the local NHS leaders in the 44 areas that comprise the sustainability and transformation footprints. I have a couple of days to go, but I am more than three quarters of the way through. We are going to rank informally the whole lot on 29 July and then use August to work through what the combination in aggregate of all the local propositions amounts to. As you would expect, the reality is that some places have been working together quite effectively for a period of time; they have a quite well-articulated view as to how they locally would implement the five year forward view, and are looking to fire the starting gun, which we expect to be able to do in October. At the other end of the spectrum, there are some people, frankly, for

whom this is the first time they have shared their views together locally on how services need to change, so they have a further path to tread.

One very positive element of the way those conversations are developing is that local authorities and local government leaders are much more involved in a way that they have traditionally not been—the national health service has tended to be a bit of a sealed system—so all over the country local authority chief executives, lead cabinet members and leaders are participating actively in the conversation about what health and social care and integration should look like in their area, given the likely funding envelope. In a nutshell, there is a lot of work to be done, but I am quite encouraged by how those conversations are developing in most parts of the country.

Q11 Helen Whately: From what I have seen in my area in Kent I am encouraged by the way the STPs are bringing together multiple organisations, including social care, across the area and looking in a very effective way over all healthcare and the health economy for the area. I agree that is good, but can I push you a bit? You said that some plans are well advanced and some not nearly so, but, of the 44, are we talking about one or two that are well advanced or 20 or 30, because it is so crucial to the delivery of the five year forward view and we are already well over a year into that five-year period?

Simon Stevens: Yes. The majority of the country will have well-designed service improvement and change plans that we will be able to back come October. In terms of the timetable, they have to get their financial modelling done by mid-September/October; that is when we are looking for the sign-off on the plans. We have decided to bring forward the annual NHS commissioning cycle—the funding cycle—and make it a two-year cycle, so 2017-18 and 2018-19 will all be done by Christmas. In effect, people will be using now until October to finalise their STPs and October, November and December to divvy up the money in the local health economies. They will then be able to spend January onwards with their sleeves rolled up getting on with it, instead of the faffing with transactional negotiations that otherwise consumes so much time.

Q12 Helen Whately: It still sounds quite a long time and I do not think we have quite got to the bottom of the number that are in good shape.

Simon Stevens: No, that is because, as I say, 29 July is when we are going to moderate them across the whole of the country.

Q13 Helen Whately: Chair, I am conscious that I have a few more questions and we are getting lengthy answers, which may be helpful, but I am struggling to get through the questions.

Mr Stevens, you have seen the state that these STPs are in and have been spending quite a lot of time looking at them. We have all talked about the need for a shift of activity and funding from hospital settings into out-of-hospital settings and, as you mentioned in your article this morning, to primary care. Are you seeing STPs with real, robust plans for shifting activity like that and shifting funding? Can you give some figures on the shift of activity and funding that STPs are going to do from hospitals to out of hospital?

Simon Stevens: Yes. We are definitely seeing that. In fact, even though people are basing and discussing the best way forward locally, we see quite a lot of convergence as to what it will look like. There is a lot of effort around bringing GP practices together, scaling them, integrating with community nursing services and, as a result, when they look out over the next three or five years, ensuring that more of the marginal funding increases go

into primary and community services, and indeed mental health, rather than just the click of the turnstile hospital emergency admissions and bed days. The exact form that takes differs in different parts of the country.

For example, yesterday afternoon I was talking with the leader of Dudley council and the head of the Dudley clinical commissioning group and, to be very practical about it, they have 46 or 48 GP practices in Dudley and they are bringing them together. In the case of diabetes services, for example, they made the obvious observation that about 2,000 people with diabetes were being managed by consultants in the hospital and about 20,000 people with diabetes were being managed by the GPs in Dudley, and, in fact, they were integrating those as a combined team for people with diabetes. As a result, they predict that that is going to reduce the number of emergency hospitalisations or complications of diabetes, and they are tracking that through. They are doing it in a whole range of other areas too. In every part of the country those kinds of service redesign are picking up speed.

Q14 Helen Whately: What short of shift, in quantitative terms, will we see from acute to other settings as a result of that?

Simon Stevens: Remember, it is not a zero sum game, so it is not a question of saying what the current stock of hospital admissions is and then in absolute terms what reduction we see. All we need to do to succeed on the demand-bending part of the five year forward view is to slow the rate of increase in emergency hospital admissions and in-patient bed-day usage. All the STPs are highly geared towards quantifying that but recognise that it ultimately boils down to changed working practices between different parts of the service—the community nurses, the GPs, the social care services and the care homes—and you have to get really practical about what that will mean in a particular area.

Q15 Helen Whately: It looks as if we expect to see the quantitative reflection of this in September.

Simon Stevens: October is when they will be broadly available.

Helen Whately: Shall I move on to the capital?

Chair: Yes. There was the issue of the 2.1.

Q16 Helen Whately: One point that has come up, certainly in discussing the STP in Kent, is the constraint on capital funding. There is a need to improve facilities, both in the acute hospitals and outside them, for the shift to take place, yet capital funding is incredibly constrained and we are seeing, because of the financial constraints, the shift of capital to revenue projects to help plug the deficits. What is your view on where the capital that is needed will come from, and how much is needed?

Simon Stevens: Ultimately, we will have to make do with whatever capital is available, but it is incredibly constrained. As I said this morning, a sizeable chunk of it is being converted into revenue each year to support day-to-day running costs. There are two or three different types of capital request that we are getting from the STP process. One is just dealing with old buildings, backlog maintenance, of which we have quite a bit around the country, and it is an open question as to whether or not we will be able to sort that out. It will all depend on whether or not more capital becomes available over and above what is currently pencilled in. Secondly, we have investment that people want to make so as to be able to free up lots of other efficiencies, moving out of poorly located or inappropriately designed facilities, and beefing up primary care at scale and so on.

Thirdly, there is a set of investments that people need and want to make on technology to drive the digital agenda.

We are working through those three, and then we will have to rank them where we have a mission-critical need to do some repairs, because of the CQC or a health and safety issue, on the one hand, and, on the other, for those where it is a service redesign issue, we will have to rank them by how shovel-ready they are and how much of a payback they get us. My personal point of view, given that the costs of Government long-term gilts are now at the lowest they have been, is that this would be an ideal moment to consider an upgrade in NHS infrastructure.

Q17 Helen Whately: We should distinguish between the policy as you set it out in most of that answer and your personal view, which is that now is the time to establish a fund that could help meet the need that it does not appear there is money around to fund.

Simon Stevens: Our responsibility as the national health service is to lay out for decision makers what the possibilities look like and then it will be for Government to decide, based on a whole range of other factors as well, no doubt.

Q18 Helen Whately: Are you urging those coming up with the STPs and saying what they need, not entirely to make their decisions in advance and to say, "We know there is not capital available, so what can we do without capital?" I will not ask you to answer that question, but I put it out there.

Simon Stevens: If anything, we have been doing the opposite; we have been reminding people that there is very little capital around. That is because, frankly, with the first few STPs we had, people pitched up and said, "If we had £700 million for my little neck of the woods," or a billion or two here, and we would say, "Do you actually know how much, in total, there is?" It begins with £4 billion, or north of £4 billion, before the cap to rev transfer, so the idea that you can get £1 billion in one of the 44 is for the birds. Somewhere between "Not very much" and "More than we've got" is probably a sensible compromise.

Q19 Helen Whately: I have one final question to ask on this, which is about the accountability of the STPs. Clearly, it is an absolutely critical approach to delivering the five year forward view, and bringing together all the organisations across a region is very good, but the reality is that the leads of the STP process are very much operating as first among equals. As far as I can see, they do not have authority over the many organisations feeding in. In that circumstance, is it possible for them to come up with really ambitious plans, because there has to be consensus? If they come up with ambitious plans, what authority will they have to get them implemented, and how will they be held to account on the delivery?

Simon Stevens: That is a really pertinent question. The reality is that in some parts of the country, as I said, there is clarity about where people want to go; in other parts of the country, we have been using those processes of face-to-face engagement to push people to talk about what are the difficult issues—the elephants in the room that they are otherwise seeking to avoid—and actually drive some decision making and recommendations that can then be the subject of proper public engagement and consultation, come the autumn, where that makes sense. By definition, if you are involving, as we want to, local authority elected leaders, local authority chief executives and different parts of the national health service, of course nobody is in command, as it were, but nevertheless there is a shared sense of place, a shared sense that we are all in this together now, so if we cannot solve it on behalf of the people we are all here to serve, nobody else can. That sensation is beginning to

trump the more sharp-elbowed approach of doing what people perceive to be in their individual organisation's interests as against the interests of the people in their local area.

Q20 Helen Whately: Do you envisage that accountability will need to catch up somehow with that shift?

Simon Stevens: In some places, we are being asked to consider so-called control totals that are shared across organisations, so there will be shared accountability, maybe shared governance, that would sit with that, and I think we are open to that proposition. This is not going to fundamentally rewire the formal statutory accountabilities that exist, but, in practice, people will come together in new ways.

Q21 Chair: You have put aside £2.1 billion for the sustainability and transformation fund, of which £1.8 billion has already gone towards sustainability, so there is very little left for transformation; you just said that it is somewhere between nothing and not very much. Are you able to be more specific to the Committee about how much extra is going to be needed and for which parts of the service?

Simon Stevens: Do you mean for infrastructure?

Q22 Chair: For the whole transformation piece. As you said, it is more than just the physical infrastructure; there are other parts to transformation. Can you be more specific about how much more is needed? If you are recommending that a sum is borrowed because gilts are so low, it would be better to have an idea of what you are recommending.

Simon Stevens: Let's distinguish transformation funding, which is revenue, from capital investment, which is the infrastructure.

Q23 Chair: Yes, that's what I am saying; it is all going towards soaking up deficits. We want to know how much you think needs to be there for the transformation piece.

Simon Stevens: For the transformation revenue, the size of the transformation fund goes up from £2.14 billion this year, of which, as you say, £1.8 billion is being used for provider sustainability, to £3.4 billion by 2021. That is incremental funding, which will be used to drive the service changes and our national priorities, mental health, cancer and other things.

Q24 Chair: Are we going to see that again swallowed up in trust deficits in subsequent years?

Simon Stevens: I very much hope not. The so-called reset position is very important; in the next week or so, NHS Improvement will be setting out the agreed control total that every trust has to deliver this year that has been negotiated with them in exchange for their share of the £1.8 billion. We will be doing the same for every CCG—the control total spending that they need to deliver—and, if the national health service can deliver on those two groups of control totals, it will substantially reduce the deficit in 2016-17. That means that, whereas I think we will have to continue using the £1.8 billion to support the services that are already being delivered by trusts, the incremental pressure on the growing transformation fund should be available for the services, the change, that we want to get. I kind of accept pragmatically that we are going to use £1.8 billion, one way or another, to support existing trust services, but as that fund grows by over £1 billion over the next four years we need to be using that extra funding for the other things that we need to get done.

Chair: Does anyone have any follow-up points on finances? No. I am going to come on to Ben now.

Q25 Mr Bradshaw: What is your assessment of the impact on the NHS of the referendum result?

Simon Stevens: It is too early to say.

Q26 Mr Bradshaw: Have you seen anything of the £350 million extra a week we were all promised?

Simon Stevens: Rather than Greenpeace respraying the battle bus, it should probably just be impounded as exhibit A.

Q27 Mr Bradshaw: Are you saying that you never took that promise seriously?

Simon Stevens: I have no doubt that the reason that promise was made was very genuine concern across the country about the prospects for the national health service, and I am sure that concern will have registered with all elected Members of Parliament and the Government.

Q28 Mr Bradshaw: But you have had no indication from those now in charge who supported leave that that money is about to come your way.

Simon Stevens: As a matter of record, not yet.

Andrea Jenkyns: Is it not too early to say that?

Mr Bradshaw: I think that's up to Simon Stevens.

Simon Stevens: Genuinely, I think it is. The reality is of course that it is too early to say. There is a set of things it will be important to get right.

Q29 Mr Bradshaw: You are sounding, like me, a bit like someone who did not take that promise very seriously when it was made.

Simon Stevens: There were different versions of that promise, weren't there? There was certainly a very clear and dated commitment to make available to the national health service £100 million extra a week by 2020. I don't think the £350 million ever had a precise date attached to it, but the £100 million a week by 2020 did.

Q30 Mr Bradshaw: It was taken seriously by voters. I spoke to an elderly couple of lifelong Labour voters who thought that Labour's position was to support the leave campaign because it said on a red bus that the NHS was going to get an extra £350 million a week. People did take it seriously, even if you were sceptical about it. How much extra are we paying for medicines as a result of the collapse in the pound since the referendum vote?

Simon Stevens: Again, with the way that the PPRS works, as you know from your days as a Health Minister, it is too early to say at this point what the impact will be. There are ins and outs.

Q31 Mr Bradshaw: The reports suggesting that the £350 million has already been wiped out because of the increased cost to the NHS of imported medicines as a result of the collapse of the pound have no basis in fact.

Simon Stevens: That is not an assessment that you could make at this point for this reason as well, which is that the way the PPRS works is to cap the extra spending on medicines that are bought in Britain, and when the pound is strong it incentivises parallel imports from the continent that do not themselves all show up in the PPRS rebate calculation. The effect of a weakening of the pound also produces in all likelihood some reduction in non-PPRS attributable parallel imports, but offset against that are some of the exchange

rate effects you talked about. To understand the net effect of those two, we will have to wait and see.

Q32 Mr Bradshaw: What about the workforce concerns that you elaborated on in your *Daily Telegraph* piece today? Perhaps you could outline those for members of the Committee in a bit more detail.

Simon Stevens: It is an uncontroversial statement of fact that in every year of the NHS's 68-year history we have, in addition to brilliant and highly trained British workers, relied on health professionals committing their professional career to come to this country and work in the national health service. That is certainly still true today, with over 130,000 staff from the European Union working in health and social care, so it will be very important that those staff continue to understand that they are both an intrinsic and important part of the teams of carers across the national health service and that they will continue to have a big welcome in this country. The last published figures, for example, show that about 400 staff at Great Ormond Street were from the European Union, and there are many hundreds more at University College Hospital, and indeed in hospitals across the country. There is no reason why the arrangements that are set to be negotiated should not give us that security, and, as I pointed out this morning, just about every country that has an Australian-style, points-based immigration system recognises the great value of attracting nurses, doctors and health professionals. Whether or not we have one of those as part of our ongoing commitments to folks who moved here prior to Brexit, it seems to me that it is a pretty unambiguous message to European nurses and doctors that we would like them to stay.

Q33 Mr Bradshaw: That is not the message that has been given up to now. Are you saying you would like the Government to give a categorical assurance that their status here is secure?

Simon Stevens: I have not heard anything inconsistent with that, but if we are able to be all clear on it that would be a great thing.

Q34 Mr Bradshaw: No, I am sorry, but the new Prime Minister has made it quite clear that she is not giving that assurance, because she sees them as a bargaining chip set against the 3 million-plus Brits who are resident in other parts of the European Union. They have not been given that assurance and I am certainly picking up a lot of uncertainty in my constituency, not only among those people themselves but their employers and their colleagues, that they feel their status is insecure. Are you not saying you would like some stronger, more categorical assurance from the Government that they will be staying, working and serving our national health service?

Simon Stevens: The sooner we can have that, the better.

Q35 Mr Bradshaw: What about the impact on our medical research and development? The UK is the biggest recipient currently of research funds vital for medical research and medical advancement. We have already been excluded from talks at European level around research, and Sir Bruce may want to add something about that. What is your early assessment of the likely impact on our medical research, and what assurances have you been given by Government Ministers that the money we lose from the European Union will be substituted from national coffers?

Professor Sir Bruce Keogh: Perhaps to set the scene, people need a clear view as to the impact of medical research that is conducted in this country, a lot of it down to the good

work of the chief medical officer and the National Institute for Health Research. We constitute about 1% of the world's population. We produce 3% of the global funding for medical research. We produce 6% of the papers, 12% of the citations and 16% of the world's highest-quoted medical research. An assessment of the NIHR by RAND independently has shown that it has made the NHS more cost-effective and safer, and it improves health not only in our population but worldwide. We get a big contribution from the European Union, particularly through Horizon 2020. Between 2007 and 2013 we contributed €5.4 billion to the European research coffers and we got €8.8 billion out. To replace that works out at about £500 million a year. I am not sure whether Simon has had any reassurance, but I certainly have not heard anything to indicate that that would be replaced.

There is another issue, because there is a period of uncertainty while people try to work out what is happening. We already know that there have been a number of individuals who have indicated that they are not that keen on coming to jobs in the UK, people of a very significant academic background, and we are already hearing of collaborations being put on ice while this uncertainty is resolved. It is quite a significant issue.

Q36 Mr Bradshaw: Can you be a bit more specific about some of the people who are now not coming here?

Professor Sir Bruce Keogh: I would rather not do so here, but I could give you a note.

Q37 Mr Bradshaw: Perhaps you could give that in writing to the Committee.

Simon Stevens: The overall context to this, Ben, is that there obviously is uncertainty and the new Government will have to frame what the negotiating asks look like, but from the point of view of the NHS, at least, we have to go into it with a positive approach. We will have to use the opportunity to the extent that there are changes in the immigration system to level up the arrangements that exist between non-EU and EU health professionals able to work in the NHS. It has been somewhat arbitrarily split. We will need to make sure that we are very thoughtful about the way our medicines licensing works, if and when the European Medicines Agency relocates. We will perhaps take the opportunity to have a more flexible set of procurement rules than the EU has gifted us with, shall we say. We will look at the extent to which, as we talked about earlier, in the way that the Chancellor has described, opportunities for infrastructure investment are opening up before us as part of a positive view as to what the future of the country might be. My point on this in the *Telegraph* this morning was that "When there are lemons, make lemonade," so let's make lemonade.

Q38 Mr Bradshaw: Infrastructure is great, but it is no good having buildings if you do not have people to put in them or the money to spend on treating people. Can I ask you about passporting rights? What assurances have you been given by Ministers that the British Government will seek to protect the rights of British people travelling or living overseas to free healthcare in the Brexit negotiations?

Simon Stevens: This would fall into the category of all to play for. Quite clearly, 23 June was but a few weeks ago, so of course not all of these things are yet nailed down. The NHS will be explicitly staking out our stall and going into bat for things that will make a difference for the NHS and for patients. As it happens, there are different ways of connecting the reciprocal agreements that exist between countries that do not rely on the European Union and the EHIC arrangements. Many of the other cross-border

arrangements are EEA rather than EU. We have reciprocal agreements with other countries outside the European Union, such as Israel and other countries as well. We will have to go into bat for a sensible set of arrangements.

Q39 Mr Bradshaw: Last, but by no means least, Chair, on public health, what indications or assurances have you had from Government Ministers that we will retain the very important public health measures that guarantee quality of air, water and food safety? All are currently set at European Union level and are absolutely vital to public health, and indeed public safety in Britain.

Simon Stevens: The honest point is that that would be for the UK Parliament to decide. It will be for yourselves to decide what the transposition of those kinds of arrangements looks like.

Q40 Mr Bradshaw: But as head of the NHS you have an interest.

Simon Stevens: As you can tell, I am not afraid to speak out on issues of public health when that is required, but, ultimately, it will be for Parliament to decide these matters. If you are looking for some upside opportunity, on occasions we have had our hands tied by the way in which the European institutions have interpreted some of the things we might have wanted to do on public health but have been constrained from doing, whether on labelling or on changes to the tax treatment of things that are damaging to the public's health. Perhaps we can gain some benefit from taking back control of some of those decisions.

Q41 Mr Bradshaw: As long as they were not watered down, do you mean—if they got better?

Simon Stevens: Yes.

Q42 Dr Whitford: I have a follow-up question about the European Medicines Agency, which has allowed drugs to come to patients very quickly because they go through single licensing. The second part is that at the moment it is based here, which has been a big advantage for our research and pharma companies. Sir Bruce, what do you see as the impact of that moving away, which it virtually inevitably will?

Professor Sir Bruce Keogh: I am not sure what the impact is going to be. Currently, we have a very effective MHRA, and we have a plan for accelerated access to medicines in this country. As to the interrelationship between all of those, I am not clear how it will play out. I do not know whether Simon has a view on it.

Simon Stevens: As Bruce was saying, our patients have access to 1,043 centrally recommended medicines as a result of the common licensing marketing authorisation process. Even if physically the EMA moves out of the UK, there are those who argue that there will be a strong case for our seeking to continue to be members of that cross-European medicines licensing regime. That is one issue that the Department of Health and the Government will have to consider in due course, not least because a lot of the expertise to get this job done for the whole of Europe resides with the British scientists who are working at the EMA.

Q43 Dr Whitford: Do you think there is a danger of our very big pharma footprint in the UK moving with it, because obviously one of the attractions, particularly as many pharma firms are multinational, has been research in English and dealing with an EMA in English that is just down the road in London?

Simon Stevens: Obviously, the life sciences industry is incredibly important to this country and we want to sustain and grow it. As we think about what the right post-Brexit arrangements are, we clearly have to factor in the points that you are making, Dr Whitford.

Q44 Julie Cooper: Turning to the subject of mental health service provision, everybody is looking forward to the delivery of parity of esteem by 2020. It would seem there is a long way to go on that. What steps are you taking to ensure that the funding required to improve mental health services is being delivered in the places where it is most needed?

Simon Stevens: The first thing is that through the Mental Health Taskforce we have set out very clearly a set of very concrete improvements that we want to see over the next several years. In fact today we published the full detail of what that will look like for each of the next four years, the money that goes alongside it and the training to expand the staffing in mental health services to get us there. Everybody will be able to see it now—we have called it "Implementing the Five Year Forward View for Mental Health"—so, in a sense, that is the answer.

Q45 Julie Cooper: Would you accept that mental health is in an urgent crisis situation? Would you accept that where we are at is a service that has been the poor relation for very many years over many Governments, and therefore there is a mountain to climb?

Simon Stevens: Yes. I think I said that in the preface to the original document. There are some good things that have improved about mental health services over the last several years. We have the first two national waiting time standards in place for mental health; 3.5 million people have had access to psychological therapies since 2008 when that programme was launched; and there has been a big reduction, a halving, in the number of people in mental health crisis who find themselves in a prison cell. It was precisely because we were all dissatisfied with the state of mental health that we explicitly laid out the very concrete improvements that we are committing to bring about.

Q46 Julie Cooper: What concerns me is the back-ended funding and the need to hold back £650 million in a contingency fund. How does that fit into the plan to address this as an urgent issue?

Simon Stevens: It is completely consistent with the recommendations of the independent taskforce. We asked them to give us their independent evidence-based recommendations as to the best buys for mental health improvement, and they did. The reason it is phased in the way it is, as set out in the document, is that that is the phasing of the extra transformation funding available to the national health service. Obviously we can expand at the rate that the funding is available.

Q47 Chair: For those who cannot see the document, do you want to refer to it?

Simon Stevens: It is called "Implementing the Five Year Forward View for Mental Health", and it is published by our new national director for mental health, Claire Murdoch, who is one of the most seasoned mental health chief executives, and Tim Kendall, the national clinical director for mental health.

Q48 Chair: That was published today.

Simon Stevens: It was published today.

Q49 Julie Cooper: You are confident, with that plan and this funding structure, that parity of esteem will be achieved by 2020.

Simon Stevens: I think I said—probably to the Public Accounts Committee; apologies, I have had the opportunity to appear before a number of Committees—that I do not think anybody should pretend that by 2020 we will have perfection when it comes to mental health services. One very concrete way of thinking about that is children and adolescent mental health services, which I have described as one of the creakiest parts of the mental health system. At the moment, about one in four young people in need are getting the help they need, and, as a result of these improvements, it will be one in three. That is going to be a great gain for the 70,000 or so young people who are going to get treatment who otherwise would not, but it is not mission accomplished.

Q50 Julie Cooper: Staying with adult mental care for the moment, one of the biggest issues, and it is massive in my constituency, is the availability of mental health beds, and therefore the ability to section a patient who is in danger of self-harming, and so on. These issues are a daily experience for us as Members of Parliament. We hear horrific stories. Will the plan address this as a matter of urgency? We all feel it very much day in, day out, and I can honestly say that 50% of the people who come to my constituency office have mental health needs of varying degrees of severity. I hear horror stories on a weekly basis of families struggling to get a bed, and people spending nights sitting in an arm chair waiting for a bed so that they can be sectioned—clearly unacceptable levels of treatment.

Simon Stevens: When we talk about availability of beds, it is interesting to remember the recent report commissioned by the Royal College of Psychiatrists by Lord Nigel Crisp. That found that there is the same kind of delayed discharge/blocked bed issue in acute mental health services as there is in a typical district hospital. In fact, that report found that one in six in-patient beds are occupied by somebody who could be looked after elsewhere if there were better community mental health services. In a typical acute psychiatric in-patient unit of perhaps 100 beds, maybe 15 to 25 would be people waiting to transfer elsewhere or who had been admitted because community services were not available. That is why the mental health implementation plan published today has a particular focus on building crisis home response teams, and, together with the money going into liaison psychiatry and hospital services, that is going to be another £266 million, I think, by 2020 to free up some of the pressure on in-patient beds. That is very important.

The second thing I would mention briefly is that a lot of the problems that arise are because the local mental health services are not responsible for the flows of their patients into the secure services—the tertiary services—so, today in fact, again, we are announcing the first six parts of the country where local mental health services are going to control the investment decisions, the budgets and the patient flows into the medium secure services. They are pretty confident that they will be able to use that to reinvest in local services to reduce the proportion of patients who end up having to be looked after a long way from home. In places like Sheffield, they have effectively eliminated out-of-area placements for people with in-patient mental health needs.

Q51 Julie Cooper: That will be really welcome. Moving to the mental health needs of children and adolescents, the NSPCC has raised significant concerns that currently the mental health needs of children who are the victims of abuse and neglect are not being met. Are you confident that they will be met in the new provisions proposed in the five-year plan?

Simon Stevens: As I said a moment ago, I do not think it will deal with every unmet need across the country. We have to be completely honest about that. What it will do—you can see it on pages 6 to 11 of the document—is build the number of staff available to work in

these services; it will expand the support that parents get as well as their children and it will build up local rather than remote services in parts of the country where people have traditionally had to travel a long way, particularly, say, the south-west and parts of Humberside. It is a very important step forward, but nobody should believe it is the end of the journey.

Q52 Julie Cooper: How can you be assured that the implementation of local transformation plans will not allow this to slip down the list of priorities, as we have seen so often in the past?

Simon Stevens: It is partly because we now have very clear expectations as to what the services need to be, not just the money going in, and partly because we have held back and earmarked some of the funding to be allocated nationally rather than just distributing it all locally at the beginning. In the document, you can see funding tables for each of the improvement areas in mental health: the blue lines are the money that has been given out to CCGs and the pink lines are money that Claire Murdoch is nationally able to hold people to account for and hand out specifically for the things that we need to get done.

Julie Cooper: Thank you very much.

Q53 Maggie Throup: We began the session talking about the cuts to public health funding and to social care, and how that could have an impact on the ability to achieve the ambitious five year forward view. I want to narrow it down to patients, because that is what is important—that is what we are here for. What would be the consequences for patient care if the vision of the five year forward view is not achieved?

Simon Stevens: There will be a combination of more of the same and opportunity missed, if I can put it that way. By more of the same, I mean the increasing pressures on A&E departments, because of the fraying of social, community and primary care. It would mean more frail older people probably stuck in hospital when they want to go home. "Opportunity missed" would mean that we were not able to advance on the improvements we want in child and adolescent mental health or the 30,000 extra lives that we know we can save with improved cancer services and so on. That is why it is really important and why everybody in all 44 parts of the country, as well as nationally, is committed to making it happen.

Q54 Maggie Throup: Do you think it will result in the increase of explicit rationing of NHS services?

Simon Stevens: As with every healthcare system in the world, we do not spend all our national wealth on healthcare, so of course there are limits to what any healthcare system does. It just so happens that in this country we have chosen to do it on a basis of fairness, where care is allocated on the basis of need, not ability to pay, for any given amount that the country chooses to spend on the national health service. We have always made those kinds of choices at the margin.

Q55 Maggie Throup: Some patients already feel that healthcare is being rationed, such as limited access to drugs or a second cataract. Do you think patients might have to accept more of that?

Simon Stevens: Under any circumstances the national health service is going to be bigger, doing more treatments and hopefully doing them better in 2020 than it is now, in just the same way as it is bigger and better now than it was five or 10 years ago. I do not think the question is that what the health service does is in some way going to shrink. The question

is how fast we can expand and improve relative to all the new treatments and technologies that are available, and relative to what people expect a modern health service to be like. That has been the balancing act since 1948.

Q56 Maggie Throup: In my area, we have Erewash CCG, which is a vanguard site, and I think locally patients are already seeing a difference in the way healthcare is delivered. Do you see that as patients receiving healthcare in a different way and perhaps not actually perceiving that it is being rationed?

Simon Stevens: These two apparently contradictory statements can be true at once: most people are very satisfied with the care they get on the national health service and rightly regard it as being of very high quality, and at the same time most people can also see that there are ways in which the care they get could perhaps in some way or another be improved. There is often the sense that people are being passed from pillar to post, the sense of "left hand, right hand", and, as we bring together, integrate, and join up services—between what GPs, outpatient services and the district nurses are doing, and so on—and as we connect mental health services, physical health services and health and social care, yes, I think the public experience should, as a result, improve.

Q57 Maggie Throup: Do you think then that, obviously with money being limited—wherever we are, it is always limited and not a bottomless bit—there are ways that restrictions to healthcare can be acceptable to the public?

Simon Stevens: In the middle of the 1990s, we had a big debate about postcode lotteries and rationing. One response to that was to set up NICE to be clear about what the cost-effectiveness would need to be of new treatments that were appraised by NICE to get on the national health service. We have been pretty straightforward about that since NICE came into being in 1999 or thereabouts. Was it? Both Bruce and I were involved in setting it up, but unfortunately our brain cells are eroding as to when that was. Of course there are choices about how we spend our money and there are ways in which we then try to make sure we are getting the healthcare bangs for our buck, but we are pretty rational in the way we do that.

Q58 Dr Davies: Can I turn to the issue of high-cost drugs? Does the current process in terms of the provision of high-cost drugs effectively balance the needs of the relatively small number of people who receive them against the needs of all those requiring services from the rest of the NHS in what is a cash-limited system?

Simon Stevens: It has worked pretty well hitherto, but there is some reason for thinking that, given the number of new drugs that might come into this category, we need a bit of a rethink about elements of the way it all works. In particular, the interaction between the overall PPRS, which is the voluntary scheme, the NICE appraisal process and NHS England's responsibility as the national specialised commissioner—those three pieces—needs to align better and there is quite advanced work as to what that would look like. It is something called the accelerated access review, which I think will converge the processes in a more satisfactory fashion.

Q59 Dr Davies: Expenditure for the specialised services commissioning process has been increased by 7%, I believe, for 2015-16. How can you look to alleviate the pressure on this arising from high-cost drugs? How do you see it moving forward?

Simon Stevens: Bruce will want to come in on this as well, I am sure. Some drugs may be high cost, but they are also high value. They are wonderful new treatments that we would

want to make available even if we had to do so on a phased basis. A lot of those products are expensive at the early stages and then, over the passing of the years, they get cheaper. For conditions where there are a small number of patients and therefore prices tend to be high because of the research costs, NHS England has had some success in the last 12 months in being, shall we say, a disciplined negotiator with the relevant pharmaceutical company about the price that we would be willing to pay. Because we have not, in a sense, been handcuffed by a NICE pricing process and have been able to be clear that, if taxpayers were not able to get a good price, the NHS would unfortunately not be in a position to buy drugs from the company, we have seen some very good confidential deals that people have been willing to offer us.

The same has been true in the renegotiation we have had for a number of the medicines that were in the cancer drugs fund mark 1, where, once people really understand that we mean it, they are willing to think very creatively about the way in which we can structure reimbursement arrangements, particularly linked to patient outcomes—new ways of reflecting real-world value for the products that they are developing. Do you have anything on that, Bruce?

Professor Sir Bruce Keogh: There are possibly two things I would like to add. If you look at some of the changes we have made to the cancer drugs fund, in a previous incarnation I think it was seen as a bit of a cash cow by some of the pharmaceutical companies, but it has been restructured in such a way that it will do three things. First, in conjunction with NICE, we will ensure that as a drug reaches market authorisation it also has its guidance, and that will give some indication as to NICE's view of that particular drug. The second thing is that we will give early funding to drugs that are approved by NICE.

The interesting bit in all of this is that, given that the NICE formula is basically effectiveness versus cost, there will be some drugs where there is a degree of uncertainty. That uncertainty will relate either to the effectiveness or the cost. We will put those drugs into a managed access fund, which will enable us to assess them for clinical effectiveness and for information that may be of use to other regulators or of commercial interest to the companies. It is that assessment, I think, that will focus the minds of people on both the effectiveness and the cost. Even talk of that has produced, as Simon said, some pretty interesting reductions in the price that we pay for drugs.

There is a second and perhaps more serious issue that we have to consider with time. We are starting to see the emergence of drugs that are able to treat conditions that were previously untreatable. Hepatitis C would be an example of that. We are starting to see the same sorts of things beginning to emerge in the cancer world. They are relatively quick forms of treatment that produce a quick response, but they are very expensive. Over the passage of time, we will have to think about new funding models to pay for those particular drugs. The pharmaceutical companies are very receptive to that discussion.

Q60 Dr Davies: You referred to NICE and the fact that they assess drugs in terms of cost-effectiveness. Should their role expand to consider affordability, because I think there have been some comments from them in relation to hepatitis C medications and treatments?

Simon Stevens: This, as you know, Dr Davies, was an issue that the Public Accounts Committee recently looked at as well. They recommended that affordability should be factored in, one way or another, to some of the big potential budget-busting technology appraisal decisions. I think that recommendation is right. Whether or not it is NICE that

does that, given that it is NHS England's responsibility to manage the affordability of these kinds of decisions for the NHS as a whole, I think where we are getting to is that for new medicines, which, like hep C, potentially have a very big immediate budget impact, there should be more latitude for the budget holder, in this case NHS England, to work with the companies on what is the right phasing or sequencing of the roll-out of the technologies. Having said that, the hep C blockbusters are relatively unusual. Although about three quarters of NICE technology appraisals are directed at my specialised commissioning budget, very few of them fall into the category of the hep C-type product, which might be cost-effective but because of the big stock of patients could also have a very high first-year budget impact.

Q61 Dr Davies: Thinking of the hepatitis C treatments, and their phased introduction, is that the kind of approach that we are going to see in other spheres with other medications, or do you think it is merely related to the precise situation, the cost and the number of patients involved?

Simon Stevens: It is pretty unusual actually. You can imagine that there could be future examples of that, but as we look out at the pipelines, over the next three or four years, I do not think we are anticipating many others in that type of category.

Professor Sir Bruce Keogh: It has focused our minds in the way we deliver treatments in a complex environment like that. Through the operational delivery networks, we have developed very clear protocols for who gets what and when, and who are the people that make the decisions. It has brought quite a lot of rigour to the prescribing process and to the clinical analytics that underpin all of that. There may be some lessons that, with the passage of time, we learn from this about how to improve our services in general.

Q62 Dr Davies: This Committee was quite concerned about the apparent profiteering on the part of some drug companies in relation to drugs that had been branded and lost their patent; the patent had expired. How concerned are you about generic medications costing the NHS more than they should when there is the lack of a competitive market?

Simon Stevens: As you know, in the round, generic medicines are a great benefit to patients and to the NHS, and we are a really rational user of generics compared with many other countries, but the particular instance that you are highlighting, Dr Davies, was of very real concern. I think Dr Wollaston wrote to Jeremy Hunt, the Health Secretary, and I think Jeremy replied with reference to the investigation that the Competition and Markets Authority was contemplating. In the light of that, it may well be that further regulatory change is required and, if it is, we should certainly press ahead with it.

Q63 Dr Davies: Finally from me, do you have any idea specifically as to what changes you would like to see to ensure the NHS is not ripped off, or do you think it should be entirely down to the Department of Health?

Simon Stevens: All those in favour of the NHS being ripped off, say yea. No, obviously, that is something that we absolutely have to avoid. In general, we get very good value from the medicines that we buy, but there are probably some loopholes, of which this is one. There are some other issues that have to be addressed as well, including the relationship between companies that do not join the voluntary PPRS but bring new products to market; that is an issue particularly for companies with one product who are not established players with a broad portfolio and a long relationship. Frankly, in one or

two of the high-profile drug issues that have arisen in recent times, some pretty sharp behaviour on the part of a very small number of companies is the root of the issue.

Dr Davies: Thank you.

Q64 Julie Cooper: I have a quick question on that. Going back to patients instead of the NHS, how transparent is the process when a decision is being made about which medicines can be available on the NHS and which cannot? For example, I have been approached by a number of constituents about the condition tuberous sclerosis, treatment for which is currently being denied to adults and children. How transparent is the process, and is there any right of appeal or anywhere for people to go for treatment?

Simon Stevens: It is increasingly transparent. Obviously, there is complete transparency about products that go through a NICE appraisal, and the new arrangements that we have put in place in NHS England for specialised commissioning are also now highly transparent in terms of the annual prioritisation round, so-called; there is something called CPAG—the clinical priorities advisory group—that, as you know, gets the bids in and does an annual assessment. There is a separate process for in-year, very urgent consideration as well. We published just last Monday the provisional list of those that have been funded and the reasons why. There is far greater transparency now than there has ever been.

Q65 Julie Cooper: Is there any space for appeal from patients suffering from diseases where the treatment did not win approval?

Simon Stevens: There is an individual treatment request process, and we are just about to consult on streamlining that so that there will be a clear appeals process for the so-called IFRs that are declined. We are consulting on what the process should be.

Q66 Dr Whitford: Can I ask both of you if we have a strategy to encourage the use of repurposed off-patent drugs, which tend to be very cheap? In my neck of the woods, in breast cancer, bisphosphonates were shown to reduce development of secondary cancer, which ends up being a very expensive condition, but they are not yet being used and promoted. What action are we taking, because we can be talking about drugs that cost pennies?

Professor Sir Bruce Keogh: I do not have an answer for that. I would need to send you a note.

Simon Stevens: Within the last month there has been an important research study—from Leeds, I think—looking at combination therapy for off-patent oncology agents. I think we are going to see more of that kind of research, so it is important that NIHR and other research funders stimulate that kind of research, given that it probably will not be done by the pharma sector itself for obvious reasons.

Q67 Dr Whitford: There is plenty of research out there. Do we have a kind of model within NHS commissioning that encourages, allows or pushes people to use something that costs sixpence a day that could prevent us needing to ask for Kadcyla at £90,000 six months down the line?

Simon Stevens: You are saying that you think the evidence generation has already occurred; it is now about how we—

Dr Whitford: Yes.

Chair: Macular degeneration treatment, for example.

Simon Stevens: Yes, but the Avastin thing is a slightly different set of considerations, given that patent still existed at the time the switch was being contemplated. In terms of the incentives to do what you are describing, Dr Whitford, we have just set off three cancer vanguards across the country, and they have the pooled funding for all cancer services so that they can substitute between different types of treatment and therapy. The reason that is important is that hitherto the way cancer drugs were funded was through two different sources, either as a direct reimbursement from NHS England's specialised commissioning or through the cancer drugs fund. Radiotherapy was paid for through a separate funding stream out of specialised commissioning. The way in which cancer surgery was paid for was a separate funding stream through local clinical commissioning groups. Obviously, this makes no sense at all, so the cancer vanguards, beginning at University College Hospital, the Christie and the Marsden, are putting together all the funding streams into a single pot and then they are incentivised to get maximum bangs for their buck. I think that would include the kind of therapy substitution you are talking about.

Chair: We are going to move on to workforce planning.

Q68 Maggie Throup: As you are aware, one of our inquiries touched on workforce planning, particularly in the primary care setting; but, without assuming responsibility for the education and training of NHS staff, how can NHS England ensure that workforce planning meets the demands of the service?

Simon Stevens: As you say, principal responsibility for answering that question sits with our sister agency NHS Improvement, working together with Health Education England. I have said that there has been a collective action problem around workforce issues for a number of years, given the fragmented responsibility between individual employers, the local HEE processes—the so-called LETBs—the Department of Health's responsibilities and NHS England's interests, and so on. I think people now recognise that more collective action both locally and nationally is needed on workforce issues, and we are beginning to see that driven very hard on the back of some of the changes that are going on around agency cost reductions, which in turn pose all the right questions about how you recruit and retain permanent staff. Certainly in terms of primary care, NHS England directly, as the agency with responsibility for overseeing delivery of GP services, is working very closely with Health Education England on the increased production of GP trainees, which they have committed to do as part of trying to get us 5,000 more doctors in general practice by 2020.

Q69 Maggie Throup: I want to give you an example. In my part of Derbyshire, we have been waiting for longer than I have been a Member of Parliament for sufficient numbers of community paediatricians, or even just a community paediatrician. This is having a great impact on the CAMHS service, which has a knock-on effect for children and their lives. There is a huge long waiting list for assessment for mental health issues and behavioural issues. There seems to be a lack of co-ordination in areas such as mental health between that situation on the ground and the report you pulled out earlier on implementing the mental health strategy. How can you square that circle?

Simon Stevens: On mental health, today's report is very practically focused on doing exactly that. It has gone through for each of the improvement service areas what will be

the workforce, where they are going to be trained from, where the money is coming from to do it and how we measure whether those people are coming through the system. We have not had that before. Health Education England has committed to producing the soup-to-nuts workforce implementation plan for all of this by December, so we are seeing progress there. We are doing the same on the primary care workforce. Until now this has been, in a sense, too bottom-up and fragmented around some of the other hospital disciplines, and it has ended up being a kind of national bulldog clip around lots of local requests to HEE, without our standing back and saying, "In the round, does this feel right and make sense for the NHS?" HEE is completely aligned to that with the work it is doing on its workforce modelling. If Ian Cumming was sitting here, he would be describing how they are looking to change that with NHS Improvement.

Q70 Maggie Throup: Do you think you will be able to deliver what you want as regards the five year forward view aspects of it, mental health and primary care, with the resources you have at Health Education England?

Simon Stevens: Obviously, the most authoritative answer to that would come from HEE, but as we talk I am looking at the draft Derbyshire STP covering your constituency to see what they plan on the workforce front, and, yes, they have a plan for 2,500 more staff doing place-based care in the key priority areas they are looking to develop. These STPs will be the way we bring together the money, the people, the change process and the capital investment into a coherent whole for Derbyshire.

Q71 Maggie Throup: For the last 12 months they have been promised extra resources for community paediatricians and it has not happened.

Simon Stevens: I would be happy to go away and talk to the local trust and the CCG, but I suspect you have already done that many times, so they would not tell me anything you do not already know.

Q72 Helen Whately: I have a supplementary question on the workforce point. It is all very well making plans for the numbers of people who need to be recruited, but none of it is any good if people do not want to work in the NHS, if people do not feel valued by the NHS and do not feel they can do a good job in the NHS and therefore leave or are not inclined to apply for jobs in the first place. What plans do you have at the moment to address those problems of morale and feeling valued by the health service?

Simon Stevens: I am sure Bruce will want to come in on this, but I agree with your analysis completely. People feel under real pressure. As it happens, when you look at the annual staff survey, which we do across the NHS, those results have been improving, which is positive, but I do not think that should mask the pressure that people are under. Without being panglossian about it, a lot of the frustrations that people experience day to day are some of the frustrations that we are trying to design out of the system with some of the service changes that are now being contemplated, but there are a whole range of particular pressures. Obviously, we have had those in hospital medicine, including with the junior doctors, and I know Bruce has been thinking about some of the changes there that could now make a difference.

Chair: We will come to that in more detail later.

Simon Stevens: The suspense will kill us all, Bruce.

Helen Whately: I know we are going to come to junior doctors in a moment, but it was a broader question.

Q73 Chair: Yes. Did you want to mention something about the broader issue of morale, Bruce?

Professor Sir Bruce Keogh: I would like to say something about general practice and junior doctors and some of the things that we are doing and could do to improve that, but the timing can be whenever you feel is appropriate, Chair.

Chair: We will come to that later, thank you.

Q74 Andrea Jenkyns: We have seen the figures for pre-registration nursing and midwifery places. Besides 2015, there has been a steady decline. The Government state that removing NHS bursaries for the nursing workforce will increase the number of nurses in the workforce. How confident are you of this and what is your evidence based on?

Simon Stevens: There are rival predictions, aren't there? The universities, the deans of nursing, those whose responsibility it is actually to recruit people into nurse training and to educate them, advocate the change and think that it will enable them to expand the number of nurse training places, given that at the moment there are far more people interested in coming into nursing than there are funded nursing places, because of the constrained way in which the prior system works. That would be one data point.

A second data point would be to look at what has happened to other health disciplines when student financing arrangements changed and the cap on places came off, and ask what has been the result. In the case, say, of pharmacy training, there has been an enormous expansion in the number of pharmacists, so much so that we probably have a surfeit of pharmacists, which is why we ought to bring them into general practice.

Q75 Andrea Jenkyns: You are confident.

Simon Stevens: Those would be two positive predictions. Set against that, obviously, there is concern on the part of the Royal College of Nursing, Unison and others. I think we will get a clear picture within the next 12 months, given that it is August 2017, I think, when the new arrangements come into place.

Q76 Andrea Jenkyns: Are you confident that we will attract more nurses into the system by removing bursaries—you personally, your own view, in your role?

Simon Stevens: As I said, with other health disciplines it has been perfectly successful. There are lots of people who would like to go into nursing to whom at the moment, because of the funding arrangements, we cannot offer places, so that would lead one to believe that it could be a positive development, but it will have to be tracked very carefully.

Q77 Andrea Jenkyns: Do you believe that removing the NHS bursaries will become a barrier in attracting mature students? I was a mature student a few years ago at university. Do you not see it as a barrier?

Simon Stevens: It is something that is going to have to be thought about very carefully. As I understand it, the consultation that the Department of Health was running on it closed on 30 June, so I think it is contemplating, in light of the representations it has received, what the final arrangement should be. I know that is a legitimate concern that has been raised, particularly as I think the average age of going into nursing is already, as it were, mature,

although I do not think you can call a 28 or 29-year-old mature. It is certainly not the 18 and 19-year-olds who are, in some people's minds, predominantly the folks going into nursing. The way the student finance arrangements work will obviously be very important. The Department of Health, at least, has suggested that the repayment for a newly qualifying nurse would be £5.25 a month, with, obviously, forgiveness if over the duration it has not been paid off; but there are uncertainties, and I am sure Ministers will carefully consider the responses to the consultation.

Q78 Andrea Jenkyns: We had a Health Select Committee away-day at which we considered maybe paying a salary for student nurses. Is that something the Government will consider in the future?

Simon Stevens: I cannot speak to that. That is something the Department of Health will have to respond to.

Q79 Andrea Jenkyns: You are going to attract an extra 10,000 nurses. Do you have a recruitment drive or plan to implement this?

Simon Stevens: In terms of the expanded training places or—

Andrea Jenkyns: Yes, attracting more people to make sure we fill the extra places that are needed.

Simon Stevens: Yes. The universities say that they are having to turn away high-quality applicants right now because of the artificially constrained funding numbers and the way the system is currently financed. Moving over to the new arrangements, in their view, would enable them to expand places.

Q80 Andrea Jenkyns: Finally, in their existing state, will it be physically and financially possible for NHS trusts to train the additional student nurses that the Government believe their reforms will produce? Do you think it is physically and financially possible? We know it is a mixed bag of trusts.

Simon Stevens: Yes, I think it is. In fact, a number of trusts have been contemplating setting up their own nurse training programmes, and indeed have been hugely oversubscribed when they have done that. The hospital trust covering Preston and Chorley, in Lancashire, would fall into that category. Karen Partington, the chief exec there, described some of the impressive work that they have been doing. One of the big gains we are going to get is the new modular approach to get to nurse qualification, so that there is a career ladder for people who might start as care assistants and then can build their way on the job to a nursing qualification without having to take three years out under the current circumstances. That is also a huge impediment for mature entrants to the profession, or people who economically cannot afford, for understandable reasons, to take three years out, however the arrangements are financed, which, by the way, will be a huge positive for social care and the care home sector. If care assistants see that there is a route into nursing through those kinds of jobs, it will help with recruitment and retention there as well.

Q81 Chair: Before we move off the issue of the wider workforce, can you set out what you estimate to be the vacancy rate across the NHS currently, and where the critical shortages lie at the moment?

Simon Stevens: I hesitate to pull a figure out of the air, because trusts are in the process of calibrating what they need, given what they can see as their funding and control totals for

2016-17. I think NHS Improvement will be able to provide that in due course, but I certainly would not want to pull a figure out of the air this afternoon.

Q82 Chair: It is relevant to the issue we have with agency costs across the NHS. Are you able to be more specific currently about the impact of agency costs?

Simon Stevens: Absolutely, there is a huge effort to convert what is currently agency spend into permanent nursing and other jobs; NHS Improvement has the objective of cutting agency spend from what would have been around £3.7 billion on a run-rate basis down to more like £2.5 billion this year, and the reset document describing the trust sector financial position, as well as the CCGs, that we will publish in the next week or so will have more detail on that.

Q83 Chair: Are you confident that we are moving in the right direction?

Simon Stevens: On agency and converting—

Chair: On agency cost.

Simon Stevens: Yes. NHSI say that they saw a reduction in the agency run rate in Q4 last year and going into Q1 this year.

Q84 Chair: One of the other issues we referred to in our report is the ongoing impact of pay restraint. Are you able to say more about that or about how feasible you feel it is for us to carry on with the level of pay restraint we have now?

Simon Stevens: For the circumstances facing us right now, we know what we have to do and that is the basis on which trusts are making their plans. Looking out over three or five years, there are many unknowns as to what the state of the economy and the labour market will be.

Q85 Dr Whitford: Now we come on to junior doctors. The Secretary of State plans that the junior doctor contract will go ahead. Do you believe that trusts will be willing to impose the contract if they feel that there is local resistance to it? Obviously, in foundation trusts there is not a mechanism for centrally forcing them to do it, so do you think they will go ahead?

Simon Stevens: Yes. As a prediction, yes, I think they will.

Q86 Dr Whitford: Do you think there is a danger of that resulting in more junior doctors either going to parts of the UK that are not enforcing the contract or overseas? In social media and anecdotally, there has been a lot of discussion of junior doctors leaving.

Professor Sir Bruce Keogh: It is difficult to predict how people will respond. It is clear that there is a lot of discontent, and I will come back to that in a moment.

Dr Whitford: I will come to the morale issue further on.

Professor Sir Bruce Keogh: I cannot predict whether people will or will not move. People have families, commitments and friends, and areas where they want to stay, and that is part of the mix that we need to consider when we take junior doctor discontent into account. I will go into that in some detail.

Q87 Dr Whitford: Once junior doctors have a training number, they lose that number if they move, so when they are a little bit up the ladder they tend to be fixed in an area professionally as well as for social reasons. Do you know what the application rate is at

the beginning of the training, because certainly in Scotland we have had a 27% increase in applications from foundationers?

Professor Sir Bruce Keogh: No, I have not seen those figures.

Q88 Dr Whitford: I have not seen any figures. I have seen them for Wales and for Scotland. Do either of you have figures?

Simon Stevens: HEE will have those figures and I am sure they could get them to you.

Q89 Dr Whitford: But you have not seen them so you are not aware whether there is any impact.

Simon Stevens: It is a live situation, obviously. It is only within the last several weeks that there has been an outcome for the junior doctors, and the resignation of their leader and all the rest of it. Anything you can do in Scotland to help support the national health service in England would be greatly welcomed.

Dr Whitford: We are just nicking yours.

Simon Stevens: I wasn't going to point that out, but yes, feel free to stop.

Q90 Dr Whitford: No. One of the things I welcomed was the plan that it would be brought in in a phased way, which was, to some extent, something that the shadow Health Secretary and I called for, but what audit or assessment will be done, because there is no point in bringing it in in a phased way if no one is paying any attention to issues that arise?

Simon Stevens: This might relate to some of the things that Bruce wants to talk about, because it is pretty clear, talking to lots of junior doctors around the country that, yes, there were a bunch of issues to do with uncertainty about the way the contract will work, but there are also a huge number of issues to do with the way training more generally is structured. To the extent that the NHS can make some very concrete positive moves on some of those other issues as well, it will go some way towards stabilising the situation, but Bruce has been leading some work on that.

Q91 Dr Whitford: I totally agree with that. There is a lot of work to be done, particularly in the foundation years.

Professor Sir Bruce Keogh: I would like to open these remarks by saying that NHS England—Simon, myself and others—were not party to the contract negotiations. That was a matter for NHS Employers, the BMA and the Department of Health. I would like to make remarks both about the junior doctors and about general practitioners, if I may, because I am concerned about morale in the medical profession at the moment.

Our junior doctors are the next generation of consultants, GPs, academics and, some of them, NHS leaders in whatever form that might take. They are a young generation with a different set of expectations from the older generation, but they have an equally strong, if not stronger, sense of values, and they are highly committed to improving patient care. That will have come out in some of the things that we have seen recently. That set of values and their desire for improvement have amplified their growing discontent over a number of years about some issues related to their training, particularly issues related to the way they are treated by some NHS organisations, which has led to a real perception of not being valued and not being treated appropriately. I will come back to that because I do not think that in any other industry you would take the generation between 25 and the late

30s and not use them for their creative ability, their ambition, their professionalism, their altruism and so on. The engine of the future sits in the younger generation.

Things became very complicated when the contract discussions were linked to weekend mortality, and that in turn unleashed the simmering discontent that has become manifest for everybody to see on the streets. Be that as it may, the contract has now been imposed and the issues that you raised are live ones, and the implementation of the contract will rest largely with NHS Improvement. There is still a lot to do to improve the working lives of junior doctors, in my view. I have sought the advice of my clinical fellows, and there are many of those, some even here today, and I am going to give you a little list of things that can be done. It is by no means comprehensive, but it will give an indication of the sorts of things that you will understand from your own junior staff can be done to help them.

There is concern about periods of training. Some training periods are just four months, some are six months. There is a feeling that in a four-month period you cannot become engaged in a team sufficiently well that you become trusted by nursing staff and senior medical staff to be allowed to really fly and learn as much as you could, and in particular that applies to the craft specialties. They would be very keen for Health Education England, the deans and others to relook at that. There is a balance to be struck between exposing people to different specialties with short attachments and giving them the experience that longer attachments require. There is also a view that the annual review of competence progression is not a very standardised process. In some cases it is just a tick box and tends to be binary—you are either okay or no good—without any focus on people who are doing particularly well.

There is a sense that the flexibility of training needs to increase quite significantly. By that I mean attention to mobility for out-of-area training, or even some people coming on to the national medical director's fellowship scheme who have had to give up their number to do that. The sense that the training programmes are very rigid is real, and I know it is a concern to some of the deans as well. People would like to see earlier on where their placements are, particularly the more senior juniors; the term "junior" does not really reflect the spectrum of young doctors, who are highly professional. Many of them have families. They do not know where they are going to end up as part of their training. They may be spread six months here and six months there in very different geographical areas, and they would like the opportunity to resolve that so that they can put down roots, educate their kids and have a greater view of the future. They would also like to see their rotas sooner. Some organisations are absolutely shocking: trainee doctors do not get their rotas until a few days in advance, and when you have family commitments and other things that makes life unnecessarily tricky. It is quite discourteous in many ways.

Q92 Dr Whitford: There are obviously opportunities. We are not—because you are going to have to leave at some point—going to be able to go through all of those, but we have a flavour of them.

Professor Sir Bruce Keogh: No, but I am going to go through some more of them.

Q93 Dr Whitford: Okay, you will have to stay until we are finished.

Professor Sir Bruce Keogh: This is really important for the junior doctors and I would like it to be a matter of public record, if you will forgive me.

Dr Whitford: Sure.

Professor Sir Bruce Keogh: They would like to see long-term training supervisors or mentors, because if you move around a lot you lose consistency in your contact with consultants. They would like to see streamlined induction and mandatory training, because they quite often have to repeat the same stuff; if you leave a hospital for six months and come back, you go through the same things again. They would value some support for transitional periods, when they go from different periods of responsibility—moving from one grade to another. Also, they want improved facilities on site. Some junior doctors are working where there is not even decent access to food at night.

Q94 Dr Whitford: Is there going to be a mechanism to take these things forward? They chime with me as things that I have heard from junior doctors I work with, but also throughout the conflict. What is the programme going to be to capture and deal with some of these points?

Professor Sir Bruce Keogh: There are different parties involved. The deans and Health Education England are already working on much of this. They have a role to play. NHS Improvement has a role to play in helping organisations recognise some of the issues, and NHS Employers also have a role. Many of the issues that are raised are just common sense; they are about decency, about the way that decent organisations would treat their staff. The other opportunity we miss with our junior doctors is that, when they move from hospital to hospital or organisation to organisation, they see where the good practices are and where the safety issues lurk and so forth, so they are potentially our most powerful agents for change in the national health service, and I do not think we have harvested that. I would like to see the organisations that I have mentioned come together quickly and transparently to address some of these issues with a clear set of timelines that will give junior doctors confidence that their issues are being addressed.

Q95 Dr Whitford: Okay. There are two big things that I heard from junior doctors. One was around the claim about the weekend effect, and that 11,000 people a year were being allowed to die because they were not working properly. Those of us who are in the business know that junior doctors are there 24/7. As you were closely involved with the Freemantle papers and used the phrase yourself that it would be rash and misleading to claim those deaths were avoidable, did you not feel that you could have advised the Secretary of State in how those figures were used? Because junior doctors, as you say, are of different ages and are used to evidence-based medicine, and they read papers, that clash caused a big loss of respect. Do you not think you could have had more influence in the way that developed?

Professor Sir Bruce Keogh: The first thing is that I was responsible for putting into the paper the "rash and misleading". You will also recall that about a year ago, in July last year, I warned this Committee that we needed to be very careful about what those figures meant; I think I used the phrase "before they were misused". In many respects, those figures gained credence at a time when I was actually in Cyprus, so it was not easy to intervene, and by then, if you like, the horse had bolted. The figures were misused by everybody on every side and, frankly, it is not worth focusing on that now. The issues of improving services at the weekend I think are agreed by all parties. The issue of 6,000, 11,000, or whatever number it is, is a kind of side show. We must not forget that—

Q96 Dr Whitford: But it has led us down a year of real conflict, in that targeting it on having perhaps better consultant support and access to diagnostics—the thing that would result in a better service—would have meant the energy would have moved us a lot further forward, rather than having junior doctors on the streets.

Simon Stevens: That is where we are. That is what we are doing. That is the leadership that we have given to the system under Bruce's direction. Your report, out today, is very clear on that point. You explicitly quote on page 47 the four clinical standards from the Academy of Medical Royal Colleges that are most likely to have an impact on the quality of urgent and emergency care in in-patient wards on a weekend, and that is what we are all mobilising behind.

Q97 Dr Whitford: I welcome that, but we could have done with it a year ago. We have had a year of absolute conflict. The other thing I heard from junior doctors is their concern about rota gaps, particularly the idea of them being stretched further when a lot of them, when they are on duty, can be carrying more than one pager already, which is clearly a patient safety issue. I have read feedback from the HiSLAC group of hospitals describing that 52% of A&E units face gaps in their consultant rotas in 71% of acute medical units and 30% of intensive care units. We have gaps right up at the consultant level and we know we have gaps right through the junior doctor level. How do we deal with that? We are trying not to use agency, but it is a clear and present danger to patients if there should be six doctors on and there are only four.

Simon Stevens: Yes. Part of this is going to stimulate some of the service redesign questions that are going on around the country right now—how you make these clinical models work well. We were talking with folks running Scarborough hospital, and likewise a couple of the smaller hospitals in the south-west within the last fortnight. These are driving the conversations about the new model of staffing. Without disputing anything you have just said, there is a slight paradox, given the fact that there still are 3,500 more whole-time equivalent consultants working in the English NHS than there were three years ago, so we are at an all-time high for the number of consultants. We have to be very thoughtful about the way in which acute medicine develops. We have probably discussed that in the past.

Q98 Dr Whitford: It is the fact that demand is climbing even faster than the service—

Simon Stevens: It is partly that and also partly the fact that one always wants to build the specialty and build the service, so I doubt there will ever be a time in the NHS when people could not see the benefit of having some more colleagues, but when it comes to hospital consultants we have had a very substantial increase.

Q99 Dr Whitford: But rota gaps are not about looking for extra. Rota gaps are when people who are meant to be there are missing.

Simon Stevens: As a matter of fact, we have 19% more whole-time equivalent consultants than we had back in 2009.

Q100 Dr Whitford: Are those filled posts?

Simon Stevens: Yes, these are people working, a massive expansion and—

Dr Whitford: What about at the junior—

Simon Stevens: It is in complete contrast with what has happened to GPs, which was my point this morning as well, which is that we have to rebalance where some of our investment in an expanded medical workforce is going.

Q101 Dr Whitford: Why do you think HiSLAC, and obviously the junior doctors at their level, report such a high level of rota gaps, if we have so many more people?

Simon Stevens: The junior doctors' situation is different from the consultants. These are the figures published by HSCIC showing the filled number of whole-time equivalent posts. Would we like more in many places? Sure, we would, but, if we are not going to get more, we need to think about the best way of designing services given the number of clinical staff we have.

Q102 Dr Whitford: Do you have data on the unfilled consultant posts, if you have data on the filled ones?

Simon Stevens: This is the HSCIC publication on hospital and community health service staff—the vacancy figures. Yes, vacancy figures are published, but they are squidgier.

Q103 Chair: They are what?

Simon Stevens: Squidgier—it is a technical workforce planning term.

Q104 Dr Whitford: Meaning what—that they are totally flexible?

Simon Stevens: Yes, to some degree they are.

Q105 Dr Whitford: Do you have data from them on the rota gaps among the junior doctors?

Simon Stevens: No, I do not.

Q106 Dr Whitford: This was something that came up in the issue about safety—the idea, when they can barely cover seven-day emergency and five-day elective, of that service being expanded, when they are running around being asked to do extra shifts, being asked to carry someone else's patients.

Simon Stevens: Yes, but this is the point, in a sense, that Jim Mackey has been making in the course of the last week. We have an expanded number of staff and we have a budget, and we are going to have to work out the optimal way of running high-quality services within those constraints. If it means that we have to change some services to do that, we are going to have to change some services.

Q107 Dr Whitford: Finally, how can both the morale and also the relationship gap between the Secretary of State or the Department of Health and the medical profession be repaired? To bring about the changes that the NHS will need going forward actually needs people being willing to work together.

Professor Sir Bruce Keogh: Before I get on to that, can I correct one misapprehension? You wondered why we did not have the four clinical standards and things in advance of the discussion.

Dr Whitford: I knew they existed. I meant we did not focus on them. We were down a different path.

Simon Stevens: They go back to 2012.

Dr Whitford: Yes. I have read them before. I just did not understand why we were not focusing on them.

Professor Sir Bruce Keogh: There are several things we can do. We are not going to solve everything at once, to be frank. With respect to primary care, we have the five year forward view, which has recently been published. We have appointed a very credible director of primary care. We have accelerated the funding, which had been negative. From about 2008—2008-09—it was 0.8%, and we increased it to 2.7% in 2014-15, 4.1% in 2015-16, and 4.4% in 2016-17. We are looking for ways of expanding primary care staffing, which means expanding the number of GPs and associated staff. We are looking at ways of reducing the bureaucratic burden for GPs. We are keen to develop the primary care estate and invest in technology, and we will be looking at ways of helping with caseload management. We are taking this very seriously in NHS England. That deals with one particular group.

Q108 Dr Whitford: I am talking particularly about the relationship between junior doctors, who are the most upset, and the Department of Health, the political side. I totally understand and admire the idea of strengthening primary care, but rather than going through the entire five year forward view, what can we do to fix the relationship?

Professor Sir Bruce Keogh: The second issue was the series of things I mentioned about junior doctors earlier. The organisations I alluded to being seen to be addressing those will go some way to restoring confidence. That is all we can do at the moment.

Q109 Dr Whitford: The plan is to take that forward fairly quickly.

Professor Sir Bruce Keogh: Yes, I would expect that.

Dr Whitford: Thank you very much.

Q110 Chair: Could I ask a follow-up question? Do you find it slightly odd that as chief executive of NHS England you are not party to the contract negotiations, and do you feel that that means you do not have sufficient levers to influence the process?

Simon Stevens: We would like to see over time NHS Employers assuming more of the leadership around workforce planning and pay negotiation; in a sense, that process was set in train in the early 2000s with the creation of NHS Employers. Had NHS Improvement been in existence for three or four years, instead of whatever it is, a year or so, you would expect that, as the regulator and overseer of hospitals and community trusts, they might take on more responsibility over time from central Government.

Q111 Chair: But as the person who has overall responsibility for the way the system works, would you like to have more of a grip on some of the levers through the system?

Simon Stevens: We are collectively making the system that we have work. I do not think—we have talked about it before—there is a huge appetite for throwing all the cards up in the air again and watching them land in some new legislated set of solutions.

Q112 Chair: No, I do not think anybody wants to see that, but do you feel that you are managing with the workarounds you have, or do you feel you need more powers to be able to change parts of the system? I am trying to give you the opportunity to say which parts of the system you do not have the levers to operate and what needs to change.

Simon Stevens: There is a shared sense of what needs to get done between all the national leadership bodies in the NHS and the Department of Health. We are aligning behind the

kind of changes that are set out in the five year forward view, and I think there is no disagreement in principle between any of the national leadership bodies about that.

Q113 Chair: One of the purposes of the Act was to take powers away from the Secretary of State and hand them to you. Do you feel we need to go further in that process—that the Secretary of State needs to step back from micromanaging it and leave it to you?

Simon Stevens: No, I think we are aligned around what needs to get done. The Government's democratic mandate to the national health service is effectively focused on delivering the things that the national health service said needed to improve in the forward view anyway, so we are collectively pursuing the same goals.

Q114 Chair: To look at it from the other way around, do you feel that NHS England should be speaking with a louder voice when it hears things that are being said by the Department of Health that perhaps you do not agree with? For example, we have heard about the use of evidence for the seven-day NHS or the funding arrangements.

Simon Stevens: Without commenting on that specifically, in general there are conversations that one has and advice that one offers in a spirit of trust privately, and there are occasions when one needs to speak publicly. You have to be able to work out the difference between the two.

Q115 Chair: But some people would argue that it is time for NHS England to take a more muscular role and to say things more robustly.

Simon Stevens: Probably we are more outspoken publicly on the big things that need to change about the national health service and our operating environment than has ever been the case in the history of the national health service. I am not generally regarded as a shrinking violet.

Q116 Paula Sherriff: I want to talk about A&E performance. It is not very good at the moment, is it?

Simon Stevens: About nine out of 10 patients in this country are seen and treated in A&E within four hours, which is not the 95% standard but is better than any other major industrialised country in the world.

Q117 Paula Sherriff: It is not quite nine out of 10, first of all, and it is very variable in different parts of the country. In March or April, one of my local hospital trusts was struggling to achieve 70%. They had some particular challenges around that time, but it is an opportune moment to say that we recognise that all the staff in our NHS, not least in our A&Es, are working incredibly hard, and often at the thin end of the wedge in A&E.

Simon Stevens: Yes, I agree with that. The figure I have is that it was 90.2%, so I would call that nine out of 10.

Q118 Paula Sherriff: The evidence we have is that during May, the most recent data we have—we are looking at the type 1 category—it was 85.4%.

Simon Stevens: Yes, but that is not the category that the 95% standard is set for.

Q119 Paula Sherriff: We might be splitting hairs.

Simon Stevens: Yes. The standard is 95% for all A&Es and the performance was 90.2% across the country.

Q120 Paula Sherriff: Okay, so we are still falling short by 5%.

Simon Stevens: Sure.

Q121 Paula Sherriff: That is considerable, and, as I said, it is variable.

Simon Stevens: It is.

Q122 Paula Sherriff: At Mid Yorkshire Hospitals Trust, for example, on occasions they have been struggling to hit 70%. When you take it down to that, if you turn the tables, so to speak, three out of every 10 patients waiting more than four hours is not fantastic, is it?

Simon Stevens: No, it is not. That is why we are doing five things to seek to improve A&E performance during the course of this year, the first of which is making sure that there is proper screening of all patients who turn up in A&E to see whether they could have been looked after by a GP or in primary care; secondly, increasing the proportion of calls going through 111 that are handled by a nurse, a paramedic or a doctor so that smart decisions are made in terms of the advice that people are given; thirdly, ensuring that ambulances are able to make clinically appropriate decisions about when the 999 call needs a vehicle to go out; fourthly, a set of changes inside every hospital to ensure that not just A&Es but all the acute medical wards that back them up are flowing smoothly in the way that they do at places like Luton hospital, with a 97% and 98% four-hour A&E performance; and, fifthly, making sure that we have better discharge processes so that when people are ready to go home, they can actually get out of hospital. That is the work that NHS Improvement will be doing with every hospital this year.

Q123 Paula Sherriff: That is all very well and good, and we applaud and support hospitals that are achieving those standards under incredibly difficult circumstances, but at the weekend I spoke to a medical professional and had a chat about how things are generally. They told me that they feel that, because of the targets they are expected to reach in terms of discharging or admitting and someone being in a bed within four hours, they have to take unnecessary risks, on occasions, when perhaps they would like to spend longer making a decision, in order to achieve those targets. We have to be very careful about concentrating on the wrong parts of the equation, so to speak. Is it not the fact that we are pushing patients into A&E potentially because of a crisis in primary care? We do not have enough staff and we have an extremely demoralised workforce, and they are the areas that we should concentrate on.

Simon Stevens: I agree with part of that, absolutely. Precisely the reason why the goal was set at 95% rather than 100% in four hours was to provide clinical flexibility at the margin. As you will remember, under the prior arrangements it was 98%, and it was reduced to 95% to give that flexibility. The underlying point you are making is the right one, which is that, if we do not get in place the right, strong GP services, community services and social care, more people will turn up in A&E, which will then place unsustainable pressure on A&Es, and they will not be able to deliver on the kinds of goals, which we would all want, frankly, for our children or family members.

Paula Sherriff: Absolutely.

Simon Stevens: We talk about four hours. Four hours is still quite a long time. There are not many other aspects of one's life when one has to wait for four hours.

Q124 Paula Sherriff: Given that, nationally, we have not achieved the 95% target for, I think, years, as opposed to months, is it worth the paper it is written on?

Simon Stevens: The approach that NHS Improvement is taking this year, including for Mid Yorkshire trust, is that, rather than saying there is a 95% standard and people are going to get fined based on missing that 95% standard, instead we are going to talk to every hospital, as they have done, and agree what would be a good rate of improvement, a feasible rate of improvement that they could practically make this year. Then their sustainability money, their share of the £1.8 billion that we talked about earlier, is linked to whether they make the improvement that has been set. The improvement goal for Mid Yorkshire trust will be different from the expectation of Luton.

Q125 Paula Sherriff: Some might suggest that we have been hearing this rhetoric for a number of years. Prior to being an MP I worked on the frontline in NHS—immediately prior to coming here. If we just look at some of the figures for England, in June 2014, we were around 92.8%, in reaching that target, pretty close to it. The following year, in June 2015, it was 92.3%, so it had slipped slightly, albeit in the same ballpark. We do not have figures for June 2016, but if we look at May it was 85%, which is a marked deterioration. So what progress is actually being made?

Simon Stevens: Of course, a far higher number of people are being treated in A&Es within four hours than was the case two or three years ago, because the number of people going to A&E is on the rise.

Q126 Paula Sherriff: Why do you think that is?

Simon Stevens: I think we know the answer to that. It is a combination of increased population, increased frailty and pressures in other parts of the system, plus the fact that the lights are always on in A&E and you know if you turn up you will be seen. That is why it is so important that, at the same time as doing this work inside A&E departments, we do the work to improve the offer for the public for urgent care services that do not rely on going to A&E. If you think about what is happening in Greater Manchester and what is happening in probably at least half of London, by this Christmas there will be seven-day-week, 12-hour-a-day access to urgent care, but without having to go to the hospital A&E department. It will be one of the hubs run by the GPs for that community. It is already breaking out in many parts of the country, and the STPs are going to put that in place just about everywhere.

Q127 Paula Sherriff: When do you anticipate, Simon, that we will achieve the 95% target—this arbitrary target that is in place? When, in your professional opinion, do you think we will achieve that?

Simon Stevens: The performance agreements that NHS Improvement has with each of the trusts, which will be published as part of the reset document, aim to get them there by the end of the year, by March, but obviously that will depend in part on the numbers of people A&Es are having to look after and the extent to which other things in the system work well. It is certainly the case, by the way, that many A&Es have to deal with many more patients than they were originally designed or built for, which is part of the reason why some infrastructure investment would be so welcome as a way of improving those services.

Q128 Paula Sherriff: I have a few more questions, if that is okay. We could argue all day about whether there is a crisis in primary care, but we would all concur that there are significant challenges at the present time.

Simon Stevens: Absolutely, completely.

Q129 Paula Sherriff: What impact do you believe those challenges in primary care are having on people physically turning up at A&E?

Simon Stevens: There is a clear connection because of the gearing. Again, as I said this morning, if you have 300 million GP visits and under 25 million A&E visits, you only need a small percentage change in GP availability for it to have a big knock-on, proportionally, in terms of what A&Es have to deal with. As it happens, the rate of increase in emergency hospital admissions has been relatively in line with expectations over the course of the last year or so, but A&E attendances, including over the last few months, have definitely been much higher.

Q130 Paula Sherriff: Anecdotally—I have statistics to corroborate this—we have seen a significant increase in patients not just waiting more than four hours in A&E, but we seem to be returning to the bad old days. In fact, I was in hospital in January at St Thomas's and the doctor treating me told me that we were going back to days he had not seen since the 1980s, with people lying on stretchers for 12 hours. During a fairly recent observation session at one of my local hospitals, I saw five patients who had come in via red-light ambulances lined up on stretchers; they were waiting because there simply was not the capacity to deal with them. Do we have the luxury of time to try to deal with these situations, which potentially are going to end up on the front page of, particularly, our red-top newspapers?

Simon Stevens: Certainly nobody wants that to happen, but in a sense, joining up the different lines of questioning that you have advanced, you are arguing that it is important that clinicians should be able to make the right choice rather than just admitting people arbitrarily. The reality is that the number of people waiting long periods, including on trolleys, is way down now on what it was five or seven years ago, but there are real pressures in the system. In some hospitals, the situation is not acceptable. The hospitals know that and are working now with the team that Pauline Philip, the leader of Luton hospital, is assembling to deal with the whole of the process flows inside the hospital, because it is not just about the A&E. The reason people end up waiting in A&E is often that there is not a bed elsewhere in the hospital, and there may not be a bed if you have wards full of people waiting to go home. We have seen this May compared with last May a 32% increase in the number of in-patient bed days for people awaiting social care services. We cannot solve the hospital problem without solving the social care problem in many parts of the country.

Q131 Paula Sherriff: Absolutely. I have two more questions. Given that staff are undoubtedly under significant and exacerbated pressure, and the challenges both with the number of patients coming through and the pressure to meet targets, do you think there is more chance, or it is more likely, that they are going to make mistakes and there are going to be errors with things like medication?

Simon Stevens: Obviously a lot of A&Es are very busy, but the standard of care in A&E departments is generally extremely high. The public scrutiny that goes alongside the CQC inspection regimes, which are not always popular, but nevertheless bring great transparency, enables us to spot where there is a problem and do something about it.

Q132 Paula Sherriff: My final question alludes to a situation that affects my local area, but I think it will be equally relevant to a number of Members' constituencies. Two main hospitals serve my constituency. One of the A&Es is currently undergoing a significant downgrade process, despite the fact that the hospital is in an area with significant diversity of population, with a lot of non-English-speaking residents. At the other hospital—

Huddersfield— they are closing the A&E. They are proposing to close the A&E despite public outcry. Dewsbury is the one that is being significantly downgraded, which would mean the whole of the Kirklees district is left without a full A&E, because the facilities at Dewsbury would be tantamount to a minor injuries clinic. Are these decisions simply being made for financial reasons to try to achieve some of the savings? I have looked at this till I am blue in the face and I cannot see rhyme nor reason, any evidence whatsoever, to support these closures or downgrades, and I have tried very hard and spoken to literally hundreds of health professionals.

Simon Stevens: I do not know the particular circumstances of your local A&E, but I am more than happy to look into it. I am sure it is one of the debates that is going on as part of the planning process in your local area. In some parts of the country anyway, it is the case that, precisely because of the pressures that you describe, there is a view that it would make more sense to create more substantial specialist teams, but I am happy to look at the particular circumstances.

Paula Sherriff: I would be really grateful if you would because I personally believe—it sounds very melodramatic—that lives will be lost as a result of these changes.

Chair: I am conscious that you have to leave us very shortly. Do members of the Committee have any final questions that they would like to ask? No. In that case, thank you both very much for coming this afternoon.

Simon Stevens: Thank you.