

# Select Committee on the Long-Term Sustainability of the NHS

## Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 13 December 2016

10.05 am

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Members present: Lord Patel (Chairman); Bishop of Carlisle; Baroness Blackstone, Lord Bradley; Lord Kakkar; Lord Lipsey; Lord McColl of Dulwich; Lord Mawhinney; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 30

Heard in Public

Questions 278 - 285

### Witness

[I](#): Simon Stevens, Chief Executive, NHS England.

## Examination of witness

Simon Stevens.

Q278 **The Chairman:** Good morning, Simon. Thank you for coming to help us with our inquiry into the long-term sustainability of health and social care. We are looking long term, 2025-30, and beyond. This session is being broadcast on parliamentlive.tv and on the BBC parliamentary. You are popular, obviously. We will let you have the transcript, and you know the rules. Welcome, and thank you. For those of us who have not seen you for a while, it is you, despite the beard.

**Simon Stevens:** I have come in disguise, Lord Chairman, given that it is the distinguished end of the corridor.

**The Chairman:** We all know you, but if you would not mind please introduce yourself for the record, and if you have any statement to make, please feel free to do so.

**Simon Stevens:** Thank you. I am Simon Stevens and I am the chief executive of NHS England. Given the number of distinguished witnesses you have had before you already and no doubt the roster of questions you have, I suggest we just go straight into it.

**The Chairman:** I will start off. Now in healthcare it seems that a problem develops, you resolve it and the problem develops again. Looking ahead to 2025-30, what do we have to do to make healthcare sustainable year on year? What is stopping us?

**Simon Stevens:** When you say 2030, that sounds a long way off, but it is 14 years away, so I thought it was instructive to think about what the NHS was working on 14 years ago and whether we got those judgments right. Fourteen years ago we were in effect trying to solve a different set of problems than the problems now confronting the National Health Service. We were trying to convert our substantial extra money into improved speed of care, in particular cutting long waits for routine surgery. We put a set of ways of doing that in place, and as a result, as everybody knows, the wait for routine operations has come down from 18 months to less than 18 weeks for most people, which is a dramatic change. I started work in the National Health Service in 1988, and in that year there were 220,000 people waiting more than a year for their operation. Now it is under 1,600. We put a set of solutions in place 14 years ago to deal with the problems of the 2000s, and frankly I think you can say that the NHS was successful in that. Net public satisfaction doubled as a result.

However, 14 years later we are dealing with a different set of situations. So the question looking 14 years out is: to what extent will the problem set in front of us now have been dealt with, and to what extent will new issues emerge? My view is that the right way of thinking about that is to identify the things that are directly under our control that we can therefore take action on to future-proof what we think the health service

needs to look like, and the way care is organised and integrated between different parts of the health service. Indeed, the social care system would fall into that category, as would decisions that we have to make about the workforce.

The second category is changes that are outside our direct control but that we can nevertheless predict: changes in longevity, demography and the disease burden that we are likely to be facing. Thirdly, there is a set of things that are outside our control and are uncertain, so we cannot directly plan for those but we need to make some “no regrets” moves and some big bets and place down some markers on the board for things that we think might pay off but which we are not sure of. As we think about the actions we need to take, we need to get some serious changes layered in around the organisation of care and workforce in our control and we need to be responsive to what we can see coming down the pipe in the way of demography and epidemiology.

For the things that are outside our control and which potentially have the most fundamental impact—I would put two into that category—we have to think about different scenarios. The two most fundamental things that I think will shape what the National Health Service looks like in 14 or 15 years’ time will be the performance of the UK economy, given that for a tax-funded health service that is fundamental, and changes in medical innovation and technology.

**The Chairman:** As the chief executive, what would you be hoping for?

**Simon Stevens:** As in?

**The Chairman:** Strategy beyond 2020.

**Simon Stevens:** I think we have to marshal our forces on various timelines. As you know, we have a set of changes that we are looking to implement now through 2020. Some of those will be accomplished on that timeframe and some are more profound changes that will take longer. In three months’ time, I intend to publish the delivery plan for what the National Health Service will look like for the rest of the Parliament. Probably going into 2018, given that it is important that the strategic questions that this Committee is addressing are out there for public debate, I intend that NHS England will publish a set of proposals, a manifesto if you like, for what going into the next Parliament should look like over the medium term: the kind of timeframe that this Committee is debating.

Q279 **Lord Kakkar:** Simon, I would like to explore funding models with regard to both health and social care systems and what you consider those funding models need to look like to ensure sustainability into the long term. Then beyond that, if I may, I would like to explore three other issues. First, we have heard evidence that the variability in funding year on year makes it very difficult to plan in a meaningful way to achieve that medium and longer-term approach, and that there might be merit in having settlements that last for five or 10 years rather than the short

timeframes that we have experienced so far.

Since the current funding settlement is at the lower end of what had been suggested was going to be required, how do you think that current funding settlement and the changes in social care funding are going to impact on longer-term sustainability? We heard from the Office for Budget Responsibility its assessment that health spending will need to grow by more than GDP growth beyond 2020. What do you think the implications of those projections are?

**Simon Stevens:** I think you can argue that a tax-funded National Health Service as a funding mechanism has served this country well since 1948. It has produced a steadily improving and expanding National Health Service and has done so in an equitable way that is highly valued by the people of this country. There is no evidence that the support that the people of this country show for that as the core funding principle of our health service is in any way diminishing.

However, there are some consequences. The interesting question that you are posing is whether there is a way of having our cake and eating it—to use what I understand is a popular phrase these days—by which I mean: could we keep the benefits of a tax-funded health system but do something to overcome the lumpiness of our funding settlements that, over the course of the history of the National Health Service, has meant that even though the average spending growth may have been reasonable, we bounce off the backs between feast and famine, sugar highs and starvation, when it comes to the funding of the National Health Service, which in the end produces poorer quality of care and a less efficient use of resources.

My reading of history is that all the existential crises in the National Health Service over its history have arisen about once a decade and have been due not to anything happening in the NHS itself but to some form of economic crisis in the UK economy. Is there a way of smoothing out those bumps? If we were able to do that, I believe we would get more health bangs for our buck.

**Lord Kakkar:** You very carefully suggested that that would be a sensible thing to do. Is that achievable, in your experience of the National Health Service since 1988, with all the commitment there has been from successive Governments towards the NHS? Why do you think that has not been achieved? What action might be taken to try to achieve that more sustainable and secure long-term funding approach?

**Simon Stevens:** It is partly that health funding settlements have largely been pro-cyclical to the performance of the UK economy for the reasons I discussed. It has partly been because the squeeze is ultimately understood to have gone too far, and it produces a backlash through the democratic process that says, “We now need to sort ourselves out”. In the same way, the Wanless approach in the early 2000s looked back and said that we had spent £220 billion less than the European average over 15 years and we needed a catch-up period. That is one of the issues.

A related issue is that we are not connecting the public's willingness to fund the health service with the mechanisms that transparently bring that about. I know that other witnesses before you have talked about the pros and cons of greater connection—the “H” word for hypothecation of various sorts. There are pluses and minuses to that, but something that smoothed the funding increases, gave longer-term predictability and, more transparently for the public, connected what was being invested with the results they were getting in the NHS would be a great addition.

**Lord Kakkar:** If I may, I will come back to the two short supplementary questions. One relates to the current funding settlement being at the lower end of what you had requested. How will that impact, beyond this period, into the 2020s and 2030s? The second relates to the observation of the Office for Budget Responsibility that health spending will need to grow more than GDP after 2020.

**Simon Stevens:** On the first question, I would say that the reforms, which we may come on to talk about, to the way workforce training is financed are helping to untie or unconstrain the connection between the availability of funds in any given year and the numbers of new nurses or doctors going through the system. In that sense, that will help, again, to produce less lumpiness and short-termism in some of the workforce expansion that we clearly need.

On other elements of the future-proofing that are implied by the constraints that we are under right now, I think the main question will be whether, at some point during this Parliament, it is possible to liberate more capital expenditure in the National Health Service that would help investment in some of the new service models that we can see are part of what the future needs to look like. I hope we will have a chance to talk about some of those, because that is a profound redesign of the way clinical care works in the National Health Service, which will put us in good stead not just now through to 2020 but in the five and 10 years beyond.

**Lord Kakkar:** Do I understand correctly that if that type of capital investment for driving forward new models of care that you think will have a big impact on future sustainability is not made available in this Parliament, for whatever reason, that will have a serious detrimental impact on future potential sustainability?

**Simon Stevens:** You are perhaps gilding the lily in the way I framed it. I simply say that there is an opportunity to ensure that we drive productivity through well-targeted capital investment and lever in some of the wider service changes. In particular, we have this historic fragmentation between the way GP services work and hospital services work, and that is hardwired back not even to the 1946 Act but, I would argue, at least to 1911. The result, as the famous commentator and historian Roy Porter said, was that, “The founding deal in the National Health Service was that the consultants got the hospitals and the GPs got the patients”. We have evolved a model where we have general practice as a cottage industry and hospitals as factories, and we and every other

industrialised country can see that that needs to change. In order to do that we have a set of things we have to get right, but some of that is also going to require capex.

**The Chairman:** Lord Warner, Lord Scriven and Lord Lipsey all have supplementaries.

**Simon Stevens:** I am sorry, my Lord Chairman. This would otherwise have been Lord Kakkar's third attempt to ask me the question about the income elasticity of demand post-2020. Yes, my view is that it is likely to be a positive income elasticity above one. In other words, as countries get wealthier they want to spend a higher share of their national income on health services. That is the revealed preference of all industrialised countries in the post-war period. Although one might step off that escalator for short periods of time, there is no particular reason to think that that would be the revealed preference of the British people in perpetuity.

**Lord Warner:** Simon, can we come back to this issue of lumpiness? The evidence that the Committee has heard is that it is more than lumpiness; there are extraordinary variations and no consistency even between health and social care in that lumpiness. I assume that when you talk about smoothing mechanisms you are applying that to social care as well as to health. Is that a correct assumption, before I ask my question?

**Simon Stevens:** Yes, I think that would make sense, although obviously, as you know much better than me, the funding sources of social care are more mixed than they are in the National Health Service. A combination of central government grant, local authorities raising their own funds, personal contributions to social care, elements of the benefits system transfers and the contribution the National Health Service also goes into what are defined as social care services. There are at least five different funding streams going into social care financing in a way that to some extent offsets some of that lumpiness but not completely, seen through the lens of the central government grant.

**Lord Warner:** My main point is this. You mention that from time to time there is a crisis, and in the standard British way we reach for a commission to see if they can sort out the crisis and make a recommendation. At the moment, the cry has gone up for a royal commission. Is there not something so systemically flawed in this system of allocating resources, which would enable you to invest for the longer term, that we need a commission but we also need something that is standing and that helps the people with day-to-day responsibilities to concentrate on those and not get drawn from the longer term by the preoccupations of the moment? If we look at what happened in the Treasury, the OBR was set up to give the Government some kind of independent view, because the public were fed up with Chancellors giving optimistic economic forecasts that suited them politically. Given the size of health and care in public expenditure amounts, should we be thinking about some kind of independent body that keeps an eye on the longer term rather than reach for a commission every time there is a crisis?

**Simon Stevens:** It is an idea that in some respects has its attractions. With other countries' systems, which are financed with universal coverage, you get less lumpiness as a by-product of the funding mechanism in its own right. Beveridge systems are more prone to lumpiness, so the question arises: can you overlay the sort of mechanism that you describe? I do not think it is a particularly useful model, but in the US there is a group called the Medicare trustees, who have to report to Congress on the solvency of Medicare, the publicly-funded part of the US healthcare system, which in turn drives political debate about whether or not, on a medium to long-term prospect, Medicare is being properly managed. There are virtual models like that, if you like.

The alternative view, I suppose, is the one that I interpreted Robert Chote as putting before you last week, which was that it is legitimate for elected Governments to make these kinds of trade-off over time rather than pre-empting the decisions as between different elements of public spending. Certainly NHS England has sought—we did this in 2014 with the *NHS Five Year Forward View*—by default anyway, to play some of that role, prior to the last election, in explicitly setting out the NHS stall and saying, "Here are some of the choices facing the country". That was the first time the NHS had done that.

**Lord Scriven:** Thank you, Mr Stevens. In one of your answers you said that we have to get best bang for the buck. Clearly, there is the global amount that is given. I want to talk about going forward with the global sum, whatever it is, on productivity and variation of care, on which, the Committee has heard, the NHS has a pretty poor record. To make the NHS more sustainable in the future with the amount it gets, what strategic and systematic changes will have to be made so that we get the best bang for the buck, both in productivity and in dealing with the variation of intervention?

**Simon Stevens:** I think the NHS has a spectacularly good record on productivity and efficiency, certainly as judged against any other major industrialised country. Three things can be true at the same time. First, we are, in macro terms, a very efficient health system. Secondly, there are nevertheless still significant opportunities to remove waste and reduce clinical practice variation. Thirdly, despite those two things, if we are to continue to have the kind of health service that the people of this country want, it is likely that the NHS will need further investment in years to come. I do not think there is any inconsistency between those three things.

**Lord Scriven:** That is your personal view. Other witnesses have had a different view. As chief executive of NHS England, in order to get best bang for the buck and to deal with the productivity and variation issue, what strategic and systematic changes are you looking to make, or which will have to be made, in the long term to make sure that we get even better and deal with the inconsistencies?

**Simon Stevens:** I would underline the evidence that you have had from some of the previous witnesses that we are obviously aiming to drive

about £14 billion of productivity differences out of the provider sector between now and 2020. When Jim Mackey was before you he laid out many of the measures that have been taken through reducing the waste identified by Lord Carter, by driving out some of the other practice variations that people such as Professor Jim Briggs and Professor Tim Evans have identified in clinical practice surgery and medicine, and by dealing with some of the differences that exist in the configuration of services, which in turn means that we have different usage of expensive parts of the hospital system depending on where you happen to be in different parts of the country. I do not think anybody disputes that the NHS has a huge efficiency programme in front of it, which it is mobilising for, and that comes on the heels of £20 billion worth of efficiency that we delivered over the previous five years.

**Lord Scriven:** Can I ask one further question, very quickly? Looking forward, not dealing with where we are now—you talked about the three things that are predictable and that you can manage and plan on—are there any long-term strategic or systematic changes that the NHS will have to make, which it has not started now, to deal with the productivity and the variation issues that have been identified by the Committee? Can you think of any levers, any management changes—not necessarily structural changes—that you think will have to come in to make the NHS more sustainable to deal with getting more bang for the buck?

**Simon Stevens:** Yes, I think there are a number. The first is changes to the way the workforce in the NHS is supported and deployed. For example, in the case of nursing—and Lord Willis probably knows more about this than anybody else in the room—a major programme of reform in nursing is under way involving changes to the way support is given to people to move from care-assistant roles to nursing associates, and nursing associates to graduate nurses, and changes in the skills mix between different disciplines in different areas that we have to improve on. We know that we have bottlenecks on the early diagnosis of cancer, so we need more nurse endoscopists to go alongside gastroenterologists, for example. We know that we need to be more directive in some respects about the disciplines in which our new doctors are practising. If anybody had said 10 years ago that looking out in the decade to today we were going to expand the number of hospital consultants three times faster than the number of GPs, they would have said that that was probably the wrong answer, but that is what has happened. We have a range of changes that we need as to how we deploy our workforce.

More fundamentally, the fact is that many of us believe that the changes to medical practice that are going to be layered in over a 30 or 40-year medical or nursing career mean that it is quite important that as new practitioners are trained they are trained not just for the state of knowledge today but to be highly flexible over the course of their careers. That is not a new phenomenon, but it is something we have to accelerate.

**Lord Lipsey:** You cited economic growth as an important determinant of

the future of the NHS. Is there not an important stabiliser there in so far as 70-odd per cent of your main costs are pay, and that generally speaking, over the long term, pay will rise in line with GDP, so if GDP is slower you will have slower pay rises, which will help to compensate for the lesser tax funding that you would expect to get?

**Simon Stevens:** Yes. Offset against that is obviously the Baumol effect in labour-intensive services, probably more so in social care than even the NHS.

**Lord Lipsey:** To follow that up, one of the other major factors that I would be worrying about if I was in your shoes—which, thank God, I am not—is the combined potential effect of Brexit and a clampdown on immigration from the rest of the world. You are very dependent for labour force on the rest of the world, and if you cannot recruit from there you will have to pay Brits more to do it. Is that not likely to be a very serious inflationary element in the future course of the costs of the NHS?

**Simon Stevens:** It will certainly be important to get this right. We have perhaps 135,000 staff from the rest of the European Union working in the NHS and the social care system, and about a quarter of our 150,000 or so NHS doctors across the country are from overseas—36% qualified abroad. We have traditionally, like a number of other countries, relied on supplementing UK-trained staff with internationally trained staff. It is important that we also expand domestic supply, and I think that is why the Government decided to expand medical school places by 1,500 beginning in 2018—a 25% increase. Obviously that will take time to layer into the system, but that is one positive sign. Taking the cap off nurse training places, so that we move away from the ridiculous situation where we have more people wanting to be nurses than we train at a time when we want more nurses, will also help.

**Lord Turnberg:** When you were answering the Chairman you were talking about unknown unknowns and known unknowns, and those sorts of things.

**Simon Stevens:** I do not associate myself with the author of that particular epithet.

**Lord Turnberg:** I interpreted it that way. Among the known unknowns are the advances in medical technology and how far they are going to take us. I have two questions about that.

One is that traditionally we are very slow in taking up technologies. How long will it be before we are able to take full advantage of what are remarkable advances in treatment, which will cure many diseases we cannot cure now, and certainly help to prevent deterioration in them? How do we encourage a more rapid uptake?

The second is that they are likely to be expensive; all new therapies and inventions are going to be expensive, at least initially. The NHS bears the brunt of that, but the benefit of increased productivity goes to the

Treasury. How do we sort that out?

**Simon Stevens:** Goodness. Over the course not only of our history but that of other industrialised countries, as countries have become better off we have been able to afford more of the good new things that are represented by medical advance. I would use a data point to illustrate this from the other side of the Atlantic. In 1900, Americans were spending twice as much on funerals as they were on medicines; now they are spending 10 times more on medicines than they are on funerals. You can argue whether 10x is the right ratio on their drug prices, but the fact is that that represents the kind of transition that countries can afford as they become better off.

You heard from previous witnesses that part of the reason why new technology in healthcare does not always reduce costs—often it increases it—is partly because more people can get benefits. It is not all in that direction. I have brought one example here this morning, an ECG machine that straps on the back of my iPhone. It is going to be available on the NHS from April and costs less than £100. It is going to be deployed in this country for people with atrial fibrillation, of whom perhaps 500,000 do not know they have it, and it causes more than a fifth of strokes. Some innovations, particularly the spillover effect of what are called general purpose technologies into healthcare, could bring us some cost relief rather than simply layering in additional cost.

**Lord Turnberg:** Some.

**Simon Stevens:** Some, but there are others where frankly we are going to have to create headroom to be able to afford the innovation that represents, and we do that in a measured and managed way. Even in the last 20 or 30 years, I recall it being said that solid organ transplantation, new joint replacements or HIV antiretrovirals were going to bankrupt the NHS. The truth is we take a measured approach to these. We have done the same with new hepatitis C drugs, somewhat controversially, over the last year. Rather than saying, “We’re going to spend a couple of billion in one big bang”, we are layering these in based on clinical need. It is also a two-way street; it depends on the prices at which we can secure these new advances from the life sciences industry. I think we have an opportunity, coming up to and post-Brexit, to strike a new social contract with the life sciences industry, which we want, that would get us innovation and create the headroom to afford that and to ensure that the NHS and the country continue to be a vibrant and stimulating place for life sciences research. That is the sweet spot that we have to aim for.

**Lord Warner:** Can we come back to this issue of productivity and efficiency? We have heard a lot of scepticism in the evidence about the NHS’s capacity to drive the kind of numbers being envisaged for productivity improvement. They seem to be much higher than the British economy generally, let alone in the health service. You mentioned £14 billion in the next few years. What happens in the next few years in our view has quite a lot of impact on what happens in 2030. My question is: is some of this realistic? If Lord Carter provides £5 billion, give or take, in

efficiencies, where does this other £9 billion come from? What is coming to us from the people having to deliver this is great scepticism about the kind of annual increases in productivity that are being sought? How confident are you that this is not just a remainder figure that the Government have decided on, and how real is continuing progress of over 2% a year productivity increase?

**Simon Stevens:** A lot has to come right to deliver those kinds of numbers. It is worth reminding ourselves that this is about creating headroom for other things that the health service wants to do over and above the funding increases that we are getting. This is not taking money out of the health service; it is freeing up from our current cost base. I doubt that, over the timeframe the Committee is inquiring about—from 2020 to 2030—those kinds of compound rates are sustainable. The argument that the econometricians have put together, looking at the variation data, is that 2% efficiency comprised of the annual 1%-ish that the health service has traditionally been capable of delivering and that medical improvements and technology help you get, together with 1%-ish of catch-up, recognising you have this big spread between performance, gets you to this kind of opportunity for the next several years, but I do not think it would be a safe assumption, looking out over 10, 15, 20 years, to think that 2% plus productivity, which is probably higher than the UK economy as a whole has delivered in recent times, is a safe basis on which to plan.

Q280 **Lord Willis of Knaresborough:** I was interested, when you opened your remarks today on sustainability going forward, that you mentioned two things. One was GDP growing, which would get more money in, and the other was new technologies. But you did not mention the workforce as being one of the three pillars of sustainability. You have gone over some of the ground with Lord Scriven. I was interested in what you said on page 30 of your *Five Year Forward View*: “We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money”.

Currently, we have a shortage of about 6% of clinical places in the NHS, we are losing around 9% of our nurses every year, and we are spending about £3.3 billion on agency staff. It is two years since that was written. If that continues, we will never be able to deliver the sorts of improvements that you certainly want and which we as a Committee want. We have not got workforce planning right at the moment. How do you see there being a step change in the future, so that we have an effective, flexible and sustainable workforce? How do we get the skills mix right within it? This Committee has heard lots of examples of where the skills mix clearly is not right in the NHS; there are far too many silos and there is far too much protectionism. I would argue with the royal colleges, but you might not feel that you can agree. What can we do to have good leadership? It requires significant leadership, which I suspect we do not have at the moment. There are three challenges.

**Simon Stevens:** To go back to your first comment, I said that technology and the UK economy fell into the category of things that were

not in the direct control of the National Health Service. I certainly talked about the importance of workforce, but I said that that was in our control so it is our responsibility to get that right. I absolutely agree with you that that is one of the central pillars for future-proofing the NHS.

Obviously we are seeing continued growth in the number of health professionals in the NHS, notwithstanding the important points you have made. It is clear that we have had a period of public sector pay constraint while the economy overall has been in the position it has been. Looking out over five, 10, 15 years, we are going to need to see more flexibility in the NHS as an employer and in the combination of pay and benefits on offer to staff. Frankly, some of that is the reason why there has been this spike in agency costs and temporary working over the last several years.

As it happens, I think we are making good progress this year in cutting the agency bill. Rather than the £3.3 billion or so that you mentioned, I think we are going to be substantially below £3 billion this year, and the figure is coming down. That shows that frankly there has been a gap, in my judgment anyway, in strategic workforce planning and implementation that has been distributed between decisions about future training requirements through HEE, decisions about pay made by the Department of Health and, on their behalf, by NHS employers, and the action that individual trusts as employers take when we need more collective action, certainly at the regional level. There is a recognition of that fact, and in recent times the NHS has probably been less than the sum of its parts on some of those questions.

**Lord Willis of Knaresborough:** In terms of training staff for tomorrow, we have a tradition of training staff for yesterday and what we needed before, so how do we make a quantum leap to get the right sort of doctors coming through? We have heard time after time in this inquiry that we do not have the right mix of doctors, or medics; nor do we have the right mix of nurses and care assistants to deliver the sort of healthcare system that we all envisage for 2030.

**Simon Stevens:** Some of that is at the margin. If you start with nursing, roughly speaking we have about one million care assistants in health and social care and about half a million nurses. We need to find ways of creating career ladders for those who want to move from care assistants into nursing, and that is what the new nursing associate role will do. If we get that right, that will also produce a benefit for the sustainability of home care and care homes as well as for hospitals and the NHS as an employer of nurses. I hesitate to offer a view, given the distinguished nature of the Committee's membership, when it comes to the future of medicine.

**Lord Willis of Knaresborough:** They are looking to change their ways.

**The Chairman:** It was a long time ago.

**Simon Stevens:** Looking at Lord McColl, Lord Ribeiro and, indeed, Lord Turnberg—distinguished physicians and surgeons—over their long and

brilliant careers there were massive changes in surgical practice, and surgery accommodated those successfully. This would be a good example of how changes in clinical practice have generated productivity benefits for the NHS. If you think about the combined effect of short-acting anaesthetics with minimally invasive surgery, with drugs that in some cases have displaced what would have been surgical procedures, the NHS and the surgical disciplines have adapted to that. I do not think we should throw the baby out with the bathwater here.

**Lord Willis of Knaresborough:** It is still taking six or seven years to train a doctor. Can we not do that a lot quicker? They are certainly doing that in other places right around the world. Why are we taking so long to get these people up and active?

**Simon Stevens:** There is an interesting question about how much people need to have under their belts at the point they get registration and how much on-the-job experience and training they should receive subsequently. Obviously, this has ebbed and flowed and differs between specialties. It looks quite different for a neurosurgeon than it does for a GP, say. I think we have some of those flexibilities.

**Lord Ribeiro:** One of the things you mentioned early was this question of the 1,500 new medical students, which was announced in October. As Lord Willis has said, the time to independent practice is probably about 10 years. One of the big problem areas is general practice, where recruitment is poor, 50% of the entrants are female and we know that many of them want to work part-time and not take partnerships but take salaries. One of things that came out in your five-year forward view was the primary and acute care systems.

**Simon Stevens:** Yes.

**Lord Ribeiro:** The challenge here is how you look at general practice. In your forward view, you say, "Is this model sustainable in the long term?" You have some great challenges in here. You say, "In urban areas where general practice is perhaps not as well sustained, you might give an opportunity for hospitals to take over". I can think of chief executives, such as Len Fenwick and Robert Naylor, who would have grasped that opportunity. Is it not time to start putting that into practice?

**Simon Stevens:** In places, yes. I think we need a mixed model. My philosophy on how the NHS should change, coming to this job, is that we should take account of three things. First, we should focus more on outcome improvement than on administrative reorganisations. Secondly, we should recognise that although in some senses we are small country, we are quite large and diverse when it comes to our populations and the way the health service is operating, so we should allow different evolutionary paths in different parts of the country. The third point, which is the corollary of the other two, is that we should therefore be willing to back energy, leadership and clinical engagement wherever we find it, rather than trying to create neat lines on a map and saying, "Right. You, you and you, you're it."

That is the precursor to the answer to your question, which is that, yes, we are going to see a mixed model in the way primary care develops. My reading is that GPs are not crying wolf and that they have been systematically undersupported and underinvested in, relative to the rising workloads and demands that we are placing on them, and that because, frankly, their backs are against the wall, they are now willing to contemplate some quite radical changes to the way in which general practice operates, while nevertheless maintaining the best features of it, including list-based continuity of care for populations and the personal relationship for patients who want it.

In a nutshell, I would say that general practice is a flotilla, not an aircraft carrier, so it will develop and move in different ways in different parts of the country, some of which you have described. In other places, such as Birmingham, you will see that the GPs themselves are coming together at scale, either with a very deep redesign of what primary community services look like, such as in Sandwell and west Birmingham with a partnership called Modality, or a looser aggregation of GPs in central and east Birmingham, with an organisation called Our Health Partnerships, which covers about 280,000 patients. The trust in Wolverhampton is now running 11 of the GP practices in the area, and as a result it has redesigned the hand-offs between primary care and hospital services and says that it has cut emergency admissions for those 52,000 patients by up to 20%. So it is a mixed model.

**Lord Ribeiro:** Again, your mantra has been “let a thousand flowers bloom”, and one size fits all. How are you going to achieve the leadership to see this happening? That question about the lack of leadership was raised early on. It should not come from the top. Who is going to drive this at ground level?

**Simon Stevens:** I would not say a thousand flowers; I would say horses for courses. That is an important distinction, because I think it will be fewer than a thousand, and some of them will not turn out to be flowers. In the examples I have described, in the two GP groupings it is the GPs who are driving that, together with the community nurses. In the case of Wolverhampton, it is the trust. In some parts of the country, such as what we are doing in Greater Manchester, frankly it is the local authority that has given strong leadership to the changes we want to see. Without being anything other than supportive, there are some parts of the country where you would not want to place all your bets with one or other of those groups, whoever it happened to be. You have to back energy and leadership where you find it.

**Baroness Redfern:** Following up on Lord Willis’s question on the retention of nurses, to cut to the chase and going to agencies as such, do you think it is a lack of management? Are they going for pay, for more flexibility, or leaving the NHS because of poor career progression for managers?

**Simon Stevens:** I think it is a combination. We are reversing the tide. We are now seeing a substantial switchback.

**Baroness Redfern:** I understand that. I am trying to take the lumps out.

**Simon Stevens:** Absolutely. The question is what did not work and what is working now that is turning the tide. You have had individual hospitals that have been very rigid in the shifts they have offered staff; they have said, "You do this length of shift and here are your off-duties, like it or lump it", and nurses are perfectly entitled to say, "Lump it". Some of that has been happening. In some cases there has been a ratchet effect on the rates agencies are paying, and frankly some of that ratchet has been captured by the agencies themselves, which is why I have, somewhat demotically, described them as "ripping off the NHS", which I think in many respects they have been. We can, in a sense, get the best of both worlds if we can offer more flexible opportunities and make sure the banks are working relative to agencies. We have made real strides on nursing. The next group we have to apply equivalent attention to is medical locums. We are still being exposed to very high charges for medical locums in many parts of the country, and the NHS has to exercise some collective downward pressure on the market clearing rate.

**The Chairman:** A quick question from Lord Scriven and Lord Warner.

**Lord Scriven:** Lord Willis's first question was about how to support a flexible and sustainable workforce for the future, 2030. Your whole answer has been about the NHS, which is understandable. The blurring of social care and NHS means that the workforce planning, delivery and funding is going to be very different. Can you share your thinking about how the planning, the delivery and the funding will be in this much more blurred workforce between social care and health? A lot of witnesses have said that it is going to be absolutely key in looking at pathways of care and sustainability.

**Simon Stevens:** Yes, absolutely. We would have to say that the NHS focused planning for nursing numbers, for example, has probably not served the social care sector well. I do not know whether this is something you discussed when HEE were here, but I think it would accept that its gaze or remit needs to be more all-encompassing to deal with the total demand for nurses. On the discussion we have just had, as you know we obviously have more budget pooling between health and social care in Sheffield than we have in many other parts of the country. In places such as Tameside, Greater Manchester, social care staff have been transferred over to the employment of the hospital.

**Lord Scriven:** I am sorry; I do not want to cut you off. Strategically, what will have to change, rather than these pockets, in the planning and delivery of a unified workforce? What will have to happen or change in the national leadership, or the NHS leadership, to get these good practices being delivered elsewhere?

**Simon Stevens:** The two principal workforce groups for social care, by number anyway, are care assistants and nurses. It will be important that HEE, in thinking about the future requirement for nurses, factors in the

requirement from the care sector. In the case of care assistants, as I said earlier, I think it is vital that we create these new career ladders so that people can, through apprenticeships, have training on the job, and become either nursing associates or, in due time, full graduate nurses. That will help with the recruitment or retention of well-motivated care assistants in the care sector.

**Lord Warner:** We had some very powerful evidence from Terence Stephenson from the GMC about the rigidities in professional regulation and the extent to which that was stopping them progressing the handing down of duties to physician assistants of some kind or the other, pointing to the fact they could only operate within statute and that the statute was from 1983; it was very out of date. How do you, as a user of a product of that system, see this as a barrier to doing the kinds of things you want to do in the NHS in skills mix terms?

**Simon Stevens:** There is a case, obviously, for legislation to clear the path for this, and I know that a Bill will be before you and the House of Commons at some point when time permits. What we must not do is use that as an excuse for not making some of the other changes that we know are needed right now. I can give you two very practical examples of things we have to do over the next several years. The first is that in beefing up general practice we want to put about 3,000 clinical pharmacists alongside GPs to do medication reviews and run their own clinics. We are going to fund those directly, and we are in this fortunate position on some estimates of even having a surplus availability of pharmacists. That will produce a skills mix change in primary care. Similarly, as we want to expand access to mental health services, we are looking for another 1,500 clinical pharmacists and another 3,000 mental health therapists who we want embedded in general practice. That will be quite a big shift in the skills mix in primary care, alongside core GP-ing. Yes, there is a regulatory element to this, but I do not believe that is the principal driver or inhibitor of change.

**The Chairman:** When you talk about physicians' assistants, there is no regulation, from the GMC point of view, because if they are not doctors, anybody can train them. The hospitals can train them.

**Simon Stevens:** I think the question is how they will be regulated in their subsequent clinical practice, and that is an issue the HCPC has been looking at, among others.

**Lord Warner:** There is a safety issue, I think

**Baroness Blackstone:** Is there a regulatory element in relation to the deployment of nurses? Subsequent to the Francis report, there is now a huge emphasis in hospital trusts on safe nursing, which I think makes it much more difficult for inventive and innovatory thinking about the use of healthcare assistants doing some of the work that is currently done by nurses which they could easily do?

**Simon Stevens:** I think this was a necessary correction to what had been discovered to be the case in Mid Staffordshire. You can argue that at a time when the health service is under pressure it is good to have some sort of countervailing backing in the system to ensure that we continue to ensure that staffing levels are appropriate. That is obviously one of the things the CQC is also involved in looking at. That said, not every hospital is as creative and brilliant as Great Ormond Street. Where there are institutions that are capable of exercising that sort of flexibility, obviously it would be good to enable that to come about.

**The Chairman:** You could get a job in diplomacy.

**Baroness Blackstone:** I was thinking that.

**Lord Kakkar:** To come back on this regulation question, if you look at the totality of professional regulation systems of finance and so on, do you think that regulation increasing at this pace and complexity will impact longer-term sustainability?

**Simon Stevens:** My starting assumption is that most staff working in the health service do a good job and want to do a good job, so the question is how we support them to get that right as against a sort of rear-view mirror assessment and then going around administering beatings with a stick. We need as much emphasis on improvement support as we do on the transparency and the core safety measures. That said—and this is an imperfect example—when I fly on a plane I am pleased that the CAA has made sure that the engines are being maintained and that a basic level of safety in aviation is hardwired into the system. All the lessons from aviation are that that by itself is not what produces a safety culture and the kind of improvement that we want. I think it is about how you calibrate it correctly so there are minimum levels of safety and quality through the system, but you do not rely on that as your principal method for driving improvement.

Q281 **Bishop of Carlisle:** I would like to return to the whole issue of social care, if I may. You have mentioned it several times and we know how important you feel it is. We are also aware of the huge pressure that a lack of a proper settlement for social care is placing on the NHS. According to recent press reports at any rate, that seems to be getting worse rather than better with the closure of many care homes. You said right at the beginning that social care is perhaps one of the things that is under our control, rather than not under our control.

I would like to ask two questions. The first has to do with the integration of health and social care. Almost all our witnesses have said that they see this as important. We have heard about particular areas where it is improving, but what do you think are the main obstacles overall at the moment to that happening? The second question has to do with the funding. You talked a moment ago about places where there is more budget pooling. Do you have any ideas for an alternative funding model for social care? You mentioned earlier all the different ways in which social care is funded. Is there something that would be more effective

that would enable the longer-term sustainability both of the NHS and of social care? That is rather a convoluted question.

**Simon Stevens:** No, it is very apposite and timely. If you go back to where we began, thinking about the big things the NHS has to get right, my position has been that rather than what I have described as a triple fragmentation we need a triple integration, and the triple integration is between primary care and hospital specialist services; between physical and mental health services and between health and social care. However, there are various blind alleys and false paths on offer in the health-social care integration debate.

To cut to the chase, in my opinion anyway, there are three sets of things that it would be sensible to do ranging out in time. First, I am not making a new statement, but as you know I have previously said that if there were to be any extra money available any time soon, social care should be at the front of the queue because it is quite obvious that the knock-on consequences of a deteriorating social care offer not only for vulnerable people but in hospitals are now unarguable. You do not have to redesign Beveridge to produce some immediate support for social care services. That would be the first step.

Secondly, there are things that we ought to do to integrate health and social care locally, but those solutions are best designed between consenting adults locally rather than mandated nationally, because the relationships and the right way of doing it will differ between Plymouth and Sheffield or any other part of the country you may care to mention. We have to distinguish the budget pooling from the integration of the way care is delivered. In particular, I do not believe that the simple act of pooling budgets is in itself sufficient to ensure that there is enough funding on either side of the equation. I think I said on my first day back in this job nearly three years ago that simply putting together two leaky buckets does not produce a watertight care solution.

There is a set of things that can be done practically in Salford, Plymouth, Sheffield and Tameside on the health and social care integration front, but I do not think that is the whole answer. The third of the steps, it seems to me, is that we need to think more broadly about public funding streams for older people, for retirees, in this country. We need to go beyond just thinking about health and social care funding and think about what is happening in the benefits system, the pension system and so forth. Obviously, we have a triple lock until 2020, which is three different ways in which people's pensions go up. A new way of thinking about that would be a triple guarantee for old people in this country that would be a guarantee of income, housing and care. I do not think you can think about any one of those in isolation from the other two.

**Bishop of Carlisle:** That is very helpful, thank you. Who do you think should be acting on this? Is it a political thing or is it something that NHS England should do?

**Simon Stevens:** No. It is clearly a matter for government and for Parliament.

**Bishop of Carlisle:** Thank you very much.

**The Chairman:** What about funding models for social care? That was one of the questions that the Lord Bishop asked. Do you have any comments on a possible funding model?

**Simon Stevens:** As we said briefly earlier on, we have a mixed funding model as between support from public sources, support from individuals and support from the NHS. I am hesitant at this point, surrounded by Lord Lipsey, whose explosive intervention blew up the Sutherland royal commission, and Lord Warner of Dilnot fame. Obviously the expertise is represented on your side of the table rather than on mine. When you look at the experience of other countries, you can see that if we are looking for some form of insurance model it needs to be some form of social insurance model or mandatory long-term care coverage, because I think you get market failure in private insurance markets for long-term care. The experience of the Germans, the Dutch and the Japanese all points in that direction.

**Lord Warner:** Can I ask about this business of bringing money to the party from the social care side, so that I understand where you are coming from? I do not disagree with any of your analysis. The trouble is that, at the moment, the policy for integration of health and social care seems to work on an assumption that a certain amount of money can be put into the pot by the local authorities, so they have to come to the party with a couple of bottles themselves, while the approaches you are suggesting to the triple lock leaves them out of the party because it is asking the users to come to the party with a couple of bottles, is it not? They are going to buy more of this care themselves. Does it cause you problems in running an integrated health and care system if the money is shifted more to direct provision by the users of the service than by the local authority?

**Simon Stevens:** I am not arguing that there should be any diminution in the public contribution in aggregate to social care; I am simply saying that you cannot, over the medium term, answer the social care financing question separately from the pensions question, the benefits question, the equity release from housing question, given intergenerational fairness issues and the fungibility of funding streams between different elements of the public purse. I think everybody should be contributing to the fruit punch.

**Lord Mawhinney:** I hope you will forgive me if I say that I am still a little confused. We turn on the media and hear that social care is in big trouble, it is at a tipping point, the numbers of beds is down, it cannot afford to pay their staff, companies are going out of business, and the rest of it. You told us a little while ago about three big steps, which I think you mentioned three years ago, that needed to be addressed. We had five funding streams for social care in total, manifestly not

addressing the issues either from the NHS point of view or, more importantly, from the elderly care point of view. Then you helped us to understand that we have to do this; we have to get into triple locks and we have to get political agreement to change the concept of triple locks. How much time do you think there is before even you and your colleagues will say, "My goodness, there is a real crisis"?

**Simon Stevens:** Thank you for giving me the opportunity to clarify. I believe that action is needed now, which is what I meant when I said that we could put support into social care that does not require all the complicated stuff involved in redesigning Beveridge. Secondly, there are things that the NHS, with its partners in local government, should be doing over the next several years. Thirdly, post-2020, there is a debate to be had by the parties, by government, about this broader redesign of the financial support for people in old age. I think they are complementary, but there is an immediacy, as you say.

**Lord Mawhinney:** Will we still be able to sustain a viable, social care model when some of the big issues will not even start to be addressed until some time in the 2020s?

**Simon Stevens:** As I say, I think there is a very strong case for some immediate support now.

**Lord Lipsey:** I will try not to explode again, but we are in danger of getting into the same thing that caused the explosion in the royal commission. There are important issues about how you help people to pay for their social care. There are insurance models. There is my favourite, which is the adapted Dilnot model, and some people still want free care, but that has gone. Surely the most immediate, and now crisis-level, problem is that there is not enough social care. You have 26% fewer people living at home supported by local authority carers, you have 5,000 care home beds already lost in the last year and many more under threat, so you have to put people up in your hospitals more and more because there is nowhere else to go. Is that not the priority crisis that faces us over the next few years?

**Simon Stevens:** Yes, it is.

**Lord Willis of Knaresborough:** One area that we have not mentioned but which is very pertinent to the issue that you have just been discussing is this whole issue of the digital revolution and how that will assist in maintaining quality of care without always having to have physical interventions; in other words, encouraging more people to do that but with the security of being remotely accessed by secure databases. Where is that on your agenda for action? I would have thought that is something central that we need to develop. I was in St Mary's last week looking at its patient records system, which totally wipes out the need for paper within the system but more importantly can give patients there, and indeed when they go home through their GPs, the same sort of care that they would get in the most sophisticated facility. Where are we with all that?

**Simon Stevens:** I agree with you. We have a number of care homes across the country, as part of our Vanguard programme, doing exactly as you describe. Probably the most famous is the work being done with care homes in Airedale, but if you go to Gateshead you can see that the extra support that has been put into care homes there has reduced emergency admissions to hospital by around 14%. Sutton in south London is the same. We think there is a big opportunity not just to improve the support that people in care homes are getting from the NHS but to link that up to telemonitoring, which we want to try to layer into large parts of the care home sector over the next several years.

**Q282 Lord McColl of Dulwich:** My question is about preventive medicine and public health. We are in the middle of the worst epidemic for 97 years, the obesity epidemic, which as you know is causing huge increases in diabetes, dementia, heart disease, joint disease, cirrhosis of the liver, and so on. The Department of Health's contribution to this was to persistently maintain that all the calories we eat be expended on exercise, which is totally untrue. How can we get meaningful change in public health and prevention that will have a long-term effect? What is preventing progress in shifting the system towards a more preventive model?

**Simon Stevens:** I agree with your analysis about the importance of obesity. Perhaps before getting into that we can take a brief victory lap on improvements that we have seen on cardiovascular disease over the course of the last 20 or 30 years. I think people in this country would find it remarkable to hear that we have had a 44% reduction in premature deaths from cardiovascular disease over the course of the last decade, some of which of course is the result of reduced smoking rates. One of the unnoticed but most significant data points that has been published in the last few weeks is the fact that adult smoking in this country has fallen by 1 million in five years; it is down from 8 million to 7 million. That, combined with improved secondary intervention in general practice across the developed world, has meant that we have seen these massive reductions in heart attacks and strokes. That is the good news.

Set against that is the fact, as you rightly say, that we have this significant new health threat in the form of obesity, starting with childhood obesity. The well-known figure now is that when one in 10 children start primary school they are obese, and one in five children when they leave primary school are obese. Something is not working properly for our children during those early years. Obviously there is a whole set of things that we need to get right to tackle that. Some of them are things that require a regulatory response, and the Government's affirmation that they are intending to move forward with a sugar levy to drive reformulation in the soft drinks sector is welcome, together with the fact that they have set a 20% target reduction for childhood obesity, and if it becomes apparent that we are not on track for that it will be unarguable that a wider range of actions are needed.

**Lord McColl of Dulwich:** Children who are fed on whole milk for the first six years of their lives do not get obese. I do not know what all this

skimming is about, but certainly they have not yet tried to skim human breast milk because it has the same quantity of fat as cow's milk. We have a big, big problem with diet. The trouble is that the advice of the Department of Health and NICE is still persisting in the press and the media; they are still talking about diet and exercise, and exercise has very little to do with it. It is good for other things, for the heart and liver, and so on, but not for reducing obesity.

**Simon Stevens:** My reading of the evidence is the same as yours, which is that it needs to be both. We are certainly not going to deal with the pressures of obesity simply by arguing for greater exercise; we have to change dietary intake. Of course, we have had some success in reformulation with salt over the last decade or so. We have taken 15% of added salt out of our food since 2000. That has contributed to the improved hypertension and cardiovascular risk profile of the population, and on one estimate has saved the NHS £1.5 billion. Dealing with some of these broader population health risks is a key part of the medium to long-term sustainability of the NHS.

**Q283 Lord Bradley:** Can I use the issue of prevention to raise further the issue of mental health? In your five-year forward view you recognised that the cost of not dealing with mental health was around £100 billion, if I remember rightly, which is the total budget of the NHS. You have mentioned some investment in therapists in primary care and the integration of physical and mental health. What progress do you hope to make in the current five-year view to rebalance the spend between physical and mental health? In your next projection, how do you see the move towards parity of esteem between mental and physical health? What levers do you think you can apply to ensure proper integration of physical and mental health for the long-term sustainability of healthcare around the individual?

**Simon Stevens:** We will not have sorted everything out in mental health services by 2020—we have to be completely frank about that—but we do want to have made some very tangible steps in dealing with some of the obvious service gaps that exist. We have, for the first time, introduced two waiting time standards into mental health services, 25 years after we first layered them in on physical health services. We have set out a very clear implementation plan for the next four years for key services that we want to see improvement on. To take three or four examples, on perinatal mental health services, we know that about 42,000 women a year, as a result of having a baby, have a severe mental health episode, or psychotic episode. Of those 42,000 women about 12,000 are getting specialist perinatal mental health support on the NHS at the moment. We have set a highly tangible and measurable improvement goal that over the next four years all 42,000 women will be getting that support.

If you think about the fact that a number of patients in A&E departments have mental health-related problems, we know that we need to ensure community crisis response services in every part of the country, and in A&E departments to ensure that there are full liaison psychiatry services. At the moment, 8% of our A&E departments have core 24 liaison

psychiatry, the full team, seven days a week. Given the workforce and the funding, we can get that to about 50% by 2020. I could go on with a whole range of very specific things. Rather than having a philosophical debate about this, which has helped to animate the argument—I am not objecting to the philosophical debate—we now have to turn that into some very practical stuff and measure ourselves against it. We are publishing a dashboard for every part of the country to show whether we are or are not making that progress.

**The Chairman:** A quick question from Lord Scriven and Lord Kakkar, and then Lord Turnberg.

**Lord Scriven:** I have heard these words about moving from dealing with poor health to wellness and prevention for so long; I was a manager a few years after you on the same scheme. You said in July 2016 in the *Telegraph* that to move from poor health to wellness will require bold and broad reforms. What are those bold and broad reforms, particularly in the NHS when at the moment all management action is about plugging the deficit in the acute sector, and that is where the focus is? How are we going to raise the bar so that it stops being words and we achieve it for the long-term sustainability of the NHS? What are the three key planks that you are going to put in place to make sure this happens?

**Simon Stevens:** One of our first responsibilities is to our own staff. The NHS has not traditionally been a terribly good employer when it comes to looking after the health of our front-line nurses, GPs and others. NHS England is now, for the first time, funding a GP occupational and mental health service across the country that will go live everywhere from January. We have introduced quite substantial funding incentives for every hospital and employer around workplace support for MSK-related injuries, stress and other conditions that individual members of staff are experiencing, and we are trying to change hospitals and move away from a situation where they are marketing outlets for junk food into places where we have a better array of healthier and affordable food options for visitors and patients as well as for our own staff. So the first three key planks would be doing something about being a better employer when it comes to the health of our own workforce.

The second would be that in every part of the country, through the local developments proposals, the STPs—the sustainability and transformation plans that have been developed—we are looking to drive a set of actions that go beyond what the NHS by itself does and in particular engage, with variable degrees of success, with a wider array of partners, including local government, about some of the other determinants of health in a community, be it housing, schools or jobs. If you go, say, to the Manchester Health Academy in Wythenshawe you will find an academy school that is supported by Manchester City Council, with support for training for kids into disciplines that will get them into the NHS. The Manchester United Foundation is a health-promoting school. Those are the kinds of actions that are beginning to break out around the country on those broader, place-based determinants of health.

Thirdly, the key improvement has been the big improvement in life expectancy for people aged 65-plus since the mid-20th century, the 1950s, which has come about through improvements in secondary prevention managed through GPs from primary care services. All the action we take to strengthen the primary care services will also have this benefit.

**Lord Scriven:** That is all very well and good. I do not feel there is any strategic leadership in moving from what is predominantly an acute care system to a preventive system. What role are you, in NHS England, going to take that is different from the last 40 years to change how funds move within the system? That is not happening. Strategically, for the long-term sustainability of the NHS, it has to happen. It is one of the blockages. What planning is needed, and what needs to change?

**Simon Stevens:** I do not know whether you have had evidence from Duncan Selbie from Public Health England, but obviously PHE is the national agency driving exactly what you describe. The NHS contribution often, in a sense, goes beyond our narrow remit. I often make the point that the "H" in NHS is health, not healthcare. For example, we are going to be funding work with the local authorities across the West Midlands to improve mental health support into small and medium-sized businesses to prove the proposition that when you do that you get some savings on the £100 billion you were talking about as the cost of mental health. Those are the kinds of practical actions that are taking place.

**Lord Kakkar:** Do you believe that the mechanisms exist, potentially through the STPs, to incorporate the kinds of interventions that Public Health England and others might identify on a population basis to drive forward that health agenda?

**Simon Stevens:** I do not want to be Panglossian about it. Clearly, this is at the early stages of trying to bring more coherence and system leadership rather than that of individual institutions in different parts of the country. We are taking some action nationally. Again, to give you a concrete example, NHS England has chosen to fund a diabetes prevention programme for the country as a whole based on the fact that back in 2002 a well-validated RCT in the *New England Journal of Medicine* showed that lifestyle and behavioural interventions could reduce your risk of getting type 2 diabetes by up to 58%. If that was a new medicine, the pharma industry would be making sure that doctors in every industrialised country were prescribing that left, right and centre, but it was a behavioural intervention and, as a result, it went nowhere. We have taken the decision that we will fund that, run a procurement on that and 100,000 people a year are going to be getting that support. Where we see these kinds of well-validated examples that we can drive nationally, we do that. Where it requires the kinds of local partnerships that you are describing at STP level or local authorities, we will attempt that as well.

Q284 **Lord Turnberg:** We were chatting about this question a little before, but every witness we have seen, and you too, has spoken about the need for

devolution and the need for integration of NHS and social care. Greater Manchester is the example everyone cites. How generalisable is that? We have heard witnesses say that it is not. What are the problems that we have to overcome if we are going to spread that sort of thing, presuming it becomes successful?

**Simon Stevens:** I think it will be only partly generalisable, so I do not believe that it represents the new model for England. This goes back, in a sense, to our horses for courses conversation. I think there are some specific circumstances about Greater Manchester itself, about the relationships that have been able to develop and about the changes that are required. Who knows in a decade's time? Over the next three or four years I see only a minority of the country that have the prior conditions that were in place for Greater Manchester, but recognising that they were there I therefore enthusiastically backed what they are trying to do. Howard Bernstein, the outgoing chief executive of Manchester City Council, and I co-chaired the Greater Manchester Partnership Board to get this up and running over the last 18 months.

Q285 **Baroness Blackstone:** As a preamble to my question, some of the witnesses we have seen have said that the centre is too big and too top-down. You sit at the centre. People talk about 4,000 staff in NHS England and, "What the hell are they all doing?" What is your response to that?

**Simon Stevens:** It is severalfold. We have taken about 50% out of the costs of running the administrative part of the National Health Service over the last five years. By the standards of any other country, our administrative costs are very modest. However, I do not think that in itself invalidates your point. Our approach will be to lay out for each of the 44 geographies the people who are potentially available to work in their area on this other stuff, and then give them the opportunity to redeploy them on to the things that we know we need to sort out. We want to sort out early diagnosis in cancer services; we know that we want to implement the new ways of providing mental health services, as we discussed. Some of those folks need to be redeployed on to that task. Rather than a new, big bang, top-down reorganisation, which I think would have most people in the health service jumping off a cliff, we are trying to do this organically.

**Baroness Blackstone:** You are saying that you should focus more on the things that can be done only at the centre and do fewer things that can be done elsewhere. Is that how I should interpret what you have said?

**Simon Stevens:** Obviously we have been bequeathed a set of elaborate superstructure arrangements by Parliament, for which we are grateful. My basic approach here has been that collectively we should act as if the system makes sense, and then it is more likely to.

**Baroness Blackstone:** Applying that, what single plea should this Committee make in its report that would support you in your role as chief executive of NHS England on health and social care?

**Simon Stevens:** I very much appreciate the offer. I am going to decline to answer that in a way, because I know that has been a favourite question for all your witnesses. You have had such an array of evidence, including the fantastic discussion that we have had this morning, that to single out one thing would be not to do justice to the breadth of the conversation.

**Baroness Blackstone:** Very well.

**The Chairman:** I think we have given you a run for your money, so to speak.

**Simon Stevens:** Might I make one, final, historical observation, which I think is interesting, given all the debate about the fact that the NHS is said to be under huge pressure, and all the rest of it? I would like to read you a statement, if I could, from Rudolf Klein, who I think is one of the finest commenters on the National Health Service. He said: "Since its creation, the National Health Service has been in a permanent state of crisis. In the 1950s there was the drama of overspending, culminating in Bevan's resignation. In the 1960s, there was the drama of confrontation with the general practitioners. In the 1970s, the drama of confrontation with just about everybody: nurses, ward orderlies and consultants. In the 1980s, the drama of impending collapse, with large numbers of the healthcare professions abandoning the wards and operating rooms to take to the television studios to prophesy that the day of reckoning is fast approaching. The longest deathbed scene in British institutional history appears to be nearing its climax. The next instalment of the series may, who knows, even be the last?"

That was written 33 years ago. I think it is important to put one's deliberations in the historical context here. I believe that the health service has been serving the people of this country well for 70 years. I think it is getting increasingly good, it is entirely affordable and it is a net asset for the country as a whole. Thank you very much.

**The Chairman:** Left with the current funding model and the current way of developing it, it will be sustainable? Or if that changes?

**Simon Stevens:** Parliament had its first debate about the sustainability of the National Health Service in 1951 when we were spending 3% of our GDP on it.

**The Chairman:** Thank you for that. Thank you, Simon.

**Simon Stevens:** Thank you.