HOUSE OF COMMONS

Health Committee

Oral evidence: Department of Health and NHS finances, HC 693

Tuesday 18 October 2016

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Andrea Jenkyns; Maggie Throup; Helen Whately; Dr Philppa Whitford

Questions 57-178

Witnesses

I: Rt Hon Jeremy Hunt, Secretary of State for Health, Simon Stevens, Chief Executive, NHS England, Jim Mackey, Chief Executive, NHS Improvement, and David Williams, Director General of Finance and Group Operations, Department of Health.

Examination of witnesses

Rt Hon Jeremy Hunt, Simon Stevens, Jim Mackey and David Williams.

Q57 **Chair:** Good afternoon and welcome to this follow-up session on NHS finances. Could members of the panel introduce themselves to those following the debate from outside the room?

David Williams: I am David Williams, director general of finance at the Department of Health.

Jeremy Hunt: Good afternoon, Chair. I am Jeremy Hunt, the Health Secretary.

Jim Mackey: I am Jim Mackey, chief executive, NHS Improvement.

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

Q58 **Chair:** Thank you. We are going to have some detailed discussion later about the state of NHS finances and some of the accounting issues that have arisen following the NAO report, but could I start with you, Secretary of State, on the £10 billion figure? You will have heard the evidence last week and the concerns that have been set out about the seriousness of the situation facing the NHS. Do you feel that there is a problem in continuing to use that figure in that it gives a perhaps misleading impression that the NHS is awash with cash? You will have seen our report, for example, which sets out that we feel that the figure should correctly be £4.5 billion if we use the spending review period, if we use, as would normally be the case, the real-terms figures that are based on 2015-16 and if we take account of the entirety of health spending? Do you feel that there is an issue in continuing to use the £10 billion figure?

Jeremy Hunt: First, I do not believe at all that the NHS is awash with cash. There are very real financial pressures as the NHS copes with the extraordinary pressures on the frontline, particularly to do with the ageing population but for other reasons as well. The significance of that figure is simply that it relates to an increase to NHS front-line funding, as you were absolutely right to point out, and not an increase to the Department of Health budget. One way that we were able to fund the money that the NHS asked to kick-start the forward view was by making efficiency savings in the non-NHS England parts of the budget. That was the only way we were able to afford it in very constrained national circumstances. We never pretended that the number was an increase in the overall Department of Health budget, but it is what the NHS said they needed to kick-start the forward view. That is why it is significant.

Q59 **Chair:** But is it also the case that you added an extra year before the start of the spending review? In other words, the £10 billion does not refer to this spending review period.

Jeremy Hunt: To the extent that the "Five Year Forward View" became a six-year forward view, yes, the original figure was £8 billion. That was announced in 2014, and then we put in an extra £1.8 billion in the 2015-16 year. The reality, and what is important, is that it was the minimum that the NHS said they needed to get going on the forward view and that is why we felt it was very important to honour that commitment.

Q60 **Chair:** Would it be helpful if we continued to use the same baseline period—the baseline period referring to the spending review—because when we are talking in Parliament about what is being given to the NHS, the impression is sometimes given to other colleagues in the Government or colleagues in Parliament that this refers to the spending review period? Could you confirm that the £10 billion does not refer to the spending review period?

Jeremy Hunt: It refers to the spending review period and the year before the spending review period started.

Chair: In other words, it includes an extra year.

Jeremy Hunt: Correct.

Chair: And there are adjustments made in how you calculate real terms.

Jeremy Hunt: The £10 billion is a real-terms figure, and the numbers were the real-terms numbers based on what NHS England said they needed to get going with the forward view.

Q61 **Chair:** Indeed, but coming back to the £10 billion, it is calculated from 2021 prices rather than 2015-16 prices, which is not the usual way that these things are adjusted for.

Jeremy Hunt: Whichever way you calculate it, the crystal test for me, as Health Secretary, when I was negotiating the spending review with the former Chancellor this time last year, was that I was not prepared to settle for anything less than what the NHS said they needed to get going on the forward view.

Q62 **Chair:** I accept that, Secretary of State, but the effect of that is to add an extra half a billion, which is a huge amount of money. It is the way the calculations are made differently in terms of what is the real-terms increase. The other point, of course, is, as you acknowledged, that there are shifts from other budgets. You referred to front-line services, but a lot of those shifts have an impact on front-line services: for example, public health and Health Education England. My question to you originally was whether you think there is a danger in continuing to use the £10 billion figure, because it can give a misleading impression that this amount of cash is being handed to the NHS over this spending review period.

Jeremy Hunt: This amount of cash is being handed to the NHS over the six years that include the very first year of the Parliament and then the four years of the spending review, so it is being handed to the NHS. It is also important, as I would always make clear, that it is not an increase in

the overall Department of Health budget and that the way we have been able to fund it is partly through very challenging and difficult efficiencies that we made in the non-mandate part of the Department of Health budget.

Q63 **Chair:** A lot of people feel very strongly that the £10 billion figure should not be used. I will put that to you now and move on to another bit of questioning.

When you heard the evidence presented to us last week, did you recognise the picture that NHS Providers and NHS Commissioners painted of the situation in the NHS and some of the rationing? I will quote from their letter to this Committee: "Either the service receives more funding than is currently planned or we need immediate choices, however undesirable they may be, on whether to reduce the priorities the NHS is trying to deliver, ration access to care, relax performance targets, close or reconfigure services, extend charges or co-payments, or reduce the size of the workforce." Particularly in terms of rationing—this is my question to you—there have been numerous examples of rationing proposed. I wonder whether you support some of those proposals.

Jeremy Hunt: The first thing is that I fully understand the pressures that people on the frontline are experiencing now. It is a simple fact, but worth reminding everyone, that we are looking after a million more over-75s than we were five years ago and in five years' time we will be looking after another million over-75s in England. That creates massive pressure for people on the NHS frontline, so I completely understand that people working in hospitals recognise that they have never been busier; for people working in GP surgeries and in the social care sector, it is the same. Indeed, there are painful and difficult efficiency savings. The extra £8 billion that the NHS said was the minimum they needed in the forward view coupled with it a need for £22 billion of efficiency savings, and making savings on that scale is never easy.

I do not accept that in order to make those efficiency savings you have to make changes that will impact negatively on patient care. There is an easy way to make savings, which is to reduce the availability of care for patients, and there is the harder way, but the right way is to find ways that improve care and efficiency at the same time. Examples, of which you will be very well aware, Chair, are things like, if you get an infection when you are having a hip replaced, it will cost the NHS £100,000 to sort out as well as being incredibly painful and horrible for the patient concerned. There are ways that we can improve clinical practice. There are ways that we can catch cancers earlier. We know that it can be two to three times cheaper to catch a cancer at stage 1 rather than at stages 3 and 4. There are lots of things we can do, but I do not accept that in order to make efficiency savings we need to reduce the quality of care for patients. In fact, I want to carry on increasing the quality of care for patients.

Q64 **Chair:** But you will be aware that there are a number of examples where

care is being rationed—access to care—be that for fertility treatment or orthopaedic surgery. You will have seen examples of cost-shunting around the system; for example, in the west country, vitreoretinal surgery and out of hours are being shifted to other sectors. This is happening on a widespread scale. Do you think it is right that this kind of decision making should be taken at local level or should there be more central guidance so that we continue to have an equitable system, because you will know that it is becoming increasingly fragmented?

Jeremy Hunt: We have learned over decades in the NHS that when we try to centralise these kinds of difficult processes it has unintended consequences, and I think it is much better if the strategies going forward, which you may ask Simon Stevens about shortly, are decided at local level. Then they have local buy-in, with the passion and commitment of people who know what is happening on the ground, to make them work. When we hear of occasions when we think the wrong choices have been made, when an efficiency saving is proposed that we think would negatively impact on patient care, we step in, because, challenging though it is, our responsibility to the public is to make sure that we continue to make the NHS safer and higher quality and that it offers a higher standard of care, and we absolutely believe that is possible.

Q65 **Chair:** When you hear examples of fertility treatment having different criteria around the country, would you step in and say that there should be a standard service available, or would you say that is an example of where people locally should be able to decide their priorities?

Jeremy Hunt: When we hear about standards of care that are not meeting clinically agreed standards, we step in.

Q66 **Chair:** Simon Stevens, would you go a bit further on some of the points that you made to the PAC recently about your five tests for the NHS and the two additional conditions around capital and transformation funding? We heard from the Secretary of State about the NHS being given everything it asked for. Could you tell us whether you feel the NHS has been given everything it asked for?

Simon Stevens: I heard the Secretary of State say something slightly different, but the points I made to the PAC partly reprised the points that I discussed with this Committee, in the recap briefing that we provided for you a few months back to remind everybody of the basis of the forward view modelling and the criteria that we used to think about the SR settlement a year ago. They were essentially that the original modelling suggested, as you know, Chair, an NHS funding requirement in five years' time of between £8 billion and £21 billion, depending on the level of efficiency that could be produced; the continuing availability of social care relative to rising need; the availability of capital investment to lubricate new service models, particularly investments in GP services and out-of-hospital care; and the availability of preventive services through

local authorities, and the role the NHS itself has to play. That was the original modelling, as we laid out for the Committee.

For the Public Accounts Committee I was asked specifically about the five-year profile that the spending review produced, and I repeat what I said to the Public Accounts Committee, which is that for this year, year 1, of the spending review, we did indeed get the kick-start to the funding that we, broadly speaking, were looking for, which we needed because we had to absorb nearly £1 billion of extra pension costs, as well as the pressures in the provider sector coming out of last year. With the kick-start settlement this year, we will be able to cut the hospital deficit by more than two thirds; we are going to bring some stability back to many parts of the service that are under pressure; and we are going to be able to make some modest starts to the improvements that we know are needed in mental health services, and cancer and primary care services. That is year 1.

Turning to year 5, within the range of £8 billion to £21 billion—we got within that range, albeit it at the lower end—the extent to which that can work depends on other things, the other criteria, working with us over that period. For years 1 and 5, yes, you could say that we were kind of in the zone, but for the next three years we did not get the funding that the NHS had requested. This is not a controversial statement. It is what I have already said to the Public Accounts Committee, so it is not a new statement. As a result, we have a bigger hill to climb. It is going to be a more challenging 2017, 18 and 2019-20.

Q67 **Chair:** In the past, you have talked about per-person funding in the NHS. Could you set out what that means, say, for next year and the year after, the three years when things are going to be particularly challenging?

Simon Stevens: Yes. Given that we have an ageing and growing population, if you just look at the population growth, even before you take account of ageing, 2018-19 will be the most pressurised year for us, when we will have negative per-person NHS funding growth in England, but for the other years we will have very modest increases.

Q68 **Chair:** That is the year you are particularly concerned about.

Simon Stevens: That is the maths.

Q69 **Chair:** Could you also set out for the Committee the additional costs that have been added to what you are expected to provide since you made the original asks in the "Five Year Forward View"?

Simon Stevens: I am not sure that is quite the right way of looking at it, because in the context of the subsequent spending review there was a discussion and negotiation about what those asks were and how one could cut the cloth according to the funding that at that point the Government were able to make available. It is no secret that there are extra pressures in the social care system that potentially have an impact on the NHS. There are some additional pension costs that are as yet

unknown for the national health service, but which in theory could crystallise for us at the back end of the period. On other issues, we have been able to set out our stall on mental health and cancer improvement and the GP forward view since the spending review, in full knowledge of the spending review, so we have sought to calibrate the speed at which we can make progress with the availability of the extra funds.

Chair: Helen, you had a follow-up point.

Q70 **Helen Whately:** I have one follow-up to a slightly earlier line of questioning. There is definitely a very negative picture coming through in the media about the condition of the NHS and its finances. From my visits on the ground, in my area in Kent, I see a more mixed picture: areas of, yes, great financial pressure but also things that are working well. What is your view overall of the picture of the state of the NHS and how accurate is the narrative of crisis, or could there be a different way of setting out what is really going on?

Simon Stevens: As you say, it is a mixed picture across the country. However, for any of the serious conditions that the NHS treats I would not choose, for me or my family, to have been treated three years, five years or 10 years ago; I would rather be treated now. That is certainly true for cancer services, heart disease and stroke services. On any of the measures for which we have outcomes data, outcomes are better. That does not mean that there are not pressures on the parts of the system that we traditionally measure and focus on, whether it be waiting times for routine surgery or A&Es, but in the round, on the big killers and disablers in this country, care is better now than it was five years ago.

Q71 **Mr Bradshaw:** Secretary of State, you said or implied a moment ago that you did not approve of rationing, but it is already happening, so what is your message to commissioners around the country who are already rationing services?

Jeremy Hunt: When we hear evidence of rationing happening, we do something about it. It is very challenging on the frontline now for everyone, but we are very clear that the principle of the NHS is a service that is free at the point of use, and we are absolutely determined to give people the clinical care that they need.

Q72 **Mr Bradshaw:** But you heard from the Chair a moment or two ago that the providers—all of those involved professionally in healthcare—have given us in their evidence the warning that if there is not to be any extra money, and we understand from your meeting with the Prime Minister last week that there is to be no extra money for the NHS, there has to be more rationing. There has to be more rationing, or fewer priorities or services and staff will be cut. Which is it as far as you are concerned?

Jeremy Hunt: We have to have a structured and planned way to find efficiency savings in a way that improves care for patients rather than making it worse. The NHS is a huge organisation, as you know—the fifth largest organisation in the world—and there are variations in the quality

of service delivery in different parts of the country. What we try to do from the centre is to send out a very strong signal that what we are looking for are not the easy efficiencies that can reduce the quality of care or access to services or treatments, but the efficiencies, of which there are many, that improve care. If you look at best practice from around the NHS, you see that the two go together.

I will give you one example: the hospitals with the best CQC ratings are the hospitals with the lowest deficits, not the ones with the highest deficits. Good management tends to mean better care for patients allied with better management of resources. I do not want to pretend that is an easy process, but that is the message that we focus very hard on sending out from the centre.

Q73 **Mr Bradshaw:** When NHS professionals tell us and you that the potential for efficiency savings to close the kind of financial black hole we are talking about is pretty negligible, do you not agree with that?

Jeremy Hunt: They do not tell us that the potential for efficiency savings is negligible.

Q74 **Mr Bradshaw:** In terms of the size of the financial challenge.

Jeremy Hunt: Yes. They do not say that the potential is negligible. They say it is going to be very challenging, and I agree with them that it is going to be very challenging, but when you were in government, the previous Labour Government asked David Nicholson to go through the same or a similar process and he came up with the Nicholson challenge, which was to save £20 billion. Over that period, we think we delivered most of that. We may not have quite got to £20 billion, but, from memory, we got well above £15 billion. It was possible to make significant savings and we now have to embark on the same process a second time around. Of course, it is more challenging the second time around because you have taken some of the low-hanging fruit, but it is a process we are absolutely committed to doing.

Q75 **Mr Bradshaw:** When we were in government we sustained increases in NHS funding; it was not in the biggest financial crisis it has ever faced.

Jeremy Hunt: You left us with that financial crisis.

Q76 **Mr Bradshaw:** You said a moment or two ago that you thought the £10 billion you claim to have found for the NHS was the minimum in order for Mr Stevens to be able to deliver his "Five Year Forward View". You have already heard from our Chair that it is not £10 billion. The Committee found that it is closer to £4.5 billion. You accept, do you, that funding to social care has been cut and funding to public health is set to be cut significantly over the course of this Parliament?

Jeremy Hunt: First, what we delivered for the NHS was, after exhaustive discussions both with NHS England and with the Treasury, what the NHS said they needed to get going to kick-start the forward view, and whether

you call it £4.5 billion or £10 billion does not matter; it is what the NHS said they needed and it was extra money going to the NHS frontline. We have always been completely clear that, as we talked about earlier, some of the way we funded that was by making savings to the Department of Health's central budget. I wish we did not have to do that, but in the constrained financial circumstances that we are in, it was the only way to fund the NHS's plan. You asked about social care and public health. It was not possible to protect the social care budget either in the last Parliament or in this Parliament, and that has created particular challenges in social care which we are working very hard with the social care system to address. We have also looked for some efficiency savings in the public health budget.

Improving our record on public health in this country, which is a very good record—a couple of weeks ago the United Nations said this was the fifth healthiest country in the world to live in, behind Iceland, Andorra, Singapore and Sweden—and maintaining that record is also about changing public behaviour, and it is about legislation and changes to the fiscal system. The sugary drinks tax was introduced in the last year and regulations on standardising packaging for cigarettes, all of which have a very big influence but are not about the public health budget per se.

Q77 **Mr Bradshaw:** But you accept, do you not, that protecting the public health budget and the social care budget were two preconditions of Mr Stevens's five year forward plan?

Jeremy Hunt: What he said—you have the opportunity to ask him as he is here—was that we needed to protect social care provision and public health provision. We are trying very hard to make sure that we do that as we go forward, because we fully recognise the fact that the NHS and the social care systems do not operate in silos, and when there are problems in one system they have a direct effect on the other. That is why the integration of the health and social care systems is so important.

Q78 **Mr Bradshaw:** I intend to ask him right now, but before I do, can you confirm that the Prime Minister told you when you met her last week that there would be no more money for the NHS?

Jeremy Hunt: First, the meeting was not last week.

Mr Bradshaw: Or in the last few days.

Jeremy Hunt: Secondly, it was a private meeting.

Q79 **Mr Bradshaw:** What about social care? Is there any hope for social care?

Jeremy Hunt: As you well know, Mr Bradshaw, from your time in government, discussions between Cabinet Ministers, the Treasury and No. 10 about the future contents of Budgets and autumn statements are confidential matters.

Q80 **Mr Bradshaw:** We have an autumn statement coming up. Are you

fighting for your Department? Are you fighting for the NHS?

Jeremy Hunt: All I will say is that I stand by my record as Health Secretary in fighting for budgets for the NHS in both the autumn statement of 2014, when I secured an extra £1.8 billion for the NHS, and in the spending review last year when I secured a bigger increase for the NHS than any other Government Department.

Q81 **Mr Bradshaw:** Mr Stevens, it is the case, is it not, that at least two of your five conditions have not been met?

Simon Stevens: They are certainly under pressure.

Q82 **Mr Bradshaw:** Does it ever occur to you that you are being set up as a fall guy?

Simon Stevens: No, because—

Q83 **Mr Bradshaw:** What would it take for you to walk?

Simon Stevens: I am perfectly explicit about the circumstances we are facing. There is a shared understanding of what that looks like and it is perfectly reasonable under those circumstances, having been clear about the situation we face, to seek nevertheless to ensure that the NHS provides the best care it can across the country, and that is what we are all doing.

Q84 **Mr Bradshaw:** But you took this job on, as a long-time NHS professional, at a time of maximum fiscal restraint on the NHS and maximum demand. You made a deal with the Government to go through with the five-year plan based on certain conditions being met. They have not been met. What is your response? Are you just going to carry on and hope that something better turns up?

Simon Stevens: The NHS is going to carry on. The NHS needs to continue looking after the people of this country, and that is what I think all of us want to see. I will certainly be putting my continuing efforts into doing that.

Chair: I am going to come on to some questions about demand.

Q85 **Maggie Throup:** I would like to kick off with a question to you specifically, Simon. Can you describe how you see managing the changing demand in the NHS being different from managing changes in other Departments such as Defence?

Simon Stevens: Right. Your point is to what extent are efficiencies that are being produced in the defence sector, or other Government Departments, analogous with the NHS. I certainly think the NHS can learn from reforms in all public services, particularly in the defence sector, where there have been some important improvements in defence procurement. We have a big procurement efficiency programme under way in the NHS too. There are also some important differences between what we and the defence sector are doing. I think the regular troop

strength went down by about 20% over the course of the last five years: nobody, I think, is proposing that we should reduce the numbers of our nurses, doctors or therapists by 20% as an efficiency. That is clearly not what we are going to do. Likewise, the defence budget is linked to a share of GDP; for some pretty good reasons, the NHS budget is not, but were there to be the equivalent for the NHS of the 2% GDP guarantee, our NHS funding would be higher in five years' time than it is currently projected to be. There are some important differences from the defence sector.

Q86 **Chair:** The question was more in terms of demand, because the point is sometimes made that the Home Office, the Treasury and all sorts of other Departments have made efficiencies. Is there a way in which demand in the health service is different from increases in demand in perhaps the Home Office and defence sectors?

Simon Stevens: Clearly. If you look at crime, it is down by about 30% over the last five years, which is a fantastic thing, whereas the demand for hospital specialist consultations is up by 20% over the same period. The number of people getting an urgent cancer referral is up by 55%, so we are facing completely different demand dynamics in the national health service, and indeed in any country's healthcare system, from those in any country's criminal justice system.

Q87 **Maggie Throup:** Is demand growing faster than was assumed in your "Five Year Forward View"?

Simon Stevens: Demand last year was a bit less, demand in the first five months of this year is a bit higher, and it is geographically pretty varied. There are some places where the number of people going to an A&E department is spiking quite substantially and other areas where it is less so. In aggregate, for the first five months of this year, cost-weighted activity—the jargon for trying to assemble all the different parts of what the acute part of the health service does—is up by, in the zone of, 3%. The default assumption in the forward view was 2.8%, but that disguises a lot of individual variation between different hospitals and geographies. I suppose we should not be particularly surprised about that, because at the start of the five years we pragmatically and, I think, defensibly put more of the extra resource available to us into stabilising hospital finances than into building community and primary services. The consequence is that if you want demand offsets you have to actually do something in terms of alternative services, but that is a process that will be slightly slower to get going because of the pressures we have met through the £1.8 billion sustainability fund to support hospitals.

Q88 **Maggie Throup:** It is great saying that you anticipated a 2.8% increase and it is only 3%—there is still that gap—but some cost centres, such as A&E, are more costly, a much higher percentage, so it is not just about a percentage increase; it is about absolute figures as well. Do you want to comment on that?

Simon Stevens: Yes. A&E attendances for the first five months of the year are up, in the 3.6% to 3.9% zone overall, but in some individual hospitals it may be 10% or 15% and that is putting real pressure there. The underlying point is that most of the increase in A&E attendances are people who choose themselves to go there. It is not that they are being referred there. That illustrates the fact there is an opportunity to redesign the way the NHS's urgent care services work and strengthen the availability of GP services, integrate 111 with the GP out-of-hours services, and deal with all the confusion that exists around walk-in centres, minor injuries clinics and urgent care and all the rest of it. We can see that in parts of the country that are getting going on that agenda that patients are more likely to get the care they need in the right place at the right time, rather than having to wait in A&E.

Q89 **Maggie Throup:** Was the anticipation of Government policies, such as improving mental health care and the cancer strategy, taken into consideration in the "Five Year Forward View"?

Simon Stevens: The sequencing was, as you remember, autumn 2014, the "Five Year Forward View"; nearly a year ago, the spending review; and then, subsequent to the spending review, the national blueprints for improving mental health, cancer and GP services. We were able to look at the funding available when we set out those blueprints.

Q90 **Maggie Throup:** You have already talked about trying to encourage more people to access A&E for the right reasons, and co-ordinating 111 and various other systems. Are the Government's efforts to address demand for NHS services sufficient? Are they moving fast enough? You say it is happening in some areas but not in every area.

Simon Stevens: Over the next several years, we want to try to pivot from having to use the extra resources that are going in just to sustain the current pattern of services, however they happen to have arisen over time in different parts of the country, to a more deliberate redesign of services that helps us ensure that we get people able to use non-hospital alternatives where that makes sense. One thing we have to do to get that right is to support and strengthen GP services. We have talked previously about the fact that over a 10-year plus period GP services have lost out relative to other parts of the NHS. Given that more than 300 million patient visits a year are to GP services, compared with 22 million or 23 million to A&E services, you can see that only a slight erosion in the availability of GP services has a very big knock-on consequence for A&Es. It is also remarkable that we are spending about as much on hospital outpatient departments as we are on GP services. The opportunity to bring together the specialist consultations and advisory services that happen in outpatient departments with the teams working in primary care is part of the service redesign that the forward view is intended to stimulate.

Q91 **Maggie Throup:** It is also about demand, isn't it? Do you think the Government are doing enough to cope with that demand?

Simon Stevens: I am not sure it is the Government per se. Demand arises as a result, as you perhaps imply, of the ageing population, a growing population, and the fact that we can continually do more and better. There are some things around the broader public health environment—we have talked about social care—that obviously have an impact, but fundamentally it is the fact that we have a growing and ageing population and the availability of new treatments that, down history, has driven demand not just in this country but in other industrialised countries too. There is a very good piece of analysis by the Office for Budget Responsibility looking forward to what the likely continuing trends will be in the national health service. That sets the kind of medium-term outlook for what we as a country, we as citizens, should rightly expect of our health services.

Q92 **Maggie Throup:** Last week, we heard evidence from Stephen Dorrell. Do you recognise the effects on the NHS of cuts to other public services that Stephen Dorrell talked about? If you cut in one area, there is a knock-on effect on other areas.

Simon Stevens: Yes. The underlying point that Stephen was making is that there are lots of points of connection between what is happening in schools and education and the child and adult mental health services, and for frail, older people it is the availability of support at home, be it from family and carers, the social care services or the NHS community health services. That is why we are trying to ensure that across the country people take a place-based view of all the things they need to get right in order to improve the availability and the quality of care. I was pleased to see Stephen so passionate in his support for that approach, which is now being embarked upon.

Q93 **Maggie Throup:** How are you pursuing that whole of public service approach?

Simon Stevens: In some parts of the country, such as Greater Manchester, there is a very advanced version of what that looks like, with shared local government and NHS leadership and pooling of budgets, both at borough and, potentially, at Greater Manchester level. We have seen that in some other geographies as well, but even for those that are not doing it we have been seeking to ensure that people, as well as dealing with all the here and now issues, have their eyes to the horizon and look at what are the bigger changes needed in health and social care and the wider public service over the next five years in a structured way. That process is happening across the country right now,

Chair: Ben, do you want to come in with your points about social care?

Q94 **Mr Bradshaw:** Of course. Everybody seems to agree, from Simon Stevens to the Care Quality Commission—whose report last week, Secretary of State, described the health and social care system as at a tipping point—that were there to be any extra money found by the Chancellor in the autumn statement he should prioritise it to social care.

Do you agree with that?

Jeremy Hunt: As we discussed earlier, I am not going to make any comments about the contents of the autumn statement, but I accept the broad point that the financial pressures, high though they seem in the NHS, are even more acute in the social care system.

Q95 **Mr Bradshaw:** Does the Department conduct any research as to the actual impact of the crisis in the social care system on the NHS in terms of extra cost, and what a particular amount of extra money to social care would mean in terms of easing the pressure on the NHS?

Jeremy Hunt: We see the impact of pressures in the social care system in the A&E performance figures that we collect every month, so we are aware of those pressures. We are also aware that it is profoundly illogical to look at the health system and the social care system as separate entities, because they are very closely related. The most successful parts of the country, in terms of the quality of care they provide, are the ones that have close working relationships between the health and the social care system.

It is important to say that the Care Quality Commission report that you talked about is very significant for two reasons. First, it is the first time, now that they have completed the vast majority of their inspections under this new report, that we have an independent view of the quality of provision. Although it makes sobering reading, for example, to see that 56% of hospitals are offering good or outstanding care, which means that 44% are not, I am the only Health Secretary anywhere in the world who knows that about the hospitals for which he is responsible. That is important. In the case of social care, their assessment was that 72% of the services provided are good or outstanding. On GP provision, it was 87%.

Our starting point has to be that we need to improve the number of people getting good or outstanding care, but it is also a check for people like you, who scrutinise the performance of the Government in managing the health and social care system, because you can see what happens to those numbers as the Parliament progresses, as a way of understanding whether standards are getting higher or not.

Q96 **Mr Bradshaw:** Do you also accept, therefore, that delivering some of the service transformations, which we will talk about in a bit more detail later, that should deliver better services and save money, such as the one that is being debated as we speak in Westminster Hall on proposals to close some of our community hospitals in Devon, and to close scores of beds but to put that money into better care at home, will only work if there is the care at home and if the funding is there to go into social care?

Jeremy Hunt: You certainly need to replace any reduction in provision in hospital beds with community alternatives, yes.

Q97 **Chair:** Can we touch a bit more on some of the new promises that are being made for the health service? At the party conference, you made a welcome announcement about the uplift in medical student numbers, but could you say a little more about where the funding for that is going to come from, given that Health Education England's budgets have been cut?

Jeremy Hunt: Yes. This is a very significant announcement for people who recognise, as I do, that over the coming decades we are going to need to put increasing amounts of resources into the NHS and social care system, because we know that if you do not plan for that well in advance, and you do not have the extra doctor, nurse and midwife capacity in the system, the taxpayers' money you spend does not end up being used as well as it might and having the maximum benefit for patients. It is a very important long-term announcement, but of course we are training an extra 11,000 doctors in this Parliament compared with the last Parliament, so it comes on top of commitments for this Parliament as well. I am sorry—

Q98 **Chair:** My question was about funding. No one doubts the need to address the workforce across the NHS, and indeed social care. My question was that there is a very significant cost attached to the number of doctors that you are proposing to train at a time when Health Education England budgets are being cut, and of course there are implications for the NHS as well in terms of the time and the placements and so forth. Where are those placements and where are the staff to carry out the training? Have you set a cost to that and where will it come from?

Jeremy Hunt: That is an important question to ask. The answer is that we think that in this spending review period, between now and the end of the Parliament, the cost will be less than £100 million for that commitment, because when you are training up to 1,500 more medical students the costs to Health Education England and to the NHS come towards the end of the period of training, when they are doing their placements in hospitals. So we think it is possible to absorb it within the £116 billion annual budget, which of course will be going up as well between now and the end of the Parliament.

Chair: You do not think there will be a significant cost within this spending review period. Ben has a follow-up point.

Q99 **Mr Bradshaw:** NHS Employers recently said that they are very worried about the Government's plan to charge bursaries for student nurses and the potential impact that might have on nursing numbers. They say that the idea should be piloted or phased. Is that a proposal you would be prepared to consider?

Jeremy Hunt: We need to proceed with the plan but with our eyes open. I recognise that people going into nursing are different from people doing other types of higher education; a lot of people go into nursing as mature

students, for example. Part of that recognition lies in the fact that, even after these changes, nursing will still be basically the only degree that we do not charge tuition fees for, so there is recognition of the special nature of nursing. We are not removing financial support for people who do nursing degrees. We are replacing the bursary scheme with a loan scheme, which will give people access to more cash than they would have got under the bursary scheme. Like the other student loan schemes, if they are unable to repay it after a certain period of time, the loan is waived. Why are we doing this? Because we want to fund, we believe, probably an extra 10,000 nurse training places as a result of the changes, which will come on top of the 40,000 additional nurses we are training during the course of this Parliament.

Q100 **Mr Bradshaw:** If you will not pilot or phase it, do you at least have contingency plans to monitor applications, when they begin shortly, with a view to doing something pretty drastic if they fall off a cliff?

Jeremy Hunt: We continually monitor the rate of applications and, as you know, currently we turn away two in three of the people who want to do a nursing degree. There is huge demand in excess of the supply, but my own view is that, if we are planning a sustainable NHS and social care system for the future, we need to train more doctors and nurses. That has to be a priority, so I think this is the right step to take.

Q101 **Chair:** Do you feel confident that at the end of the training period the funds will be there to employ the increased number of staff you are putting in place?

Jeremy Hunt: Yes.

Q102 **Dr Whitford:** In your speech at conference, you suggested that it cost £200,000 to train a doctor and that they would have to pay that back if they did not do the four years. Does that not add up to £300 million to train those extra doctors? If there will not actually be any extra cash, and if it is £300 million every year, is that not going to add pressure on Health Education England that it does not have now?

Jeremy Hunt: Yes, there will be an annual pressure on Health Education England when we get up to our run rate of the extra doctors that we are training. It will kick in in the middle of the next Parliament, not during this spending review. The alternative is not that we do not spend that £300 million but that we end up spending it on agency and locum doctors.

Q103 **Dr Whitford:** I am not suggesting that at all. I do not think there is anyone who has not welcomed the expansion of medical student numbers. The concern is more about its being an additional pressure on a department that has already been cut—doing things without extra money to do them.

Jeremy Hunt: The Department has not been cut. We had a debate earlier about whether—

Q104 **Dr Whitford:** In Health Education England? I thought their budget was being cut.

Jeremy Hunt: The Department has not been cut. That was the phrase that you used.

Dr Whitford: I apologise. I meant the department Health Education England; they have had their budget cut.

Jeremy Hunt: I am confident, and we have the agreement of the Government to support Health Education England in order to fund this extra number of doctors.

Q105 **Dr Whitford:** Okay. Could I come on to some of the drier stuff and start with you, David? You met the Committee in February and May, and when we asked about the risk to the total resource expenditure limit, it was not flagged up to us that it would breach, and obviously it is breached, by £207 million. When you came at either of those times, were you concerned that that was going to happen in February and May?

David Williams: At that time, I thought we would bring the departmental spend within the Treasury DEL. That was the backdrop to conversations with the Treasury and then through to Parliament through the supplementary estimates process. But these are quite fine margins on a large budget, so the excess against the Treasury DEL reflected the limit of the measures we could sensibly take in-year.

Q106 **Dr Whitford:** Of £207 million, so that was within your margin of error.

David Williams: Clearly, £207 million is a lot of money by anybody's standards, but against the size of the annual DH budget it is less than a day's spend, and, at the end, volatility in some of the numbers was more than we were able to adjust for centrally.

Q107 **Dr Whitford:** It is quite hard to see at that fine level until you get to the end.

David Williams: Yes.

Q108 **Dr Whitford:** It is quite hard to manage the budget to that level.

David Williams: Obviously, the departmental position is a factor of the consolidation of 450 separate organisations, commissioners and providers, and while we look to get, through colleagues in NHSE and NHSI, our own sources of information—the best intelligence we can—through the year, naturally forecasts about spend and income will move around.

Q109 **Dr Whitford:** Obviously, there were an awful lot of measures taken to reach that. It could have been an awful lot worse. Secretary of State, were you surprised at how many different tweaks had to be carried out to get even that close to the expenditure limit?

Jeremy Hunt: I leave the accounting issues to accountants, but I have been very aware of what an incredibly challenging job it is, with the financial pressures that we face in the NHS, to land within our current resources. We are absolutely committed to doing so, but David's job, if he will allow me to say so, is a bit like trying to land a jumbo jet on a postage stamp; it is very hard on a £116 billion budget to predict exactly how all the year-end figures are going to come when you are collecting information from hundreds of trusts and CCGs across the whole system.

Q110 **Dr Whitford:** I accept that, but the criticism from the Auditor General is that a whole lot of unusual, shall we say, actions have been taken this year that are simply not repeatable—having two sets of accountants going through books to find anything that can be moved from one column to another, the £417 million error in national insurance, which was not declared in supplementary estimates, even though HMRC flagged it up, and that came to the benefit of the Department of Health, and then all the shifting from capital to revenue, which meant that the capital budget was nearly broken, had there not been the miraculous donation from MHRA of £100 million. Those are not things that we can say will happen in 2016-17, are they?

Jeremy Hunt: We will take all the help we can get. It is a very challenging process, but I agree with you that—

Q111 **Dr Whitford:** But is not the criticism of the Comptroller that what was being done was putting effort to manage the books rather than to achieve financial sustainability? A huge amount of money, time and effort has gone into moving figures around on a piece of paper so that we can say, "Phew, we almost managed it," instead of looking at the real-world problem, which is sustainability.

Jeremy Hunt: It is important to remember what the Comptroller and Auditor General actually said. He said that what was done was legitimate and within the bounds of accounting standards, but we fully accept that there were a number of measures taken that were one-off and not repeatable. I would not accept that we have, in any way, not been focusing on long-term sustainability. We have taken a huge number of measures, not just this year but last year: the very important measures that we started last year, for example, to reduce the cost of agency staff in the NHS where we think we have a good chance of saving around £1 billion off the NHS budget this year; the measures we are taking to help hospitals reduce their procurement costs are very important; the measures to improve the efficiency of their rostering are very important; the measures that NHS England are taking with the sustainability and transformation plans all started last year to enable all areas to have long-term balance. There has been a huge effort put into long-term sustainability.

Q112 **Dr Whitford:** But even looking at that, out of the sustainability and transformation funds, £1.8 billion is going to debt instead of transformation. If you are moving capital to revenue, buildings are not

being maintained and new buildings are not being built in the right place. Is that not actually hamstringing the NHS from getting to a point where it can work more effectively?

Jeremy Hunt: I do not agree. The £1.8 billion is going to the hospital sector, but that does not mean that it is not going to transformation. In fact, a condition of—

Q113 **Dr Whitford:** I thought it was just going to help with the sustainability of the actual £2.5 billion deficit.

Jeremy Hunt: It is going to help hospitals become sustainable, but a very strong condition of that funding is what Jim Mackey and his colleagues have been doing to ensure that, as a condition of getting that funding, hospitals are making the long-term changes necessary to put their finances on a sustainable footing, such as centralising procurement, improving the way that they roster staff and tackling their agency staff issues. While they make those changes of course they need support, but that £1.8 billion is a very important part of sustainability for the biggest NHS sector.

Q114 **Dr Whitford:** Maybe we could bring Mr Mackey in on that, because my understanding was that that was simply to not have it shut down and go bankrupt. With the huge provider deficit that we have, is the £1.8 billion not simply swallowed in that?

Jim Mackey: As Jeremy said, it is allocated to the provider sector in return for them demonstrating progress on a number of things that are linked to long-term sustainability, delivery of the Carter programme, path and back-office consolidation, procurement—all those things are conditional—and compliance with the locum and agency cap. It is not as simple as, "There's the money. It's all sorted. Don't worry about it." People have to demonstrate progress on restoring financial discipline and balance in the long term.

Q115 **Dr Whitford:** They have to achieve some of those steps before you give them the money. The £1.8 billion will go out in bits and pieces as they reach certain thresholds.

Jim Mackey: Yes.

Q116 **Dr Whitford:** Is it not correct that £1.2 billion of the capital for next year has already been earmarked to move into revenue?

David Williams: For 2016-17, we are budgeting on that basis, and that would be a switch that we would look to make at supplementary estimates.

Q117 **Dr Whitford:** That is a quarter of the capital budget for the year we have started. Mr Mackey, do you not think that is going to be an issue? I have worked in a hospital where maintenance kept getting put on the back burner because there was always a bigger problem, until you were trying to push trolleys past the buckets catching the leaks.

Jim Mackey: Capital is a big worry for all of us; it has come up several times already today. We are all doing what we can this year to live within the overall level of capital resource. There will be a capital requirement that comes out of the STP process, and over time, to really unlock long-term sustainability, long-term efficiency and productivity in the service, there will be a capital requirement about which we will have to have a discussion.

Q118 **Dr Whitford:** Is the problem not that this is the supposed year of plenty in these five years? This is the big year, and actually the next two years are going to be really tight, to the point where, as was mentioned, it is a negative per capita payment to the system. How are we going to build the buildings or change the service in the coming years?

Jeremy Hunt: That is why it is so important that the provider sector moves into financial balance, because it will obviously start to have a long-term impact if we have to continue having capital-to-revenue transfer. That is why it is a very important message for people running hospitals to understand that it is not cost-free to the NHS if they continue to run deficits. This is an area where, over the last year, we have made very important progress. Now only 15% of trusts are not on track to get their finances back under control. That is 31 trusts.

Q119 **Dr Whitford:** But 80% of them are in deficit at the moment.

Jeremy Hunt: As in their last year's figures, but 207 trusts are now on track to restore financial control.

Q120 **Dr Whitford:** You expect them to be out of deficit by the end of the financial year next spring.

Jeremy Hunt: Either out of deficit or on track with their agreed reduction in deficit, but certainly on the way to completely eliminating their deficit, yes.

Q121 **Dr Whitford:** Mr Mackey, what do you think the implications are at local level of the capital to revenue—both from the point of view we heard about in our primary care report of poor primary care provision in buildings, people working out of old houses, and on the issue of safety in buildings— if maintenance starts to go way down the shopping list?

Jim Mackey: If we had a blanket stop on maintenance and backlog maintenance spend, it would absolutely produce lots of problems. That is not actually happening. What is actually happening is that at local provider level people are making decisions in the round, looking at risks and what needs to be done and making judgments. Where they do not think they can live within that resource, they have conversations with us and we manage that with David in the Department and with other colleagues. Overall at the moment, it looks as if we can broadly balance in capital this year. Overall, probably—

Q122 **Dr Whitford:** But that is only with the donation from the MHRA of £100

million.

Jim Mackey: David is best to comment on that.

David Williams: For 2015-16, we were about £50 million under the capital DEL limit after £800 million—

Q123 **Dr Whitford:** Including that £100 million.

David Williams: We would have been £50 million over, but it was a perfectly reasonable measure to pull that money back in from the agency.

Q124 **Dr Whitford:** Obviously, these are all not things that are usable going forward.

Jim Mackey: That is why I was talking about this year. Broadly, this year we think we will be there or thereabouts in capital. It will be very tight, but you cannot constrain those things for ever, and we are absolutely having a conversation about that.

Q125 **Dr Whitford:** You are out and about with the providers all the time. Do you get a sense, both at chief executive level and particularly financial officer level, of the pressure of having to do this? When we talked about things going forward, we used to talk about patient-centred care, whereas at the moment it is very much budget-centred care. Are you finding that people want to leave being a financial officer? I imagine it is a pretty pressured role at the moment.

Jim Mackey: Yes, it is really hard out there. I do visits every week. Last Friday I was in Hull, for example, and I was in Manchester on Wednesday last week. Generally, almost always, you meet people who are absolutely committed to delivering everything in the round. The conversation is not just about money. Most of the conversations are about service quality, improvement, flow, managing staffing and engagement—those sorts of things. There is a lot of energy going into STPs. Over the last year, there has been a rebalancing of these things and people absolutely recognise that money, quality and performance all have to sit and work together. I am heartened by that. I see people who are working hard, and a lot of people who are demonstrating huge progress, but it is incredibly challenging.

Also, I would say in that regard—I was thinking about this and talking to colleagues over the weekend—I lived through the times of plenty, in the early 2000s when we had huge growth. I might have said before to this Committee that the worst financial year I worked through was 2003-04, when growth was probably about 6%, but we were trying to do a lot with it so it was still operationally very difficult. People still had big cost reduction requirements. I think we will all retire, and then a generation of NHS managers out there will all retire, never having had an easy year financially. I do not think anyone in the world in healthcare has an easy

year financially, because it is very complex and demands are increasing all the time. It is our job to make best use of the money we have.

Q126 **Dr Whitford:** Secretary of State, with regards to the £417 million that came by accident from national insurance receipts—maybe David will know more about this—will we have to pay that back, and are we happy that that kind of error will not happen again?

David Williams: I am certainly not happy that the error happened in the first place, and we have taken steps to make sure that it is not repeated in future. At the start of the year we budgeted through main estimates for £18.9 billion of budget from national insurance contributions and we received £19.3 billion in the end. It is the element of non-voted budget. If we had known about it in the run-up to the supplementary estimates, we would have had a conversation with the Treasury about whether we would have sought to retain that or whether there would have been an adjustment in the voted element of the health budget.

Q127 **Dr Whitford:** That would have been the more normal thing, would it—to adjust the voting?

David Williams: That would have been the more normal outcome, but I would not want to speculate on what the outcome would have been for 2015-16, given the conversations we were having with the Treasury around landing that year against DEL and within the vote. It does not need to be paid back. In practice, at that stage, the spend was going to be the spend that it turned out to be. The only question has been whether it has come in within the parliamentary vote.

Q128 **Dr Whitford:** Normally, it would have been adjusted for, but then the deficit, or the overspend, would have been £624 million instead of £207 million.

David Williams: No. It would have made no difference to the Treasury DEL out-turn. It would just have meant that we were £200 million over the parliamentary vote rather than £200 million under.

Q129 **Dr Whitford:** But you were £200 million over, were you not?

David Williams: We were £200 million over the Treasury DEL, but we were £200 million under the parliamentary vote as a result of the £400 million of national insurance contributions.

Q130 **Dr Whitford:** So it is not the Treasury one that counts.

David Williams: I try to manage both of them.

Dr Whitford: I have noticed.

David Williams: As far as possible, it would be nice for them to be the same number, but the impact of the national insurance contributions' late arrival has no impact on the position against the Treasury controlled sectors.

Q131 **Chair:** This is about more than accounting, though. Isn't part of the problem that it gives a misleading impression of financial balance? Because you had to make so many of those one-off adjustments and have the extra windfall from MHRA, doesn't it give the impression that the NHS was in financial balance when in fact it was not really?

David Williams: To echo the Secretary of State's opening remarks from this session, I do not think anybody looking at the 2015-16 out-turn would imagine that financially it has been plain sailing for the Department or the NHS. One of the features of parliamentary supply and the way in which departmental spending limits are set is that we are required to fix an annual budget. To do that, sometimes you need to take one-off or short-term measures. In our conversations around the financial sustainability of the NHS, we spend at least as much time talking to Simon and to Jim about the exit rate, the run rate, as we do about how we are doing on an individual year, and obviously we think about how the money works across the period of the "Five Year Forward View" as well. It is one aspect of financial management within the Department, but not the only element.

Chair: We come to Helen's questioning about plans for restoring the balance.

Q132 **Helen Whately:** I want to start with a question about social care, to return briefly to an earlier topic. There seems to be emerging consensus that social care needs more money, but the question to the Secretary of State is, do you have a picture of what difference every extra pound of money that would go into social care would make to the performance of the NHS?

Jeremy Hunt: I do not think it is possible to paint that kind of picture accurately because it all depends on the efficiency of service delivery on the ground. We know that councils that have sustained social care provision and co-operate closely with the NHS allow us to run better hospitals, because we can discharge people from hospitals; we can get a flow going through hospitals and therefore maintain the quality of A&E provision. The councils where we do not have those strong links are the places where we have the biggest problems, because we cannot discharge people from hospitals.

Q133 **Helen Whately:** Can I ask the question the other way round? We hear about the fragility of social care and the great pressure there. If that situation continues and the finances of social care do not get better, do you have a picture of what that would mean for the NHS?

Jeremy Hunt: The only solution in the continued pressure on money, both for the NHS and even more so for the social care system, is to speed up the integration of health and social care. Essentially, there is a huge amount of waste in keeping people in hospitals when they could be discharged for better and cheaper care in the community. Where you join up those systems, as is starting to happen now very excitingly in parts of

the country like Greater Manchester, you end up with better care for patients and less cost in the system. The only way through this incredibly difficult financial conundrum is to speed up that process of integration.

Q134 **Helen Whately:** That brings me, very seamlessly, to the sustainability and transformation plans as a vehicle for doing that. I am going to turn to Simon and Jim on this question. The STPs are a critical mechanism for delivering the "Five Year Forward View." By now, I think you will have seen fairly well-advanced drafts of the ones for the 44 footprints across England. Having seen those, to what extent are they on track to deliver the service changes envisaged in the "Five Year Forward View" and the financial sustainability needed?

Simon Stevens: There are two things going on in parallel. There is the medium-term planning for the next five years. In the jargon, it is STPs, but all it really is, quite simply, is the right group of hospitals, GP services, mental health and community services, local government, social care and community groups getting together and saying, "If this is the funding available in our community, what is the best way of dealing with some of our long-term and deep-seated needs to join up services, rather than just the year-by-year firefighting that otherwise would be confronting us?" That is the first process that is going on.

In parallel with that, Jim and I have now asked the health service to use the next two or three months to make the agreements for funding for 2017 and 2018. I think the answer to your question is that for places that have really well-developed plans for the next five years, in a sense the next two years are going to be straightforward. All they need to do is memorialise the first stepping stones of that in their annual—in this case, two-yearly—contracts. For parts of the country that have more deep-seated challenges, where there are more disparate groups of organisations involved in having these conversations, it may well be that, frankly, the most important thing for the next several months is to focus on 2017-18 and 2018-19 and, having done that, come back to finalising what their position out to 2020 looks like some time next year. It is an ongoing process. It is a process that people are very positive about, recognising that we do not expect that everybody will be able necessarily to answer all the exam questions straightaway. There is a job of work to be done to help to support, review and develop those proposals with communities over the coming months.

Q135 **Helen Whately:** To be a bit more specific, how many of the plans at the moment are projecting break-even, and are going to achieve the ambitions for services that have been set out by the Government, such as achieving seven-day service and the "Five Year Forward View", mental health and so on?

Simon Stevens: We have not seen the next version of the plans that people have been working on. They are going to share them with us quite shortly and then we will need an opportunity to review them and discuss them further with different communities around the country. As I said,

our expectation is that some are really quite well advanced and well articulated and that others will need time, having got their 2017-18 and 2018-19 proposals put to bed, and that is fine. In the real world, that is what your witnesses at the last hearing were really asking for.

Q136 **Helen Whately:** There is concern, and we hear the view, that some STPs have been given a figure and told they have to work back from that and make it work somehow. What will happen if some of the footprints say they do not think they can make it add up?

Simon Stevens: The NHS has a budget in the spending review from now to 2020. In a sense, all that people are looking at is what their local share is of the budget currently on the table for different counties, towns and geographies across the country. We are not expecting—I am not expecting—that people will have been able to find answers to all of these issues, looking out five years, over the next couple of months. I am expecting that they will have made a good-faith effort to answer some of the bigger questions, and where there are still gaps or unresolved issues that we—we being Jim and I and colleagues—need to work with them on going into next year, that is what we will do.

Jim Mackey: To add to that, and going back to the earlier points about last year and all the effort going into managing to a number, there is a huge amount of effort going into long-term sustainability. I met with an STP lead last night who absolutely does not know how they are going to fix what their gap is over the length of the STP process; but they have a process. They understand what the gap is, they have some ideas and they have started a process of resolving the gap and having a discussion locally about what the options are. That is a healthy, natural process. One of the big benefits of the STP process is that for the first time in an awful long time people in systems and communities have started having those conversations. If they were not doing that, we would be tipping the sofa out at the end of next year, the year after and the year after that. That is one of the big differences for me between this year and last year—a huge focus on next year—but as to the expectation that we all get up one day in December and everybody guarantees delivery over the next five, 10 or 20 years' time, it is more complex than that; it is going to be an ongoing conversation and process.

Q137 **Helen Whately:** I appreciate that, and the value of the STPs in bringing together organisations to have the conversation. Are you seeing STPs specifying a shift in activity with the funding from the acute sector to other settings? There is always the problem that people talk about the need for that shift but in practice all the money keeps going into the acute sector. Are the STPs able to quantify that shift?

Simon Stevens: That is right. Precisely one of the benefits of the exercise is to get people to be much more explicit about what actions would need to be taken in order to bring that about in the real world. It goes back to Ben's point on the Devon process, but it is true in Kent as well. Actually there is consensus emerging from all of these local

proposals that are being driven by GPs, clinicians, local NHS and local government leaders across the country—they are not something that we are producing for them—and the consensus goes something like, "You have to strengthen primary care and get it operating at scale." A lot of parts of the country are talking about populations of between 30,000 and 50,000 for organising urgent primary out-of-hospital services. On the back of that, they suggest that it would be possible, as we invest in more GP services, to expand the public offer so that patients are able to get more evening and weekend appointments, which they need. That, together with the local versions of the upgrades to mental health services that we need and cancer services, will be the meat and drink of what the proposals amount to.

Q138 **Helen Whately:** The theory and the narrative you have given there is absolutely clear, but—

Simon Stevens: It is precisely because we want it to be more than a theory that we are not saying that there is a single kind of big-bang moment when you put a ribbon on these things and say, "There we are. Mission accomplished." We are saying actually that in the case of Kent we are going to have to do quite a lot of work, given the complexity of Kent, despite what they will have done within the space of the next fortnight. I do not think that in the next fortnight we will have mission accomplished in Kent.

Q139 **Helen Whately:** But in your position of having a national overview, you are able to do a sense check. For instance, you could do a, "Let's just add it up for all 44 and say what shift we are seeing, on percentage terms, from acute to out of hospital." If you do that, it would be a helpful sense check, I would imagine: do you get an overall shift happening?

Simon Stevens: We certainly want to do that. It will be a shift compared with people's outlooks as to what would have happened absent that, so you are judging against counterfactuals. That is why, in a sense, these are the local instantiations of the broader service redesign and efficiency agenda that the NHS is embarked on. We recognise that you cannot just design all that in every community across the country from within a square mile of this building. You have to trust and empower the local NHS, together with its partners, to come up with the answers, but then to work with them to review and support, to ensure that there is rigour and deliverability.

Q140 **Helen Whately:** I am just asking whether there is a quantitative sense check on the overall ambition with what is happening. Similarly, is there a shift overall happening in mental health? There is a national aspiration to increase the share of funding going to mental health. If you do that, and take a step back from the 44 STPs, are they delivering on that so far in their plans?

Simon Stevens: On the definitions that were in force through the NHS over the last several years, the data that the CCGs have provided us

show that overall mental health spending went up last year compared with the year before, but we want there to be a lot more precision and a lot more transparency at local level, so we are going to be publishing the CCG assessment framework and a very detailed dashboard that will show where the investment, the service levels and the extra staff and clinics that are part of the mental health forward view are or are not, and it will be there for everybody to challenge.

I am talking to local Mind groups in a few days' time and one of my asks of them will be that they act as our eyes and ears locally: where people say these things are happening, they need to help us check that that is the case. It will be the same with the mental health NHS provider trusts. Where you have transparency, you can ensure that those improvements are actually occurring.

Q141 **Helen Whately:** I take that. I think your point generally is that these are locally developing plans—absolutely right. It would be helpful to get a picture of how they come together nationally and some sense check on the quantitative shifts. I will leave that point and move to a question about delivery of the STPs. They are clearly very important for the whole objective financially, and in terms of services, so the fact that they are delivered is critical. Who will be responsible for delivering the STPs, and how will they be held to account?

Simon Stevens: In a sense, we should not get too hung up on the acronym or the words; we are talking about a process. The very fact of having the right group of people together hammering out a shared view as to how care needs to improve does not in itself change the formal statutory accountabilities that exist in the national health service. Ultimately, when plans are agreed and funding is allocated, individual CCGs, trust boards and other partners will together each be responsible for delivering their part of the equation. What we are trying to engineer is a sense of shared endeavour, and potentially collective accountability as well, for some of the objectives that span the domain of any individual organisation. This is a complex thing to pull off. The reality in many parts of the country is that that is now very well advanced.

In Devon, since the success regime, and the move of Angela Pedder, one of our best performing hospital chief executives, from the Royal Devon and Exeter to lead that, there is now a governance mechanism for Devon that you can look at and say, "There's a there there," by comparison, say, with Kent, which is such a large county with so many bodies. When we sat down and had the conversation, as I did with colleagues from Kent in July, there must have been 20 or 25 folk who came to participate, which was wonderful. There was the leader of the county council, the leader of Medway, the leaders of all the different NHS organisations and so on, so it was a large group of people, and still at an earlier stage, I would say, of developing that shared sense of accountability.

Chair: There are two follow-up points. Ben, you want to make a quick point about Devon.

Q142 **Mr Bradshaw:** Very quickly. You spoke about Angela's leadership in very difficult times, and you mentioned that you were going to talk to local Mind groups about the situation in mental health services. Can I suggest that you also canvass the views of MPs? I do not know about my colleagues, but certainly my surgery at the moment is dominated by dreadful stories about the failures in our local mental health provision, particularly the growing number of people reaching crisis point and ending up in A&E and staying in A&E for weeks, or in an acute medical unit, in Angela's former hospital, because there is nothing for them in the community at all. I would be happy to talk to you and show you some of the examples.

Simon Stevens: Thank you. In fact, I am coming to Exeter in a couple of weeks' time and will be looking at the mental health services in your constituency, so I would love that opportunity.

Mr Bradshaw: Excellent.

Q143 **Dr Whitford:** There are two things. One is that we call them sustainability and transformation plans, but our biggest sustainability challenge is not the money; it is demand and the lack of doctors. Obviously there are things that people are trying to do about that, but they are not going to give us benefit for almost a decade. Is it not a problem that between here and there we are trying to tighten the money as well, which simply is not going to be possible?

Simon Stevens: In substance, we are benefiting from the continuing trends in overall population health improvement, and there are some encouraging signs. Within the last couple of weeks, we have seen the latest adult smoking figures, which show that the number of adult smokers is down by 1 million over the course of the last five years, from 8.2 million to 7.2 million. That will have a more profound impact on the future demand for cancer services, and on cardiovascular disease and many other conditions, than just about anything we have talked about this afternoon. But, obviously, that and a range of other health threats account for about 40% of the demand that is presenting in the National Health Service. We have a job of work to do to ensure that some of those benign trends continue and some of the worrying trends—around, say, alcohol-related liver disease and childhood obesity, which we have already discussed—really are tackled because, as you say, you will not notice the effect next year or the year after, but over five, 10 or 15 years you most certainly will. The fact that we have had a 42% reduction in cardiovascular deaths over the last decade, for example, means that there are fewer ambulances going over Westminster bridge to St Thomas's A&E now. It is the dog that is not barking because of the improvements that we have seen.

Jim Mackey: You are right to point out concerns about the workforce, and that is a big issue. This process is helping people to look at pooling staff, sharing resource in different ways and being less institutionally orientated about having a pool of staff here when they could be helping

out over there. What has also given a bit of heart is the announcement that the Secretary of State mentioned earlier about the expansion of the medical workforce. It will take a long time to come to fruition. In the past, that has been used as a reason not to make the decision, but now the decision is made, so it will happen eventually. Again, people are focused on the tactical steps they need to take to keep moving things on until that production opens up fully.

Q144 **Dr Whitford:** The concern is that it is a 25% increase in doctors, but will we actually employ them? Will we have the money to employ these doctors is a concern.

Simon Stevens: We will employ them.

Q145 **Dr Whitford:** The other thing is, within the STPs, will there be a different system of finances? Simon, you were suggesting that they will still all be responsible for their bit, come April, so does that not still mean that that business of tariffs, the perverse incentive of tariffs and everything else, is still going to stop someone sacrificing their organisation for the greater good? Do we not need to have a shared pocket of money?

Simon Stevens: It is the right question. It is also the right question because it is one we have an answer to, which is that we have said that for 2017-18, for next year, parts of the country that want to come together, pool their resources and get off the tariff treadmill can do that. Our default expectation for the year after, for 2018-19, is that the majority of the country will be in a shared funding control total environment, and we said that in the planning guidance.

Q146 **Dr Whitford:** Does that not take us back to Helen's question of who is responsible? If a whole group is responsible for a shared budget and that budget is broken, who will actually have to come and answer?

Simon Stevens: There is a before and after part to that. Prospectively, looking out to next year, we are saying to people, "Here is the total funding available for your area." If they come to us and say that we need to take more of the pressure in order to offset some of the investments they need to make in another part of the system because they think it is the right thing to do in the round, we will adjust individual organisations' financial performance prospectively, and then—

Q147 **Dr Whitford:** Do you not think that having a pooled budget would be better?

Simon Stevens: That is what we are saying. We are saying, "You have to start with where you are coming from"—the individual budget responsibilities—"but here is the shared funding envelope for your area. If you want to make adjustments to that you can, prospectively, but explain to us why moving some money from here to there is what you think makes sense." Then when we get into 2017-18, we are saying that, collectively, that group of leaders and boards has a shared responsibility for ensuring that the whole thing stacks. If during the course of the year

a bulge shows up in one part, others have to help out, which is de facto one and the same as what you are describing.

Q148 **Dr Whitford:** Will the tariff system and things like that disappear within that? They will just plan—

Simon Stevens: We are giving people the option to step off the tariff system from next year if that is what they want to do.

Q149 **Chair:** Further to that point, we are often told that tariff reform is happening. Are you now downgrading tariff reform and encouraging people to go on to this instead, or are they both going to happen in parallel?

Simon Stevens: Let's not overstate the case. It is a rather arcane conversation, but there is benefit to having specificity about what is happening in different parts of the health service. What is increasingly problematic is that parts of that are paid for on a click-of-the-turnstile basis, other parts are on a block-funding basis regardless of the amount of work, such as some of the community services and mental health services, and some are a kind of intermediate hybrid, like some parts of GP services. Increasingly, as we try to get people to focus on what are the right things for the health of this population, as against different funding streams for the component ware, then, yes, people want to move away from that, but I do not think it would be practical to go cold turkey from 1 April next year. We need a voluntary transition process, which is what Jim and I are setting out.

Q150 **Chair:** Before we move on to our final block of questions, can I take you back to your comment on the local situation in Devon? Many of the proposals for Devon are absolutely dependent on there being capital funding, on workforce and particularly on social care. The shifts into social care simply cannot happen when you cannot find workers who are prepared to work at the prices offered and when we now see, as you know, provider exit across the country. How much do you feel that this is going to scupper the proposals? Could you perhaps comment on that—the fragility of the system, as it has already been referred to by the CQC?

Simon Stevens: You are right to identify the risks. Equally, however, there is a highly engaged and competent set of leaders across Devon who are grappling with the issues, so the conversation we will want to have with them is to understand how they are factoring in those kinds of risks and, in the light of those, charting their best way forward. I do not want to be glib about it, and of course what you say is right, Dr Wollaston, but—

Q151 **Chair:** It is just that sometimes we ask communities to take a leap of faith: "We will close your community hospital but in return this is a vision of something that could look better." Local communities need to have faith that those things could actually happen.

Simon Stevens: I agree.

Q152 **Andrea Jenkyns:** This is clearly a challenging period in the NHS. I recently got back from a visit to Taiwan where, although they have a different funding mechanism, they still have concerns about longevity and sustainability even with their funding system, but they have a hell of a lot that we can learn from—innovative things they are doing over there. Simon, what additional corrective measures are you preparing if the financial reset does not work, because obviously that could be a possibility? You hinted in your 14 September meeting that we cannot wave a magic wand and we need to prepare for either outcome.

Simon Stevens: Plan A is vitally important for the reasons both Jim and Jeremy have given. With another five months'-worth of the year in front of us, the year is not baked, as it were, financially and we still have the opportunity to have a big impact. The work that Jim will no doubt want to describe in a moment on some of the interventions and support to get the trust control totals to the right place, and the equivalent processes that we need to put in hand for CCGs that are under financial pressure this year, is really important.

To go to the spirit of your question, one of the things we have done this year, in addition to the £1.8 billion of sustainability support for providers, is to create a 1% contingency reserve, stripped out of CCG budgets, which we would like not to have to spend in this way, but at the moment it is being held as a back-up in the event that it is needed.

Q153 **Andrea Jenkyns:** How long will the contingency reserve last, do you think, if you need to use it?

Simon Stevens: That is an in-year figure for 2016-17, for this year. That is what we have done, but to state the obvious, we would rather use that money to invest in the good stuff we want to do in the NHS.

Q154 **Andrea Jenkyns:** Of course, yes. Secretary of State, do you support the calls for an open and honest public debate on what the NHS can provide on proposed funding levels?

Jeremy Hunt: If you are talking about an open and honest debate about coping with the pressures of an ageing population and changing public expectations—for example, the desire to access medical advice at weekends and the very strong desire that we have in the NHS to offer the safest, highest-quality care anywhere in the world—we need to be open about the fact that, going forward over the next decade, we will need to invest more resources in our health and social care system. But if you mean a debate about the type of funding, the way we fund, I do not see—

Q155 **Andrea Jenkyns:** It is more about the levels. What can we get for the current levels?

Jeremy Hunt: It is a given that over coming decades we will need to put more into the health and social care system. Of course, people can make choices, but it is entirely possible to continue with our existing funding

system; when you make international comparisons, single-payer systems have tremendous advantages, but we need to recognise that with the growing pressures we face over the coming years there will need to be more resources.

Q156 **Andrea Jenkyns:** If more money were to become available, where, in your view, ought that money to be directed to have the biggest impact on achieving the long-term financial sustainability of the NHS?

Jeremy Hunt: More money has become available and, as we have said a number of times this afternoon, the financial pressures are more acute in the social care system than they are in the NHS, but that is not to say that they are not very severe in the NHS as well. The important point is what Dr Whitford said: as you put extra resources into the NHS, it is important that that money is spent not just as a sticking plaster for short-term pressures but in a way that allows you to deliver long-term sustainability. One of the things that we were very careful to do in the spending review was to protect the amount of money going into IT transformation—we had the Bob Wachter review—because the majority of our hospitals do not have IT systems that are up to international standards, and of course that means that you spend a lot more on doctors and nurses filling out paperwork; and some hospitals have multiple IT systems that cannot exchange information.

We are starting to make some really good progress. In the period since I have been Health Secretary, the majority of A&E departments can access a summary of GP medical records, which is very good for patient safety, which I know is your particular concern. Those kinds of long-term changes, which actually improve safety, improve the quality of care and reduce cost, are what we need to prioritise.

Q157 **Dr Whitford:** Talking about IT, Secretary of State, does that not bring us back to capital spend, because usually IT systems come out of capital? If we cut that by a quarter for next year, we are all going to be filling out bits of paper for an awful lot longer.

Jeremy Hunt: We still have a substantial capital budget, and as you will have seen from the very ambitious plans that we announced at NHS Expo in September, we are able to fund a very big expansion of our IT provision in the NHS. That is very important if you look at global best practice, although we need to be very conscious of the mistakes that have been made in the past, and that these things can go very badly wrong, but that process means that, hopefully, we have learned from those mistakes.

Q158 **Dr Whitford:** My career has lived through almost all of them. You mentioned extra funding under Andrea's question. Where would you imagine extra funding coming from? Are you talking about additional money from tax, or other methods, such as insurance systems, or whatever, for bringing extra money to the NHS?

Jeremy Hunt: Since I have been Health Secretary I have visited a number of countries that have different systems of funding their NHS, and I have not found a system that works better than our own. For all its pressures, most health economists argue that single-payer systems are very efficient. They ought to mean—they do not always mean—that we get the best prices. Certainly if you look at insurance-based systems, the cost of an MRI scan in America is three times what it costs in Britain, despite being the same machine, with doctors at the same level of expertise. Insurance-based systems, as we see from the way our car insurance works, can bid up prices, and sometimes they do not keep costs down. For me, the level of funding, and the recognition, as the ageing population expands, that going forward we will need to put more money into the NHS, is more important than the way we fund it.

Q159 **Dr Whitford:** Do you not think, therefore, that some of the fragmentation, outsourcing and financial competition that have been introduced bring with them some of the inefficiencies that go with a private insurance system? In actual fact, you should simply deliver the best care you can at the frontline with public money, rather than having three people competing to do it, with all of the cost that is now non-frontline and based around the current system of outsourcing and private providers.

Jeremy Hunt: It is easy sometimes to exaggerate the amount of outsourcing that actually happens. It is about 7.6% of all NHS spend, according to the most recent figures I have seen. There is innovation in the private sector and the voluntary sector that we should never close our eyes to in the NHS. Once you have an open competition and you decide who the most appropriate supplier is—my view is that it should be decided by clinicians at local level, not by politicians nationally—we need to make sure that we take on board what you have just been saying, which is that services need to be fully integrated into what the patient receives, so that from their point of view it is a single, seamless integrated NHS service.

Q160 **Dr Whitford:** Is that not hard to do when the drivers of a private company and the drivers of the NHS are somewhat different? Once a contract has gone to a private provider, the NHS does not have bid teams; they are not going to be bidding. If the knee service somewhere has been won by one of the big private providers, the NHS knee service in that area will simply not exist in five years when the contract comes up for renewal. At the moment, it is running almost half and half for things being outsourced. They are not going to come back. It is small at the moment, but it is still exponential growth.

Jeremy Hunt: I do not recognise that picture at all. I think it has increased from 4.8% to 7.6% over the last six years, and when it comes to—

Q161 **Dr Whitford:** But contracts that have been put out to bid are reported as going almost half and half to NHS and private providers.

Jeremy Hunt: I do not recognise those statistics at all. I think the overall amount of outsourcing in the NHS is low. It has been growing gradually but at a pretty slow rate. The outsourcing of elective care in the first decade of this century under the previous Government had a measurable effect in bringing down waiting times to the 18-week limit, and I think that was a positive thing for patients. There is less opportunity for that kind of outsourcing when it comes to urgent and emergency care. From this Government's point of view, our clear position is that this is not a matter for politicians. Once politicians start making those decisions, people worry that they are being done for ideological reasons. We think they should be decided by local clinicians on the ground and that what you end up with should be efficient, joined-up, integrated care.

Q162 **Dr Whitford:** But is it not a regulation that certain services have to be put up for outsourcing? You are not choosing between the two, but the idea that they must be put up for tender has come from politicians, and do you accept that if a service goes to a private company it will never come back? There will not be an NHS knee service that just sits and twiddles its thumbs for five years.

Jeremy Hunt: I do not accept that, and we have had examples of services being returned to NHS providers when—

Q163 **Dr Whitford:** Yes, in crisis.

Jeremy Hunt: When they have not been delivered successfully. The rules about compulsory competitive tendering come from the EU, and obviously with Brexit we have a chance to look at all the rules that come from the EU and we can make our own decisions, which have—

Q164 **Dr Whitford:** The NHS did not put them out. We have been in the EU for 40 years. They did not make us put things out for tender in the past.

Jeremy Hunt: I know it might be painful, but it is actually a Brexit—

Q165 **Dr Whitford:** Is it not from the Health and Social Care Act that this came?

Jeremy Hunt: No, it is nothing to do with that.

Simon Stevens: I will come in on this. It predates that. I think we have discussed this before. It is the 2006 legislation giving life to the then EU public contract regulations equivalent, which have now been updated for 2015. It has longer lineage than this; it is at least a decade.

Q166 **Dr Whitford:** If you are putting things out to tender, you have to go for competitive tender, but you do not have to put things out for tender. The NHS can deliver them.

Simon Stevens: As regards the history, the 2015 public contract regulations somewhat reduced our latitude and they are an EU-based set of procurement directives supplying both sides of Hadrian's wall, so when

we get to our Brexit negotiation, we obviously will have to think about whether we have any opportunities for flexibility there.

Chair: That is something we will be returning to as a Committee, and I am sure it will be a key part of that questioning. Helen has a follow-up point.

Q167 **Helen Whately:** I want to pick up on something Jim said earlier. You mentioned that there would be a capital requirement coming out of the STP process. In the light of the capital constraints that we know there are, I was interested to know what the scale of that looks like and where the money will be found to finance it.

Jim Mackey: We do not know yet what the scale will be. There will be a requirement, and we expect to engage with Treasury colleagues and others about demonstrating return on that investment when it has been fully worked through, but we are nowhere near being able to do that yet.

Q168 **Mr Bradshaw:** While we are on capital, we heard nothing from the Prime Minister on revenue in your meeting, but the Chancellor has indicated that he is relaxing his predecessor's deficit reduction target and is prepared to spend more money on capital. Are you hopeful that might lead to a little more being made available, at least on capital, for the NHS, as Mr Stevens has expressed hope for?

Jeremy Hunt: As you know, Mr Bradshaw, and, as I said earlier, we do not discuss internal discussions between the Treasury and No. 10 in the run-up to spending reviews.

Q169 **Mr Bradshaw:** But you would hope that might be the case, surely, as Health Secretary.

Jeremy Hunt: It is very difficult for me even to concede hoping without giving you some indication of private internal Government discussions.

Q170 **Mr Bradshaw:** Let's hope the Government listen to Mr Stevens's appeals. You said a moment or two ago that you acknowledged that you think over the next 10 years health and social care will require significant extra investment. How about Mr Stevens's idea of a target when it comes to the proportion of GDP we spend on health and social care?

Simon Stevens: Can I clarify? Actually, that was not my suggestion. It was simply a comparison with the position in the defence sector. The reason it is not my suggestion is that, in times when the economy is doing badly, it would imply that health spending was going down.

Q171 **Mr Bradshaw:** I completely recognise that, but you made the helpful comparison with defence in the context of the Prime Minister's comments that it should be as easy for you to save money in the NHS as in defence.

Simon Stevens: I have not heard the Prime Minister say that either.

Q172 **Mr Bradshaw:** That was the implication of the questioning from—

Simon Stevens: No, I did not hear any reference to the Prime Minister in the question.

Q173 **Mr Bradshaw:** Let's put it to one side. Spending as a proportion of our GDP on health and social care has fallen under this Government. Would you like to see it go back up to where it was when Labour left office, at least?

Jeremy Hunt: Thanks to the significant increases that have happened under this Government and the coalition—significantly higher, if I may say so, than promised by Labour at both the 2010 and 2015 elections—we are now, according to the latest figures from the OECD, spending 10% more than the OECD average and about the same as the western European average. That is not to say that it feels like that on the frontline, because of the huge pressure of the ageing population, the new medicines that are coming out and the greater demand for higher quality and higher safety of care. The answer is that if we want a high quality healthcare service, yes, we need to continue investing more, and we need an economy that is strong and able to support those demands.

Mr Bradshaw: What you just said is not consistent with the evidence we heard in the report about NHS finances that we published at the beginning of the summer, so perhaps you could provide the evidence justifying what you have just said about OECD and western European averages. Was that what you wanted to come back on, Chair?

Q174 **Chair:** The point I wanted to come in on is that the OECD changed the way they calculated these things, so it was not due to an increase in spending; it was because of the way that the calculations were made. We set that out in our report and we put in helpful comparisons about where we are now and where we would have been had we continued using the old comparisons.

Jeremy Hunt: Indeed, but we would not have reached the level that we reached, as reported by the OECD, if the Government had not maintained their commitments to increased funding to the NHS. The OECD make their comparison on the basis of what they think is a fair use of statistics in different countries. Obviously countries collect them in different ways, but I would not overplay that; I would simply say that, even though that may be what the OECD report, the reality on the ground is a public who are absolutely determined, with an ageing population, to have ever better NHS services and advances in medicine and technology, which means that, even with the proportion of GDP being spent, it does not feel a huge amount because of all the things we would like to do but are not always able to.

Q175 **Mr Bradshaw:** Briefly, on Brexit, one very easy thing that you could do now to reassure the NHS is guarantee that the thousands of NHS employees who are EU citizens will have a right to carry on doing their jobs here, if and when Brexit happens, as Mr Stevens requested. Will you do that?

Jeremy Hunt: As you know, these things are all part of the negotiations that lie ahead, but I have tried very hard at every opportunity to reassure the brilliant EU staff who currently work in the NHS—around 50,000 staff in total, 10,000 doctors and 18,000 nurses—and to be very clear that we want them to continue working in the NHS when we leave the EU. We are confident that we will be able to negotiate that and we think they do a fantastic job.

Q176 **Mr Bradshaw:** Are you on the Cabinet Brexit sub-committee?

Jeremy Hunt: I am not a standing member, but I will be involved in those discussions as they relate to NHS staff.

Q177 **Mr Bradshaw:** I have a final question, Chair, to Mr Stevens or whoever may want to answer it. What savings have the Carter implementations and vanguards already delivered?

Simon Stevens: By the end of this financial year, if we are able to deliver in the way that we intend across the NHS, we will have in the region of £3 billion of the £15 billion of local savings under our belts that were set out in the briefing, but I do not know if Jim wants to draw something to your attention.

Jim Mackey: Specifically on Carter, I could not give you a number today; we can provide that. It is lots of bits and pieces, procurement and other things, so I will get you a written answer on that.

Q178 **Chair:** Thank you. That would be helpful. A final technical point that we have returned to in this Committee on many occasions in the past is the status of the progress on the Bill for the regulation of healthcare professionals. It is something we mentioned in terms of our concerns about, for example, new elements of the workforce being trained who may find themselves in a position where they are uninsurable because they are not regulated. Are you in a position to tell us where we are with that?

Jeremy Hunt: I am afraid I do not have any new news on that front, but we continue to try to get parliamentary space for it at every available opportunity.

Chair: Thank you. On that note, thank you very much, all of you, for coming this afternoon. It has been very helpful.