

Public Accounts Committee

Oral evidence: Financial Sustainability of the NHS, HC 887

Wednesday 11 Jan 2017

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Members present: Meg Hillier (Chair); Mr Richard Bacon; Philip Boswell; Chris Evans; Caroline Flint; Kevin Foster; Kwasi Kwarteng; Nigel Mills; Anne Marie Morris; John Pugh; Karin Smyth; Mrs Anne-Marie Trevelyan.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, and Robert White, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-220

Witnesses

I: Chris Hopson, Chief Executive, NHS Providers, Sarah Thompson, Chief Officer, Enfield Clinical Commissioning Group, and Rob Whiteford, Chief Finance Officer, Enfield CCG.

II: Chris Wormald, Permanent Secretary, Department of Health, David Williams, Director General, Finance and Group Operations, DoH, Simon Stevens, Chief Executive, NHS England, and Jim Mackey, Chief Executive, NHS Improvement.



Report by the Comptroller and Auditor General Financial Sustainability of the NHS (HC 785)

Examination of witnesses

Witnesses: Chris Hopson, Chief Executive, NHS Providers, Sarah Thompson, Chief Officer, Enfield Clinical Commissioning Group, and Rob Whiteford, Chief Finance Officer, Enfield CCG.

Q1 Chair: I welcome you all to the Public Accounts Committee. We are here to look at the financial sustainability of the NHS. We are working on it thanks to the National Audit Office's good Report that came out in November, but it is an issue that the Committee has looked at over a long time, particularly the last year when we had 11 Reports on the NHS, all raising concerns about long-term financial sustainability.

I welcome witnesses to our first panel. It is sometimes a bit warm in this room, so feel free to take off jackets at any time. Apparently, I have to give permission but I did not go to the sort of school that knew that. Sarah Thompson is the chief officer of Enfield Clinical Commissioning Group and she is here with Rob Whiteford, the chief finance officer of Enfield CCG. If I am right, your CCG has just gone into special measures. Is that right?

Sarah Thompson: We went into special measures in the summer of 2016.

Q2 Chair: So six months ago. We know that you are here to talk about your experience on the ground as one CCG. We recognise that you are not speaking for every CCG but we appreciate your giving up time to come here today.

We also have Chris Hopson who is the chief executive of NHS Providers. Thank you very much for your evidence, which we do not want to replay in this hearing.

As I say, we have looked at this before. We have previously discussed the £2.45 billion deficit that trusts reported in 2015-16. We are concerned about this year's budget, which will raise with our main witnesses. The ongoing financial stress will obviously have an impact on patient care so we are keen to hear from the commissioner and provider point of view how you think this situation is playing out for patient experience and whether there is a proper strategy from the Department of Health and NHS England. We had a lot of one-off measures in place to balance the budget in 2015-16, which Mr Hopson may shed some light on from the providers' point of view.

We want to look today at how the sector will be brought into balance, what plans are being tested to ensure that they are deliverable and what



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support you are getting as NHS bodies to deliver the demanding requirements from the Department.

I will start with Chris Hopson. I don't want to go into too much detail. You have given us a good briefing and we also noted the briefing you provided to Members of Parliament ahead of the urgent question in the House. Perhaps I could go to the end of that and what you highlight there. You might not have it in front of you but I'm sure you know. You talk about the NHS Five Year Forward View setting out a clear, long-term vision for the NHS but then you say, "In addition, we need" and you list some of the things needed in future. In short, do you think that the NHS has got enough money to do all of those things? And what are you asking for as well as the NHS Five Year Forward View?

Chris Hopson: No, we don't think the NHS has got all the money that it needs to deliver all—

Q3 **Chair:** Sorry, could you speak up? My hearing is not so great and the acoustics are bad in here.

Chris Hopson: No, we don't believe the NHS has all the money that it needs to deliver what it is currently being asked to deliver. Over the past six months we have said on a number of occasions that we think there is now a clear gap between the priorities and demands being placed on the NHS—a combination of 4% demand growth plus a bunch of new priorities—against a set funding envelope from the spending review, which as you know goes down from a 3.6% increase this year to much lower levels of increase over the next three years.

We think there is a gap and that we need a credible and robust plan to fill it. Without wishing to put words in the NAO's mouth, I think we would share many of the NAO's concerns that the current process does not offer that credible robust plan for the next two or three years.

Q4 **Chair:** Sarah Thompson—or either of you from the CCG point of view—what does it feel like being in charge of a CCG in special measures in the current climate? Are you getting the support and the money you need to deliver?

Sarah Thompson: As a chief officer of a CCG, I have to accept responsibility and make a commitment to staying within the available resources. It might be helpful to give you some indication of the numbers in relation to Enfield. Our forecast position to the end of March is a deficit, an overspend, of £10.9 million. We have a cumulative deficit of £41 million and that originated in 2013-14.

During the course of this year, the focus of our attention has been to ensure that those numbers form part of a financial plan that sees a way forward where we will get back into budget balance. At the moment, we see that as happening in 2018. As part of our strategy this year, we have generated £13 million in savings, and that has been through a combination of focused work in our contractual relationships with key providers and, more importantly, transformational schemes.



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For example, in Enfield we spend £38 million on prescribing in general practice. Our very skilled and able medicines management team have worked very carefully with local general practitioners, looking at benchmarked information and best practice in prescribing. Through that change in prescribing practice, with no detriment to patient care, this year they have saved £2.4 million. That is a very real and live example for us of a way in which we are trying to be very careful and systematic in our approach to service transformation, offering our public good-quality care but mindful of the importance of saving money where relevant.

Q5 Mr Bacon: Is that through the greater use of generic medicines and so on?

Sarah Thompson: It is through looking at the prescribing practice of individual GPs, yes; better use of medicines, which can be more cost-effective; and looking at alternative strategies—through a combination of those things.

Q6 Mr Bacon: When you say “better use of medicines”, just to be clear, do you mean less use of medicine, use of different medicines that are generic and do the same thing, or what?

Sarah Thompson: On an individual patient basis, working with a GP, what is in the best interests of the individual’s patient care? That may be a combination of all those elements, in terms of promoting best practice in prescribing.

Q7 Mr Bacon: The thing is, using generic, non-brand name pharmaceuticals to save money is not exactly new, so if you have managed to save £2.4 million, it raises the question in my head, “What was happening three, seven, 11, nine or four years ago that this £2.4 million that isn’t now being spent was being spent?” Why wasn’t it being done before? Over the past 10 years, that would be £24 million, wouldn’t it?

Sarah Thompson: Potentially—

Mr Bacon: Given that this is not new, why is it only happening now?

Sarah Thompson: I am trying to give you an example of the world in the Enfield of the moment, where we are working carefully with our clinicians—

Q8 Mr Bacon: I understand. My question is not about that; my question is, why is this only happening now?

Sarah Thompson: I cannot answer that historically, I am afraid. I have been in Enfield since May of last year, and I am trying to give you a real, live example of work we are doing in the field to transform—

Mr Bacon: Thank you. You have answered my question.

Q9 Chair: May I ask something before I hand over to Anne Marie Morris? First, when were you appointed to the CCG, Mr Whiteford?

Rob Whiteford: November 2014.



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Q10 **Chair:** So you were there through the last financial year.

Rob Whiteford: Yes.

Q11 **Chair:** What did it feel like from your end when the budget was being put through last year? A lot of pressure was being applied—although of course you have a legal duty—to balance. Did you face particular pressures? Did you have much contact from the Department directly about that?

Rob Whiteford: Certainly we received a great deal of support from NHS England and, in setting the budget, the history that Sarah mentioned was quite important, because in 2014-15 we were a CCG with an annual deficit of £19 million. That came down to £14 million in 2015-16 and will be, as Sarah said, £10.8 million at the end of this financial year. There has been steady progress over the past three years. We were able to agree a control total—the amount we are allowed to spend—with NHS England fairly robustly.

Q12 **Chair:** You are confident now about the figures, but what led to the deficit? Was it bad management, population change or increasing demand in particular health areas?

Rob Whiteford: More than one factor led to the deficit. CCGs are funded based on a national funding formula. For some time Enfield was materially under the amount determined by that formula, so in 2014-15 we were £24 million under the amount that formula would dictate. As a result, we have increased growth over the last two years, and that has helped us to improve our financial position.

Chair: Okay, so some historic issues there.

Q13 **Karin Smyth:** I used to work for Enfield Health Authority many years ago, so I know the patch very well. Where is that deficit? Is it mostly located in the hospitals?

Rob Whiteford: Certainly a very big proportion of that deficit was driven. When we were back in 2013-14, as I understand it we were on a series of block contracts and it did not matter how many patients went to the hospital, we paid the same amount. We then moved on to a payment-by-results system where we paid by individual patient in 2014-15, and that was when a lot of the deficit emerged—a very material part of it.

Q14 **Karin Smyth:** Where is that mainly? Is that mainly in the North Mid?

Rob Whiteford: North Middlesex and Royal Free London.

Q15 **Karin Smyth:** But you still have a lot of patients going across London for all sorts of things, don't you?

Rob Whiteford: Absolutely, we do, although those contracts are much smaller for us. By far the biggest contracts we hold are with North Middlesex and the Royal Free.

Q16 **Karin Smyth:** So the problems with those trusts have been going for



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quite a number of years. That has been a problematic area for a number of years.

Rob Whiteford: With the trusts? Sorry, could you just clarify when you said “with the trusts”?

Q17 **Karin Smyth:** I guess my point is that it is not a new situation for Enfield, is it, to have a problem with those particular trusts in terms of running a deficit?

Rob Whiteford: I think that is fair to say. It dates back to at least 2014-15, and it would have dated back earlier than that had we not been on block contracts.

Q18 **John Pugh:** Specifically on that, did the volume of patients go up when you moved from block contracts to the different method of paying by individual? Could you tell?

Rob Whiteford: The volume of patients rises every year, but I think the answer to your question is no. The number of patients did not rise because we moved from one contract type to another, but it did rise by the normal amount that we would expect to see it rise in any given year.

Q19 **John Pugh:** It was just a more expensive way of paying for the same business?

Rob Whiteford: Yes.

Q20 **Karin Smyth:** Those trusts will be quite tightly supported by NHS Improvement to come within their own totals. And you are being supported now by NHS England to get yourselves out of special measures—is that right?

Sarah Thompson: That is correct, yes.

Q21 **Karin Smyth:** How do you feel the conversations are going in the field in terms of the support that is being given to the trust and the support that is being given to you? Is that aligned at a national and local level?

Sarah Thompson: It is important to say that it needs to be aligned, and we do try extremely hard. An example would be: we have just completed a set of negotiations to complete our contracts for the next two years and that has required the coming together of both regulators, the providers and ourselves. We have achieved agreement for the next two-year period.

So I think that is probably a real example of the need to work together. It has not always been easy—there have been tensions, inevitably, and I wouldn’t pretend otherwise—but the outcome has been good for the system in terms of delivering agreed positions.

Q22 **Karin Smyth:** You said that it needs to be aligned.

Sarah Thompson: It does.

Q23 **Karin Smyth:** Is it aligned?



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Sarah Thompson: It is. We come together, and there is that example of the need to work together on contracts. As issues come up, it needs to be aligned and we spend time getting that alignment. Those conversations, as I have revealed, are complex and difficult.

Q24 **Karin Smyth:** You are being very careful—I appreciate your problem. Mr Hopson, would you like to get to the nub of my question?

Chris Hopson: I think the experience of our members on the ground would be that the alignment between NHS England and NHS Improvement is better, but I think we would all agree—I suspect that NHS England and NHS Improvement would agree—that it needs to be even better. So let's not talk about this contract but go back one contract round. A number of our members reported that, as the financial pressure grows, what happens is, quite understandably, CCGs come under a lot of pressure from NHS England to negotiate hard on the contracting side. And then, needless to say, NHS Improvement are suggesting to our members that they should not accept a contract which does not enable them to meet their control total.

Certainly, a number of our members have reported that actually there ends up on occasions—there have been in the past—problems where effectively both sides are under pressure from their respective oversight bodies and it can get quite difficult. But, to be fair, I do think the situation is getting better, and certainly on this year's contracting round I would argue that NHS England and NHS Improvement have worked more effectively together. But as soon as you have the underlying tension of there not being enough money in the system, you do really risk this provider-commissioner split and the negotiation really becoming quite fraught, because both have been given very stretching control totals that, in a sense, you can only realise at the expense of the other. That is again partly why the move to sustainability and transformation plans, where we are planning as a whole system, does over time offer the ability to allocate the money across a whole system so that, in a sense, you do not waste a whole lot of friction time contracting, with commissioners and providers arm wrestling.

Q25 **Karin Smyth:** In terms of the STPs resolving that problem of two different masters, what time limit would you put on them actually being able to deliver?

Chris Hopson: I think the sustainability and transformation planning process is trying to do two things. First, it is trying to set out a path in each local area to deliver the transformation that was set out in the Five Year Forward View. The second task that has been given, which I think is an extremely difficult one, is—we know that because the NHS funding increases are slowing down, each STP area has been given a very stretching 2020-21 financial target to meet. To be frank, the feedback from our members is that they are finding it very difficult to identify how they can meet that very stretching target.

Q26 **Karin Smyth:** By 2021?



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Chris Hopson: In terms of meeting a very stretching financial target for the end of the spending review envelope, effectively. We know that first draft plans were submitted in October or November. Our members have fed back that very few, if any, feel that they have a credible, robust, rigorous plan that sets out how they will meet that very stretching financial target. Our view is that that STP process will probably need to carry on for at least another three or four months until we can get some genuinely robust, rigorous and credible plans to close that financial gap. But in a sense, the STPs are just a localised reflection of the gap that we have at the national level, so you might argue that effectively, all we have done is parcelled up a national gap and asked a whole bunch of local systems—44 systems—to try to come up with a local answer to their share of the national gap. Not entirely surprisingly, it is proving to be a very difficult task.

Q27 **Anne Marie Morris:** The STPs are clearly seen by us all, I think, as conceptually a good idea and something that ultimately should bring the different systems together across a geography, but you have already indicated some of the real challenges that that gives rise to. Let us look at the CCGs and your CETs, particularly given that you are both in special measures. If we can start with Mr Whiteford, do you feel that the plan you now have is credible and deliverable and that you have—or will have—the working relationships with the different parts of the health economy to actually deliver on time and within budget?

Rob Whiteford: My view is that it is entirely possible that we will achieve our plan. I phrase it that way because the money follows what happens on the ground, and for the money to turn around, we need the service transformation to happen as it is laid out in the sustainability and transformation plans. That is the reason I have answered you in that way. If those service changes occur, yes, the plans are realistic and credible.

Q28 **Anne Marie Morris:** But how realistic is it, and what work do you see NHS England doing to enable you to make those transformations? My concern is that much of the work that is being done on the new models of care isn't being shared. If it is not shared, how can you work that into your plan? Your "if" becomes a very large question mark, because the assumption you have made is that someone is going to come up with a solution to this problem and you will be able simply to bring it in and use it. Is that realistic?

Rob Whiteford: I am not in a position to judge the entire viability of the sustainability and transformation plan, but what I can say to you is that there is a sustainability and transformation plan with a set-out timetable. It requires investment of £100 million across north central London. As Chris mentioned, bringing everyone together into the same system helps us generate that investment. One of the biggest impacts of our financial position in Enfield is that we have had very little money to invest in primary care and community services. Bringing it together as one system through the STP will allow us more flexibility to generate that investment. What I am not in a position to do is exercise an opinion on how likely the service transformation schemes are to deliver. I cannot do that.



- Q29 **Anne Marie Morris:** All right, but the bottom line is therefore that you are relying on something to happen that hasn't happened yet: these new models of care that will enable you to move forward.

Rob Whiteford: That's true.

- Q30 **Anne Marie Morris:** Therefore, my conclusion is that there is a very significant question mark. Do you believe that this plan is bought into by all parties and something that everyone is really up for, or do you feel, by contrast, that the Government have said, "You will do it or you won't get any money," and there is therefore a nice piece of paper but no real buy-in?

Rob Whiteford: In the north central London health community, everyone has bought into it. We effectively operate with one budget now. There is one control total, one budget for north central London. Everyone has the same vested interest in ensuring that that delivers.

- Q31 **Anne Marie Morris:** Do you have any idea how you are going to be held to account? Have any performance indicators been mentioned to you? Because, clearly, you are going to have to deliver on that plan and report back fairly regularly. Has any of that been discussed?

Rob Whiteford: The CCG has a fairly comprehensive performance framework that we are monitored under at the moment. I agree with your point. To some extent, we are less than clear about how that would be monitored under an STP-wide system.

- Q32 **Anne Marie Morris:** Perhaps I could ask you, Ms Thompson, whether your experience is similar. In a way, Mr Whiteford has the benefit of this shared budget. You are one of the few in my experience of talking to CCGs and STP groups together. How do you feel with regard to your STP? Do you feel that it is credible, doable, deliverable and that your stakeholders are together and ad idem in the ability to deliver it?

Sarah Thompson: I am here to speak in large part for Enfield, as chief officer for Enfield, and we contribute to the STP in north central London. I can absolutely say that the agenda of transformation we are leading in Enfield is in large part echoed and replicated across the STP. There are benefits from that work for us. Our performance that has just been described is measured regularly on a monthly basis by NHS England because we are in special measures.

We have monthly performance meetings. I would say that the rigour and scrutiny within which Enfield must secure its recovery in the context of the wider STP is very much part of our business as usual. It is the way in which we operate. So I think the answer to your question is that I accept responsibility for delivery of financial balance in Enfield within the context of the wider work and wider work streams of transformation that will happen through the STP in the forthcoming period.

- Q33 **Anne Marie Morris:** Do you have any specific transition funding? One of



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my concerns is that we have these STP plans, we know how we are currently working and how we want to work in future but we have to get from A to B. There is the issue about money, if you like, to enable double running. That is not the same thing as transformation money because that is money to enable the project to be delivered. There is this double running. Has that been accounted for in your plan?

Sarah Thompson: No, at the moment we have to chart our course in Enfield of transformation within the available resources that we have.

Q34 **Anne Marie Morris:** Do you believe that is deliverable? Because if you move from system A to system B, is it realistic not to have double running?

Sarah Thompson: In an ideal world, if there was an opportunity, of course it would be very helpful to have seed funding to do exactly as you described but it is a given for us at the moment that we must take forward the various schemes of transformation within our available resources. We do that through business cases that have to evidence and quantify the change and the shift that will occur in financial terms. It is a very rigorous process that I have described.

Q35 **Chair:** Mr Hopson, do you want to comment on that point?

Chris Hopson: I thought that the NAO Report really brought out at a national level some of the real challenges of the process. If you talk to our members, and listen here, it is many of the same issues. The issues that the STPs are grappling with are, "Can we really reduce the acute demand to the degree to which we need to? Can we get the new care models in place sufficiently fast enough? Is primary and social care robust enough to move the care out of the hospital closer to home? Are there sufficient investment funds at a point when we are raiding the capital budget effectively to ensure we deliver the revenue to make the very significant amount of investment that is needed?" I think the capex one is a good example of where we are currently in an unsustainable position. We know that we have got a whole bunch of issues. A good example would be St George's where we know there is a series of issues.

Chair: St George's, Tooting, south London.

Chris Hopson: Yes, St George's, Tooting, where there has been a series of issues highlighted in a CQC report around the fact that we need investment in the operating theatres and we have not been able to make the investment that we needed. What we've got is a whole bunch of different calls on capex, ranging from the need for up-to-date maintenance to keep facilities up to date, investing in the new technology that we absolutely need, but at the same time also investing in those new care models, yet here we are with a capital budget that is much lower than what we asked for. We are already taking a quarter of it to basically prop up revenue. All I am saying is that doesn't seem to me to describe a particularly sustainable way of running our national health service. I really thought the NAO identified a whole bunch of those issues at a national



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level, but they are absolutely playing out at a local level. STPs are a reflection of what is going on nationally.

- Q36 **Karin Smyth:** I just want to go back to Miss Thompson. You said that one of your priority areas needed to be around primary care. The plan has £2.4 billion aligned to supporting primary care, so that we can lessen the reliance on hospitals. Have you seen that money feed through into your budgets at Enfield?

Sarah Thompson: We have most recently, because we've had national funding to develop hubs that offer our public access to services on weekends and bank holidays through until 8 o'clock in the evening. Before Christmas, we launched our first hub in south-east Enfield. The remaining three will be opened later this month.

- Q37 **Karin Smyth:** Are they additional to your current practices?

Sarah Thompson: Absolutely.

- Q38 **Karin Smyth:** How is that transforming your existing practices into a new way of working? Is it able to do that, or are you putting new services in place?

Sarah Thompson: The way we approached it was to invite our general practitioners and practices in Enfield to come forward on a lead practice arrangement. It was done through a procurement, so it is local Enfield GPs who have responded to that. They are leading in the development of those services on a locality basis. That feels absolutely right and proper for the public that we serve.

We are now looking daily at how those services are being utilised. As you may know, we are lucky enough in Enfield and Edmonton to have a walk-in service as well. Clearly, given the pressures that we know our hospitals are experiencing at the moment, people like myself look daily at the utilisation that has been made of our walk-in services and our hub services, because we want to make sure that our public have a range of opportunities to access healthcare.

- Q39 **Karin Smyth:** Is that reducing demand at the hospital?

Sarah Thompson: Because our hub opened in early December, I don't think we can make that relationship at the moment. What we are seeking to understand and look at is where the patients who use those services are coming from. We really need to gain a greater knowledge, understanding and analysis to see those links.

- Q40 **Karin Smyth:** Are you not in danger of opening up more roads and creating more traffic? Or are you able to align to see whether there is less pressure now on your two main hospitals because of that increased support?

Sarah Thompson: It is a fair challenge. You obviously know the locality well; North Middlesex hospital is under pressure. We also know that 140 people accessed our walk-in services over the last weekend.¹ We need to



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be able to respond to those demands at this time and look carefully at how we need to structure those in the longer term, to make sure that only those patients who really need to go to our hospitals are there.

We are also lucky enough to have a “see, treat and direct” function that is offered by general practitioners on the front door of North Middlesex hospital. We are trying very hard to work collaboratively with our local provider, and are looking at every opportunity to respond to our public’s needs.

Q41 Karin Smyth: How long is that front end in place for?

Sarah Thompson: “See, treat and direct” has been on since about April 2016; it slightly predates my joining Enfield. Let me just check with Rob.

Rob Whiteford: That is correct.

Q42 Karin Smyth: Has that reduced admissions to hospital?

Sarah Thompson: It has. We are happy to follow up with details to evidence the impact it has had on redirecting patients, either because they are seen and treated there and then—they are redirected alternatively to primary care—or it may be that they can return home. There are a variety of alternatives.

Q43 John Pugh: Is there a coercive element in this? You give the impression that everybody is buying into this, but clearly, if you are transforming and reconfiguring services, there are going to be winners and losers. People will not provide services from certain centres that they previously did, and things will be done differently with varying degrees of willingness.

Mr Whiteford, you said that you are working to one controlled total. That is clearly the stick in this, isn’t it? You do not get the money unless you come up with something that is doable. I just wanted a frank acknowledgement from you as to whether there is an element of duress in this, and that some of the providers, or the CCGs within the framework for that matter, are less than happy with how things are panning out.

Rob Whiteford: I can only speak for Enfield. I don’t have a sense of how a wider range of providers or the NHS health community would view it. From the Enfield perspective, our position is improving, and I think our plan is fairly solid.

Q44 John Pugh: So there is a happy, collaborative atmosphere in Enfield?

Rob Whiteford: I think there has been a happy, collaborative atmosphere, yes.

Sarah Thompson: It is not easy at all. I would say it is complex. It is all about trust and relationships, critically, with our providers in our local

¹ Clarification from witness: “140 people accessed the Edmonton walk-in service in Enfield. We can confirm that the figures were: Saturday 7 January – 139, Sunday 8 January – 110.”



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authority. But we are now seeing grip, and we have a plan to deliver financial balance in 2018.

Q45 **Chair:** Do you have a chair of your STP?

Sarah Thompson: We have a convenor, who is Sir David Sloman, the chief executive of the Royal Free London.

Q46 **Chair:** How was he appointed as convenor? We might pursue this with Mr Hopson.

Sarah Thompson: That is not something I can comment on, I'm afraid.

Chair: That is an interesting point. We thought as much. Mr Hopson, on the same point.

Chris Hopson: The experience, I think it is fair to say, of the STP process is that, by definition, it will vary. We are very strong supporters of the process. We think it is a really important process to bring your local communities together. It is fair to say that some of them are perhaps more natural fits than others.

In terms of how the work is then developed, every single member I have spoken to has said they feel they have really benefited from the degree of collaboration that the process has involved. Clearly, if you are making very tough and difficult decisions and choices that may have negative impacts on people, there are bound to be some communities where it will be difficult to strike the agreement.

The reason why I smiled about the appointment process is that there is no doubt—to be fair, in the vast majority of places, the convenor emerged with a degree of happiness and satisfaction from the players. In a small number of the STP footprints, there was a feeling that a convenor was imposed from above upon them by our colleagues in the arm's length bodies, but we got over that. We have made the process work. If we are honest, there will be some places where it is difficult to see the STP plan and process in its current form absolutely reaching the required destination, partly because in some places the footprints are so artificial.

If the key exam question, which is the one I think we are asking here, is, "Where's the rigorous, robust plan for the next three years to ensure the NHS is sustainable in a way that delivers services within the required financial envelope?" we have to have some kind of planning process and, in a sense, we have to make the STP process work. At the moment, we are, in the vast majority of places, quite a long way off from having a robust, reliable, rigorous and credible plan.

Q47 **Anne Marie Morris:** I have a final question to each of you. What is the biggest risk to the STPs, in terms of them going off the rails?

Chris Hopson: I think the biggest risk to the STPs is the danger they have been asked an impossible question, which effectively is, "How do you deliver the current full range of services and all the priorities within a financial envelope that is quite simply impossible to meet?" You will have



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seen from our submission that we are now very clear that we have reached the point in the NHS where we can no longer deliver everything being asked of the NHS. If the Government has fixed the money—the Chancellor said very clearly in his autumn statement that he was not going to change the spending envelope for the rest of the Parliament—the NHS has to ask the really difficult question of what it is not going to do to meet the financial envelope.

I echo the real concern that the planning process we have at the moment is making some assumptions, like demand management. For example, the starting point is actually worse than is currently assumed in terms of the size of the provider deficit. It is making assumptions about the speed with which we can make the transfer to new care models. As you have seen from our submission, we need a proper, rigorous, robust process that is based on a proper set of assumptions and which, if the money is fixed, asks the question, “What are we not going to do?” We cannot carry on pretending that we can do everything in the financial envelope we have. It is just not possible.

Anne Marie Morris: Right. Can we have a quick word from Ms Thompson?

Sarah Thompson: I am here for Enfield, and the biggest contribution we can make to the north central London STP is for Enfield to get back into financial balance.

Q48 **Anne Marie Morris:** The question is, what is the biggest risk to the STPs?

Sarah Thompson: I cannot really comment on the biggest risk to the STP because my contribution—the reason I am here—is to ensure Enfield makes its contribution to the STP.

Q49 **Chair:** A final question from me. We have talked a lot about systems, initials, Sustainability and Transformation Plans—STPs—but what about patients? What is your biggest concern about what the current state of finances will mean to patients? Secondly, what is your biggest concern, as we approach 11 weeks off the end of this financial year, about pressures on your budget?

Sarah Thompson: As chief officer of a CCG, my first concern is always about patient care and safety. As a commissioning organisation, we always need to be assured that in our governance, our relationships with our key providers, our ways of working, we follow up any difficulties in relation to patient care. That is where I would—

Q50 **Chair:** So do you have any concerns as we approach the end of this financial year?

Sarah Thompson: Not of a financially driven nature. You asked about my greatest concern; that is my concern: to ensure patient care and safety is always complied with.

Chris Hopson: My greatest concern is if we carry on on the current trajectory with this kind of decline in performance and increasing risk. I



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don't wish to sound dramatic because I don't think it is appropriate. You may have seen me try to be very under-dramatic in the way we have talked about A&E.

I think the biggest concern, to be frank, is if we carry on on the current trajectory, we begin to bring into question the entire sustainability of the NHS model. I'll give you an example. We have a quarterly meeting with our trust chairs and chief executives. We had 130 of them in a meeting in December, and for the first time in four years we had a serious conversation about the point at which public confidence in the NHS model of care—delivered free at the point of use based on clinical need, not ability to pay—comes into question.

I am not saying that is now, but if we carry on on this current trajectory, my nervousness is that public confidence in the NHS really seriously does come into question. As somebody who is deeply committed to the NHS, I have to say that that is a source of worry. What we are doing at the moment is not sustainable.

- Q51 **Chair:** This is a difficult question to ask because you are representing all NHS providers. Is there any particular area of patient care or treatment that you are picking up from your members as being particularly under threat? Obviously there are pressures in A&E, and that gets acute in the winter. Is there any particular area that leaps out?

Chris Hopson: Given where we currently are, it is difficult not to answer anything other than that we would clearly be very concerned about A&E. The point we have made is that as the pressure ratchets up, we are finding that there are certain systems where their resilience has been worn away. What happens is that you get a flood of patients and then you are looking at very precipitate drops in performance, which genuinely are a significantly increased risk.

Because we have a great bunch of managers and because NHS Improvement is doing a grand job—a much better job in our view of what Monitor used to do in terms of supporting our trusts—then management action kicks in. All I am saying is that, with what we are seeing in A&E departments, we definitely have a significantly enhanced risk. So it would be A&Es where we would particularly point to.

- Q52 **Chair:** This is my final point to you, because you are here representing providers. I won't recap because I'm sure you know the figures. They are very neatly laid out in paragraph 1.11 on page 18 of the NAO Report. It talks about the projection on the deficit for this year. As a representative of NHS Providers, have you got a rough idea of the percentage of your members who will not be able to balance their budgets this year?

Chris Hopson: The better number I can give you is our relative confidence about what the overall aggregate number will be. Again, we think NHS Improvement developed a good, strong plan, which our members are working to. There is a target of minus £580 million. My guess is that we are probably heading to about minus £650 million or



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£700 million, but please do not underestimate how much effort is being put into that.

As we put in our paper submission, there is quite a lot of risk to that, but you can have confidence that there is a robust plan in place effectively to stem the rapidly growing tide of deficits. We think the tide will turn, but the question we asked is, how sustainable is that long-term?

Q53 Chair: Because there were a lot of one-off measures in the last budget, of course.

We could go into this a lot more—thank you very much for your time—but we need to get on to your paymasters, in effect, if that is the right phrase. You are very welcome to stay for the rest of the hearing. Our transcript of this hearing will be available on the website in the next couple of days, but you will obviously be sent a copy. I am not sure exactly when our Report will be out, but we will send you a copy of that as well.

Examination of witnesses

Witnesses: Chris Wormald, Permanent Secretary, Department of Health, David Williams, Director General, Finance and Group Operations, DoH, Simon Stevens, Chief Executive, NHS England, and Jim Mackey, Chief Executive, NHS Improvement.

Q54 Chair: Welcome. I do not think that I need to repeat to most of you, because you have heard it before, how much we as a Committee are concerned about the long-term financial sustainability of the NHS. Our 11 Reports last year underlined some of the concerns, and this Report from the NAO brings together a lot of the concerns that we have with a lot of data underpinning them.

I am pleased to welcome our witnesses for the second half of our session: David Williams, the director general for finance and group operations at the Department of Health—welcome back, Mr Williams—Chris Wormald, the permanent secretary at the Department of Health; Simon Stevens, the chief executive of NHS England; and Jim Mackey, the chief executive of NHS Improvement. For anyone following, the Twitter hashtag this afternoon is #NHSfinance—very imaginative. Welcome back all of you, our frequent flyers at the Committee. We are sometimes called the second Health Select Committee.

Can I start with you, Mr Stevens? We heard very clearly from Mr Hopson—I don't think that you were in the room, so I will repeat roughly what he said, and forgive me that it is not an exact quote—that there is not enough money in the system; there is a clear gap. He also said that the NHS can no longer deliver everything that has been asked of it. The Government are repeatedly telling us—I have recently had letters from the Secretary of State—that the NHS is getting more money that it asks



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for. What is your view on that?

Simon Stevens: It is right that by 2020 NHS England will be getting an extra £10 billion over the course of six years. I don't think that is the same as saying we are getting more than we asked for over five years, because it was a Five Year Forward View and not a six year forward view. Over and above that, we have obviously had a spending review negotiation in the meantime, and that has set the NHS budget for the next three years. It is a matter of fact—it is not news, and I said it previously to the Select Committee back in October—that, like probably every part of the public service, we got less than we asked for in that process. So I think it would be stretching it to say that the NHS has got more than it has asked for.

Q55 **Chair:** Would you agree with Mr Hopson that there is not enough money and there is a clear gap?

Simon Stevens: There are clearly substantial pressures. I do not think that it helps anybody to try to pretend that there are not, but that is not a new phenomenon, to some extent. It is a phenomenon that is intensifying. I think that we were fortunate to get the front-loaded funding increases for this year that we said were needed to kick-start the broader change process. Had we not done that, we would not be in a position where we are on track to cut the hospital deficit by two thirds this year and also make a start on some of the improvements that we need to see on cancer and mental health services. However, I believe that there are some very genuine choices to be made across the NHS and there is a circle to be squared. I think that is right.

Q56 **Chair:** Okay. We will perhaps come back to choices—what can be offered—later, but that is not the main focus of our session today and we have covered that ground a bit before. Mr Wormald, do you think that there is not enough money and that there is a clear gap?

Chris Wormald: I agree with what Simon has said—unsurprisingly, as we discuss these issues all the time. The Government put in to the NHS pretty much exactly what they said they would put in as part of their manifesto. That was of course, in the way that Simon described, negotiated through the spending review. Not everyone gets exactly what they ask for, but over the period we put in the amount of money that we said we would, and we believe that the Five Year Forward View is deliverable—

Q57 **Chair:** So you are saying it got what it asked for but not more than what it asked for.

Chris Wormald: The statements made around that are simply making the point that the NHS, compared with other services, got an extra year of settlement and £2 billion in that year, so I do not think there is any contradiction in anything that anyone is saying here. Anyway, it is slightly irrelevant. The cash sums we are putting into the NHS are set out very clearly in the spending review. Anyone can look at them and take their own view. Our challenge as public officials is, how do you deliver the best



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health service you can for those cash sums? Certainly that is what we are all focused on.

Q58 **Chair:** Cash sums are all very well, but when you have got cash sums going in but demand increasing at a higher rate, that is a challenge.

Chris Wormald: Yes, of course it is. I am sure we will discuss this throughout the hearing. The pre-panel witnesses set out both the challenges and some of the opportunities for efficiencies and savings very clearly. They brought out that there are things that we can do here. I think it speaks for all of us on this side of the table. It is the Government's position that this is a very challenging time, but there are things that we can do. The local examples you were given actually set out the challenges very well.

Q59 **Chair:** We know what happened with the budget, which was laid before Parliament on 21 July last year. How confident are you that you will balance the budget?

Chris Wormald: We expect to hit DEL—

Chair: Sorry, explain the acronym, because not everybody listening will understand.

Chris Wormald: Our departmental expenditure limit. It is the amount of money we are given by the Treasury and that Parliament votes for us. Like all Departments we expect to hit it. I will not predict an exact number. For people doing financial and economic forecasts recently, it has not been going well for them, so I will not join the club. In a system in which we spend over £300 million a day on the health system, we work on very fine margins and comparatively small changes can have quite big effects, but we are aiming to hit DEL.

Q60 **Chair:** You said on 7 September, when we spoke to you about this before, that you agreed with the Comptroller and Auditor General that "the kind of one-off measures that were necessary this year to bring us within the parliamentary control total is not a sustainable way forward." So you are confident that you will be within budget.

Chris Wormald: I mean exactly what I say. What we are aiming for, and what was set out in the financial reset that my colleagues in NHSE and NHSI set out, is to substantially reduce the provider deficit through a series of measures on financial rigour led by NHSI, and to cover that deficit by a contingency held by NHSE. We want to balance the budget on that basis. The quarter 2 figures, the last published figures that we have given, give us encouragement that that process is working. If we deliver those objectives across the year, we will have balanced the NHS budget without excluding any one-off measures. Of course, there are always one-off measures going in both directions in all sets of accounts, but our plan is to balance the NHS budget in the way set out in the 21 July document.

Q61 **Chair:** So you are not excluding one-off measures.



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Chris Wormald: As I say, there are always one-off measures in accounts for perfectly valid reasons. I am saying that our objective is to balance the NHS budget in the way that I have described.

- Q62 **Chair:** Okay. I am not sure which of the three of you to ask—perhaps Simon Stevens and maybe David Williams. There is this 1% reserve that commissioning groups are holding on to. They have been asked to hold that. Will that be something that you are likely to claw back into the centre, Mr Williams, to make sure the books balance?

David Williams: I am not expecting to rely on that to balance the overall group position. What we are looking for is for NHSE and commissioning groups locally to maintain that reserve to balance in the first instance NHS provider deficits. That is my perspective.

Simon Stevens: David is obviously right technically, but I think the spirit of the question is: are we going to have to underspend £800 million in order to offset pressures in hospitals and elsewhere? The answer is yes, we are. We are planning on the basis that that is what is going to have to happen. Last year we did the same to the tune of £599 million; the year before we did £285 million. The reason David is right is that when the accounts aggregate to the Department of Health, he is not clawing something back, but CCGs have been asked to create and manage an underspend of £800 million this year.

- Q63 **Chair:** The buffer has basically been created locally to bail out providers locally.

Simon Stevens: It's planned. I wouldn't say it is a bail-out.

Chair: It feels like a bail-out to us.

Simon Stevens: It was implied in the reset document in July. What it means, however, is that that is £800 million not available to put in place the alternative services, the primary care services, the community services that one might have wanted to try to offset some of the demand. That is the pragmatic judgment we took in July, given all the pressures facing the system.

Chris Wormald: The basics of the reset plan were to get the deficit in the previous year, which as you know was £2.45 billion, down to about £600 million. That will be a significant achievement and will have shown that providers have really got to grips with the issue. That £600 million still has to be covered; it is still a deficit. In the year we are in, we are looking to make substantial progress towards getting back to the situation we want to be in.

- Q64 **Chair:** You are making substantial progress, but the quarter 1 deficit includes £450 million of sustainability funding. This is on page 18, paragraph 1.11, where it is laid out very clearly. Without that funding the deficit would have been £911 million, which compares with £930 million for the equivalent quarter in 2015-16. It is not as good as it is painted.



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Chris Wormald: I think we have always been clear that the extra investment is an important part of what we are doing. As has been described, the health service as well as all that—

Q65 **Chair:** You say extra investment. You are saying that the sustainability funding is extra. Let's be clear.

Chris Wormald: That is part of the front-loaded increase that Mr Stevens was describing.

Q66 **Chair:** Let's be clear about which extra we are talking about. It is not extra extra on top of this.

Chris Wormald: No, this is all part of the spending review.

Simon Stevens: This is the case that, frankly, we made—I made—for 2016-17. I think these pressures in hospitals are legitimate and real; they are not because hospitals or staff are being feckless. There are huge pressures there, and therefore it needs to be funded. That's the reason we needed a front-loaded funding settlement for 2016-17, and that is the reason why, when we got it, our case had been heard for 2016-17. I think that is right.

Q67 **Chair:** Mr Mackey, you have been quite robust in the past about hospitals managing their own deficit. Some trusts have been allowed to get their deficits exceeding 5% of their income. Why has that happened, and what are you doing about it?

Jim Mackey: The financial position deteriorated over a period of about five years.

Q68 **Chair:** Because of the 4% efficiency savings, as you are on record as saying.

Jim Mackey: Very few organisations created a very large problem quickly; most of them had been doing it for a few years. The purpose of the reset was to say, "This has got to stop now. Let's start eating into it." The work we have done with those organisations that went into special measures, for example, has been really effective in addressing that.

By the end of this year, we are expecting just over half of organisations to be in surplus again, versus 30%-odd last year, to make further progress next year and, if it is possible in the two-year planning process, to get 2018-19 to the 2013-14 levels of deficit, in terms of the numbers of organisations.

Q69 **Chair:** This must be very disappointing for you. You came to take on the role at NHS Improvement 18 months or two years ago.

Jim Mackey: November 2015.

Simon Stevens: Dog years.

Chair: It must seem like a lot longer for you. To try to do all these improvements while dealing with what are now effectively structural



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deficits—because of that 4% efficiency that was imposed—doesn't that put the improvement agenda on the back foot? In effect, you are just chasing the financial agenda to the detriment of the improvement and transformation that you were brought in to try to deliver.

Jim Mackey: I wish we were able to spend all of our time on real clinical improvement. There is an awful lot of that going on out in the service. One of the dangers at the moment is that everybody gets fixated on the money and the A&E crisis.

Everywhere you go in the NHS you see fantastic improvement activities. Often you are in an institution that actually has international standing, or at least national standing, in the clinical activities going on.

I was in Liverpool yesterday. They had the worst day in their history on Monday in A&E, and have lots of financial challenges, but I met some fantastically impressive clinicians doing amazing things. There is a real danger that we oversimplify this. I also very strongly believe that organisations will always struggle to improve if they have lost control of the money. It is part of managing the system. It is not money versus quality. All these things have to work together.

Chris Wormald: Yes. I was going to add that the Enfield CCG examples of how you bring yourself back to financial rigour by doing quality better were very clear. When we look at the hospitals with the highest CQC ratings on quality—the National Audit Office referred to this—they are also the ones with the lowest deficits.

Chair: The correlation is very clear.

Chris Wormald: Quality management and financial management go together.

Q70 Philip Boswell: Just a quick question to Mr Stevens and Mr Wormald on sustainability. The Health Select Committee report states that extra funding for Department of Health responsibilities is increasing by £4.5 billion and not the £10 billion as stated. Now, £10 billion, £8 billion, £4.5 billion, definition, duration—can you explain what those figures are? If it is £4.5 billion, what impact will that have on the improvement agenda?

Chris Wormald: The difference between those numbers—in a way, this is much simpler than it appears—is that the £10 billion refers to the NHS budget. The commitment in the governing party's manifesto was extra money for the NHS. The resources that the Department of Health have that are outside the NHS need to make their contribution to austerity measures in exactly the same way as every other Government Department does. That is not dissimilar from the situation that I had in my previous Department—the Department for Education—where the schools budget was protected but not the wider education budget.

As I said, the governing party's manifesto was very clear that it was the NHS budget that the commitment related to, so the NHS budget is going up by £10 billion in real terms. If you look at the wider health budget,



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including that outside the ring fence, you get some of the numbers that you were describing, so the numbers are not in contradiction at all. The Government, as I said, have been very clear about what their commitment was.

Simon Stevens: Yes, I think the Health Select Committee has forensically dissected that very effectively. Dr Wollaston has set out, in easy to understand terms, the difference between those numbers. To some extent the debate about 2020-this and 2020-that misses the point, actually, which is that in the here and now there are very real pressures. Over the next three years, funding is going to be highly constrained, and in 2018-19, as I previously said in October, real-terms NHS spending per person in England is going to go down, 10 years after Lehman Brothers and austerity began. We all understand why that is, but let us not pretend that that is not placing huge pressure on the service.

Q71 **Philip Boswell:** So is it misleading to say it is £10 billion, or are you getting £10 billion?

Simon Stevens: If you are clear about what you mean when you say each of these numbers, it is not misleading, but if you conflate or gloss them together, that would, indeed, not do what the Health Select Committee recommended.

Chris Wormald: Yes. As I say, it was very clear in the governing party's manifesto what it meant. I think all Government statements have made it clear that it is the NHS that we are referring to when we describe the £10 billion.

Q72 **Chair:** But as you say, within the system, money is being moved from one place to another. You could say that we are robbing Peter to pay Paul—taking money out of public health to put it in other places and setting up special funds such as the better care fund.

Chris Wormald: As I say, outside the ring fence for the NHS, health budgets make their contribution to the Government's austerity agenda.

Q73 **Chair:** Yes, so you are robbing Peter to pay Paul. You can't say that, because you are the permanent secretary, but I think that is what is happening. Public health, which is preventive work for long-term planning, is being denuded to bail out trusts and other providers in the short term.

Chris Wormald: No. We are making our contribution to austerity like every other public budget is.

Q74 **Chair:** Mr Stevens, would you like to comment on that before I bring in Mr Evans?

Simon Stevens: Parts of the offsets that were made on the broader DH budget are a result of policy changes, and they won't have a direct impact on frontline services. There are others where clearly there are bigger concerns. Sustaining preventive services that are now commissioned by local authorities is obviously one of them. No doubt we will come on to



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talking about social care. The original proposition in the Five Year Forward View was that we would need to expand capital investment. In practice, unfortunately, we have to cut it by about £1 billion a year and transfer that—

- Q75 **Chair:** We are going to come on to that. Before I bring in Mr Evans, Mr Wormald, the cash reserves of trusts are dwindling. Mr Stevens just highlighted the issue of capital funding. It was turned into a resource, so there has been a reduction in capital spending. This is all causing hidden stresses on the system that are going to come to fruition down the line. Doesn't that worry you as an accounting officer?

Chris Wormald: If I may—

Chair: Mr Williams, does not that worry you as a finance officer?

David Williams: I think the reduction in cash reserves is a symptom of the underlying problem rather than a different one. The underlying problem is that the costs to NHS providers of delivering their services are higher than the income that they are generating through that activity, but they still need to find sufficient cash to cover the cost, to meet their payroll, to pay suppliers; and where that income is insufficient, either they need to draw down on cash reserves, where they have been able to build those up in previous years—and that is what the reserves are for—or they need to borrow cash from the Department. So I would describe it as another symptom of—

- Q76 **Chair:** But it is not sustainable, is it? It is a symptom, but it is not sustainable, because you can't keep drawing down on the reserves and reducing capital expenditure year on year. You are storing up problems for sustaining it.

David Williams: No, for sustainable operation of the system you would want to have a level of cash reserve in individual organisations just to keep the—

- Q77 **Chair:** Aren't you concerned that the cash reserves are dwindling at such a rate?

David Williams: I am not surprised that they are reducing. I would not want them to reduce substantially further than I think they will be by the end of this year, but as we set out, we are part-way through a process to recover the financial performance of NHS providers. I do not expect those cash reserves to move in isolation, as it were, from what we are doing on the overall deficit.

Chris Wormald: On the basic point of whether we could continue on the trends that we saw in '15 and '16, I think all of us at different points have said to the Committee that we all accept that no, we can't. That was why a financial reset was necessary last July, why the financial rigour measures we have put in are necessary—and I am sure we will come on to some of these other things—why we need to deliver on our efficiency programmes, and why we need to tackle unnecessary demand in the system and get an assessment of that.



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Q78 Chair: But you haven't really done an assessment of the impact of that reduction in capital spend, and the turning of capital to resource. That is an impact that you, as accounting officer, must be looking at, because if you just allow hospitals to turn their capital into resource to plug the gap and you have got hospital buildings, other buildings, equipment and IT just deteriorating, you are storing up costs and problems for the future. Surely you have—or why haven't you?—done an analysis in the Department about it.

Chris Wormald: I will bring David back in a moment, but, clearly, doing capital to revenue switches is not something that you want to do. There is a prioritisation decision that protecting front-line services when they are under pressure is necessary—

Q79 Chair: We know why it happened, Mr Wormald, but, Mr Williams, are you looking at what the long-term cost of that is to the system and individual trusts?

David Williams: We have been doing some work on that. At the departmental level it is quite difficult to get a line of sight to the consequences for individual NHS providers of changes in their local capital plans. At the group level most of the reduction in capital spend in 2015-16, in our judgment, was capable of being delivered, and was delivered, through natural slippage. It is not uncommon for public sector capital programmes.

Q80 Chair: So can we unpack that? You say at group level most of it was delivered by natural slippage—so a project overrunning slightly, but, you say, at group level—so they are not amalgamating individual trust development projects.

David Williams: In terms of our expectation of how that was delivered, it was mainly as a result of natural slippage or over-optimism in the profile of spend, rather than directed management action to slow down. Around a third of the capital to revenue switch in 2015-16 was negotiated directly between Mr Mackey's organisation and individual providers. In those areas there will have been a greater understanding of the extent to which that required deliberate action; but for the remainder it was largely the result of slippage.

Q81 Chair: Wouldn't it just be easier to give a budget for the capital that is needed, rather than just for transferring capital budgets to revenue spending, so that you are actually planning for a capital investment?

David Williams: As Mr Wormald has said, I do not think that anyone here would argue that shifting money from capital to day-to-day expenditure is a sustainable or desirable approach for the long term. It has been a necessary approach to balance some of the financial pressures in that day-to-day expenditure. It is something that we will look to repeat this financial year. Supplementary estimates—

Q82 Chair: How many times can you repeat it, Mr Williams? It was done quite a lot last year and you have acknowledged that it will be repeated this year.



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David Williams: Yes. This will not be the last time, but our plan is for that level of capital revenue transfer to reduce. Certainly by the end of the spending review period, I would like to eliminate any reliance on it at all.

Q83 **Chair:** Mr Stevens, have you got something to add?

Simon Stevens: What David says is right. In practical terms—what does it mean for the NHS around the country and what do we do going forward—it is clear that given what we need to do to support GPs, we are going to need capital investment, particularly in terms of GPs coming together to be able to offer an expanded range of services. That will get better access for patients and relieve pressure on hospitals. Fortunately, we got some of that with the premises improvement programme. The first tranche of that has been allocated around the country.

What we found when we went out and asked people about the schemes they get a positive payback on was that we had our hands bitten off. There were many more schemes that we could be funding. Even before you get to the question of hospitals operating in old and dilapidated buildings or on multiple sites, or ways in which we could drive productivity if we invested in infrastructure in the NHS, there clearly is an unmet need out there. To the extent that it becomes possible to meet that need with increased infrastructure investment over the next several years, that will pay off both in terms of revenue savings and, more importantly, in terms of better patient services and a more modern set of facilities in which our staff can deliver care.

Q84 **Chair:** That is great—the nirvana in the future—but we are very concerned about the capital issues. I think it makes sense for me to finish some of my very brief questions before I pass over to Chris Evans and Kwasi Kwarteng. First, Mr Williams—can you give a brief answer, please?—many trusts are delaying payments to suppliers as a way of covering their worries about this year's budget settlement. Is that something that concerns you or that you are monitoring at the Department of Health?

David Williams: It is something that we are monitoring closely with colleagues in NHS Improvement. Clearly it is not good practice, but it is another symptom, as the Report says, of some of the financial pressures in the system.

Q85 **Chair:** So do you think it is acceptable that they are doing that?

David Williams: It is not something that I would like to see sustained over the long term. As a way of managing financial flows in the short term, I can see—

Q86 **Chair:** There is a danger that there is just a very big surge of spending in April, I suspect, as they all suddenly pay their suppliers. Anyway, we will not go into that at this point; I do not want to dwell on that for too long. With the financial pressures, the concern we have all got is the impact on patient care. On Monday, the Secretary of State announced that the four-hour A&E target is being dropped. Given the deterioration—



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Chris Wormald: No, he didn't.

Chair: He said it was no longer going to be the target.

Chris Wormald: No, he didn't say that. I re-read his statement this morning.

Q87 **Chair:** Perhaps I did not read his statement; I read the press coverage. Perhaps you can explain very briefly, Mr Wormald, what he did say.

Chris Wormald: He said that the four-hour target was extremely important and was staying. I suspect that this point is being debated in the main Chamber as we speak, and it also came up at PMQs, but the point he was making—Mr Mackey might want to comment on this—was that we need to have a conversation about how accident and emergency is used.

Chair: We read that bit, too.

Chris Wormald: It is about ensuring that the target is for the patients that accident and emergency is designed for. There is a whole series of things that we are looking at—

Q88 **Chair:** To be clear, you are saying that the Secretary of State is not dropping the four-hour A&E target.

Chris Wormald: The four-hour target is staying.

Q89 **Chair:** But it is being breached on many occasions. It is at its worst level of performance almost since its introduction, from my records.

Chris Wormald: Yes. It is an extremely important target. We believe that it is the toughest access target anywhere in the world. We are not meeting it at the moment, and we do need to get back towards it.

Q90 **Chair:** So you are planning to keep that one. Are there any plans to drop targets or extend waiting times on other targets?

Chris Wormald: Not at the moment, no. Perhaps Mr Mackey should come in on what we are actually doing around A&E, because it is an important set of questions, but the target remains.

Q91 **Chair:** Mr Mackey, are you looking at the targets at all in NHS Improvement to rejig anything?

Jim Mackey: We are not looking at targets in the round. On the A&E standard, we have got a session tomorrow with the Royal College of Emergency Medicine, and colleagues from across the service from other colleges and the specialist societies and so on, to look at how we improve going forward. The 95% standard is still a really important indicator of system health, but a lot of things have changed since it was introduced. What we have been trying to communicate this week is that there are an awful lot of people in A&E who could be seen in other settings, so we are going to try to create those other settings and help them be seen there.

Q92 **Chair:** That isn't new, though. We have had people going to A&E with



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coughs and colds and all sorts of other things for years. That is why we have walk-in centres, GP services and hospitals.

Jim Mackey: But it has grown significantly, and this is a recognition—

- Q93 **Chair:** After tomorrow's meeting, just to be clear—we need to move on a bit—is there a chance that the A&E target will be altered, dropped or redefined?

Jim Mackey: It won't be dropped. There are some measures—the clinical community is saying rightly that when we introduced the standard, there were no such things as a sepsis six bundle for our very sickest patients. It takes about 45 minutes to start and make reasonable progress on that. There are some clinical pathways that exist now that save lives that did not exist when the standard was created, and I think we need to take that on board and understand what that means for the standard.

What I am bothered about is that when departments are very crowded, risk can be unmanaged. We need to ensure that departments are able to uncrowd themselves so that clinicians can focus on the sickest patients. We are starting to work through that. If that means that clinicians want us to add into the processes to say, "If you are very sick and you have certain conditions, there should be a standard that says you are seen by a doctor within two hours, three hours or whatever", then that is what we will consider.

Chris Wormald: I have now found the bit of paper with what the Secretary of State said. He said: "This Government are committed to maintaining and delivering that vital four-hour commitment to patients".

- Q94 **Chair:** Okay. Mr Mackey, at NHS Improvement, you are looking at how to squeeze the quart into the pint pot, or whatever the metric equivalent is. You have got to look at the money, the resource and how the change will take place. In that programme, is there a plan to look at any of the targets to see whether you can change or extend them in order to free up money and resources to flow around the system, so that patients will sometimes be waiting longer for treatment?

Jim Mackey: We are not looking at any relaxation of any targets or standards in our work.

Chair: Thank you. Mr Evans and Mr Kwarteng, please be brief.

- Q95 **Chris Evans:** Mr Stevens, are you robbing Peter to pay Paul? In paragraph 1.27 on page 28, the Report states: "In February 2016, £950 million of this budget"—that is the capital budget, which was £4.6 billion—"intended for capital projects...was transferred to revenue budgets to fund day-to-day services." That was the second year that you have done that. Why did you not assess the long-term effects of this? Do you even know what the risks are if you carry on doing this in future with this budget?

Simon Stevens: That is the conversation we were having a moment ago on capital. I would say that we were robbing Paul to pay Paul. It was



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money that Paul would have been spending on capital and is now spending on revenue. As we have just said, that is not a desirable situation. It will have taken about £4 billion out of capital expenditure over the course of five years, at a time when we would have benefited from that.

Q96 **Chris Evans:** Are you going to do it again this year?

Simon Stevens: You have heard that—

Chair: We have covered this ground, Mr Evans.

Simon Stevens: It is being done again this year, and it will be done again next year.

Q97 **Kwasi Kwarteng:** Can I ask a broader question? I hate to state the obvious, but as a country we have been running a deficit for 16 or 17 years. The funding pressures aren't exactly new, although I appreciate that they are now acute. I just want to ask a question on sustainability. Short of just giving more money that I have said we do not have, and given that we have been running this deficit for 16 years, what could the Government do to make your life easier and the service more sustainable? I hear the shortage of money—

Chair: You have done a question. Mr Stevens.

Kwasi Kwarteng: That's my question.

Simon Stevens: Well, we talked about some of these things when we began this strategic change process in the NHS. Some of the changes we have got to make to services we would be making even if we were awash with cash. The fact is that we have got a set of GP services and a set of hospital services that have not evolved sufficiently for the changing needs of our patients and the way in which care now needs to be delivered in a modern health service. In 1948, half of us died before the age of 65. Now it is 14%. One in three children born this year will live to 100. So we do not have a health service that is configured for long-term conditions, joining up what GPs do with what hospital specialists do, linking the mental health services and the physical services, and in particular the connection between health and social care. If Beveridge were at it again, he quite clearly would come up with a different proposition for the way health and social care work together. Despite all of the pressures, there is still an underlying deep consensus, not just in the NHS but in most industrialised countries, about how healthcare needs to evolve.

On your question about what sorts of things would make a difference, first, the amount of illness that the health service has to look after is partly a function of how healthy we are as a population. A lot of that is determined outside of what a GP or hospital itself does. I will give you two examples—a good news example and a bad news example. The good news is that there are 1 million fewer adult smokers over the past five years, from 8 million to 7 million. That will have a hugely positive impact on continuing reductions in cancer deaths and heart disease. The bad news is the big rise in childhood obesity. There are things the Government clearly can do on that. The first part of the answer is that action

that Government can take that has an impact on health risk and future cost is of great significance over the medium term. It does not show up this year or next year, but over five, 10 and 15 years, it is enormous.

Secondly, there are aspects of the way in which funds flow between different bits of the public sector—in particular social care, but also the benefits system. I have talked about the need to rethink the way some of the funding streams for retirees work, as between health and social care, benefits, pensions and so forth. These are all part of the debate that the country needs. Thirdly - this is not day-to-day running costs, - but backing some of the longer-term changes we need, including infrastructure. There are innovative ways in which that could be brought about, which obviously requires broader Government action. Those would be three.

Q98 Chair: Thank you very much for that. We will come to Karin Smyth in one moment, but before that, Mr Wormald, I want to be absolutely clear. This is what the Secretary of State said about the four-hour standard—"if we are going to protect our four-hour standard, we need to be clear it is a promise to sort out all urgent health problems within four hours—but not all health problems, however minor." The standard currently is that you turn up to A&E and are seen within four hours. By redefining it, it has actually been dropped.

Chris Wormald: No. The Secretary of State's point is that—

Chair: It says it here in black and white. I just read it out.

Chris Wormald: I am sure my colleagues will agree with me on this. There are people who are currently going to A&E who could be treated elsewhere—

Chair: That is a different point. The point is here that he has altered the standard, so if you turn up to A&E, you are not guaranteed to be seen within four hours, unless you are in the urgent health category.

Simon Stevens: Let me come in here. There are three things going on here. The Government have said they are committed to maintaining the four-hour A&E target, but what we are saying is that first, clinical practice patterns have changed.

Chair: Which we have heard from Mr Mackey.

Simon Stevens: Secondly, in the way that you pointed out, the places where you can go to get urgent care continue to expand and evolve in the national health service. We have to capture the totality of that in what we are measuring. Thirdly—

Chair: This is the A&E target we are talking about.

Simon Stevens: The offer that the NHS makes to the public for people with emergencies and urgent conditions. We have never said we will sort out everything just because you happen to turn up to a physical place and



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then get it all sorted out in four hours. That has never, in practice, actually been what has happened.

Q99 **Caroline Flint:** But you see someone within four hours.

Simon Stevens: No. This is one of the great misunderstandings. You hear this sometimes. People think you turn up and then get seen within four hours. Actually, the standard is that you get treated—sorted out and turned around, lock, stock and barrel—within four hours, or you get admitted into hospital. What that means is that for some patients with conditions that can be treated and might take six or eight hours, often at three hours 59 minutes they are getting admitted to hospital because of the four-hour A&E target. These are some of the clinical things we need to have a look at, consistent with the spirit of ensuring that people continue to get high-quality, quick urgent care.

Chair: I still stand by what I said. The Secretary of State's description has been, as you politely put it, amended—but you could say it has been dropped as a universal commitment. I will bring in Karin Smyth, because otherwise we are going to get waylaid on this.

Q100 **Karin Smyth:** I might come back to the target. Happy new year everybody, and welcome. Mr Wormald, let me take you back to 7 September, just after the summer recess—we will be using a lot of the transcript from that investigation in our final report. You said, in response to the need for the NHS to be in a financially stable position going forward, that it needed four things: extra investment—we can argue about the numbers, but we have had that—a financial reset, which we have also had; reducing demand; and the adoption of healthier lifestyles. You also said that, for the NHS to be financially stable going forward, a combination of those four things needed to happen. How is reducing demand going at the moment?

Chris Wormald: As you have heard already, it is challenging. To deliver the Five Year Forward View—I'll ask Simon to comment on that; he has already said some things about it—we need to tackle those issues. We need to do two things. We need to change the clutch on the discussion we've just been having and address how people are treated within the health service, with more people treated in primary settings and fewer in acute settings. In the medium to longer term, as Simon described, we need fewer ill people coming to the health service. We need to see both those things.

A number of things are being done, particularly on the first thing, some of which were described by your previous witnesses from Enfield CCG—I thought they gave a very good description of the kinds of things that people do locally. There is a lot of action on that. At this point I will hand over to NHS England.

Q101 **Karin Smyth:** I will come on to that. The plan was formulated in 2014, and we heard again at Prime Minister's Question Time that the NHS is busier now than it has ever been. How can it be the case that we are getting busier and not reducing demand two years into the plan?



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Chris Wormald: There are considerable challenges and pressures at the moment, and we have been clear about that. The four things I mentioned—I think I said this when I spoke in September—happen across different timeframes. The last of them—healthier lifestyles—as Simon described, will take 10 or 15 years.

Q102 **Karin Smyth:** Can I just stop you there? Why are we getting busier?

Chris Wormald: Why are we getting busier?

Simon Stevens: I can answer that.

Karin Smyth: I will come to you in a minute, Mr Stevens. There are four things that need to be done to put the NHS in a financially stable position going forward, one of which is to reduce demand. In the two years since the plan was formulated, we have got busier.

Chris Wormald: Yes. I think that people with actual operational experience of the health service are better at answering that question than me.

Q103 **Karin Smyth:** Okay. We are getting busier, so one of those four things is not happening. The fourth thing is the adoption of healthier lifestyles. Have we adopted healthier lifestyles in that time period?

Chris Wormald: Simon has already answered that question. There are some themes—smoking is one; teenage pregnancy is another—where we have made a lot of progress under successive Governments, and we see that play through into the health service. There are other areas in which, as a society, we need to make more progress: mental health, which the Prime Minister talked about on Monday, is one of them; and obesity, as Simon mentioned, is another. As I say, the overall story of public health is of quite a lot of progress over successive Governments that we need to continue, and there are some challenges that we need to meet going through that.

Q104 **Karin Smyth:** But by now, in 2017, two of the four things that need to happen for the system to be on a sustainable footing haven't happened, have they? Would you agree with that?

Chris Wormald: To be clear, I was talking about sustainability over the long term. The crucial thing for this year was to return financial rigour to the system. That is why such priority was given to the recent—

Karin Smyth: The week after that, on 14 September, we asked Mr Stevens similar questions about the—

Chair: Sorry, Ms Smyth. Just before that, I know that Anne-Marie Trevelyan has one question for Simon Stevens that it would make sense to bring in now.

Q105 **Mrs Trevelyan:** In relation to demand management in A&E, could you confirm—perhaps you could go away and think about how we deal with this—that if you turn up to A&E you get free medication if you need it,



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whereas if you turn up to a GP you have to pay for it. That is driving an increase in demand, because it is an obvious way to get free Calpol for your kids, or whatever the issue might be. There is a question from a value-for-money point of view, but is that driving a demand increase that we could avoid?

Simon Stevens: I will have to go away and look at that specific question. I think it points to an anomaly.

Chair: In which case, perhaps you could write to Mrs Trevelyan and the Committee about that. Sorry to interrupt you, Ms Smyth.

Karin Smyth: In relation to the same question, what you said, Mr Stevens, was that the money—we'll come back to the £8 billion, the £4.5 billion and the £10 billion—regardless of the final settlement, was based on three dependencies: a well performing social care system keeping up with demand; continued availability of preventive health services; and enough capital to lever in charges. We have talked a little about the capital. A well performing social care system keeping up with demand is the basis on which the plan is formulated. Is that social care system currently keeping up with demand?

Simon Stevens: No.

Q106 **Karin Smyth:** Thank you for the short answer; that is very helpful. Mr Mackey, what is your view of the demand situation now? Why are we busier now than we have been in the last two or three years?

Jim Mackey: It is multifactorial, as always. Some of it is the social care thing. Some of it is consumer led, as Anne-Marie pointed out. We have seen in the last few weeks a very big spike of respiratory disease, which has affected the elderly; and frankly, I think a lot of the people who have been admitted in the last few weeks would not have been with us five years ago. People are living longer and they are much more vulnerable. I think that has outstripped our expectations. It is probably much worse than we assumed a few years ago. If you look at the thing in the round, you can see why the system is very pressured.

Chris Wormald: Could I reply to your question? We expect and plan to be busier every year. Demographics would make us busier every year, so it is not a surprise that each year the health service has extra demand. The challenge we set ourselves was: could we limit that demand, but not eliminate it? We expect to be busy every year. The challenge we have had over the last few weeks and the last year is that demand has been higher than we anticipated.

Q107 **Karin Smyth:** I accept that. To sum up, the NHS has not quite got everything asked for for all the years of the five years, but it has had a substantial investment. But it was contingent on a number of assumptions. Those assumptions have not materialised, have they? They have not been realised, so my real question to you, Mr Wormald, is this: are you asking the NHS or are you in the Department now refreshing the financial envelope on which the plan has been built, because two and a



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half years in it clearly is not fit for purpose?

Chris Wormald: I don't accept the premise of your question.

Q108 **Karin Smyth:** Okay. Are you asking them to relook at the financial plan?

Chris Wormald: One of the reasons why it was a very good idea to have a five-year plan in the first place was that in any very complex system like the health service, not everything goes as you plan. The idea of the Five Year Forward View is that we have a long-term plan and over that period we will make the improvements that we need. There is no disagreement between us: there are areas where we need to do considerably more and do better in order to get to financial sustainability, but—

Q109 **Karin Smyth:** I would agree that a five-year look ahead is a good thing—I don't think anyone would disagree with that—but in addition to the things that have not materialised, particularly around social care and public health, because of the 2015-16 budget pressure we started 2016-17 in a worse position than anticipated.

Chris Wormald: Yes.

Q110 **Karin Smyth:** There's also no allowance for the seven-day working, unless you can come back and tell us how much that is going to cost. There is also—I don't particularly want to get caught up in talking about Brexit—no recognition of the potential inflationary impact of Brexit on drugs, or indeed the workforce, which is a whole new risk assumption. None of those things was factored into the plan in 2014. In any other organisation, you would be refreshing the financial basis of that plan now, wouldn't you?

Chris Wormald: No, what we—

Simon Stevens: Can I—

Chris Wormald: You go first.

Simon Stevens: I think the answer is yes, you would, and that's what we are doing. The reason for the factors that you mentioned—winding back just a moment, could I add in a few other data points to the conversation? Are we getting healthier? Yes, we are. On average in this country, life expectancy is going up by five hours a day, so for each hour that we spend together this afternoon, the NHS will have given you each another 12 and a half minutes of life. That is our gift to parliamentarians this afternoon.

Karin Smyth: We're going to grow old together.

Simon Stevens: Yes, or at least it might seem like that. *[Interruption.]* That's right. That's what the NHS is doing for the people of this country.

The second point was what is happening on activity. Activity demand is up over the past year. When we did the original activity modelling, we assumed that it would continue to rise in the early stages of the Five Year Forward View, until the benefits of some of those other investments kicked



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in. For the reasons you say, some of those other investments have not been available because they have been used on hospital pressures and elsewhere in the system—the £1.8 billion, the £800 million and so on.

For all those reasons, it is therefore right to take stock now and say, “Given where we are, what practically are the things the health service needs to do and can itself offer over the course of the next two years?” We are going to do that. We are going to publish that by the end of March. It will be informed by the outcome of the contracting round, which, uniquely, is in the process of wrapping up across the national health service, even though we are in early January.

As of this afternoon, all bar 11 contracts across the country are now agreed, below £1 million—all the specialised commissioning contracts. That does not mean that there are not very big efficiency questions that have now got to be resolved over the course of the next several months. We have got to work with frontline services and then memorialise that into the Five Year Forward View delivery plan for the next two years, which we will publish by the end of March.

Q111 Karin Smyth: That is very helpful, thank you. You publish that as NHS England, so where is the discussion then with the Department about whether that is agreed or not?

Simon Stevens: We are required by the 2012 Act to publish, by the end of March each year, the NHS’s plan for the year ahead. We intend to make that a two-year look, together with NHS Improvement and obviously working with the Department, our frontline services and other national bodies.

Q112 Karin Smyth: So that would essentially be a refresh of years 2, 3 and 4.

Simon Stevens: So 2017-18, 2018-19 and potentially some elements of 2019-20.

Q113 Karin Smyth: Those are the years that are problematic—from this year, anyway—aren’t they?

Simon Stevens: Yes. In this coming year the rate of increase, but also the underlying cost pressures, are a bit lower. I think that 2018, which happens to be the 70th anniversary of the national health service, is poised to be the toughest financial year of the five-year period.

Q114 Karin Smyth: So just to be clear, is that two-year look ahead, within the five-year, the point at which the choices that you have talked about—if we are not changing the targets, not changing some of those outputs and not changing the money, something has to change in the middle. Is the document at end of March going to tell us what those choices are?

Simon Stevens: Yes. I hope that it will do three things: first, set out, in pragmatic ways, what the health service is realistically able to deliver against the unchanging national targets; secondly, in very tangible terms, explain the improvements that the extra investment next year and the year after will get us in mental health services, in cancer services and in



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strengthening GP and primary care services; and thirdly, aggregate some of the local changes that are being discussed in 44 areas across the country and draw out some of the common themes where they require national decision.

Q115 **Karin Smyth:** So you are saying that it will be an alignment between that and the product of all 44 STPs.

Simon Stevens: Yes.

Q116 **Karin Smyth:** Will it also then recognise that one of the major changes has been the decline in social care services from 2009-10 to 2015?

Simon Stevens: It will have to.

Q117 **Karin Smyth:** I would suggest that that is the major factor that has made the plan not realisable.

Simon Stevens: In terms of the effective capacity available in hospitals, the back end is obviously having an impact on the front end at A&E performance. That is absolutely common ground between everybody; nobody disagrees with that. The fact that the social care delayed discharges have doubled over the course of three years is the pressure there. That is part of what has to get factored into what the realistic plans look like. There are some opportunities there. I do not think that we have got a complete solution on social care yet. The precept flexibilities that local authorities have got do not work the same everywhere, but in places where they can make an impact it would be good if they did. Hopefully we will see further action on top of that as well.

Q118 **Karin Smyth:** That comes out on 31 March or whenever. Does that then go into the Department for discussion? Are you discussing it en route?

Chris Wormald: No, we discuss these issues the entire time. It will be the NHS E's—with NHS I's—plan, but it will be discussed with the Department in the usual way. This is all within the framework of the Five Year Forward View, which sets out the high-level strategy that we have all backed. This will set out the practical ways in which we will move forward. This is not an unusual process. We talk all the time about what the current pressures on budgets are, what the priorities are and what we can move forward with. That is a sort of weekly exercise, and this is what I and my colleagues—

Q119 **Karin Smyth:** It isn't, but what is frustrating the public and patients per se is the continued political, "You have got what you wanted and what you asked for. Nothing else to see here. Go away for five years, come back in 2020." I think it is a really helpful—as my colleague has been saying today—grown-up way of now putting those choices slightly more explicitly given the assumptions on which a five-year plan is being realised.

Chris Wormald: I appreciate your sentiments, but I think there is a slightly apples and pears conversation going on here. The money in the spending review is fixed and, as I said earlier, our collective challenge is



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how we get the best health service for the sum of money that Parliament and the Government are investing. We all accept and agree that the vision set out in the Five Year Forward View is the right one, and that is what we need to deliver for the money. What Simon is describing is how you then turn that into a set of practical steps that the health service takes—

Q120 Karin Smyth: Let's not go back over what we have already agreed, which is that it is contingent upon a number of assumptions that have not been realised. The world has changed since 2014 and it is about to change even more in the next year. A re-look at that and an explicit acknowledgement of the choices that are having to be made, then lining them up with STPs, I suggest would be very welcome.

Chris Wormald: And the kind of process we are describing is not unusual—

Simon Stevens: Good, because that is what we are doing.

Karin Smyth: It is five happy hours.

Chris Wormald: You have an overall vision of where we want to get to and you adapt the exact course by which you get there depending on a whole range of variables that you do not control and could not predict at the beginning. That is not an unusual concern and that is what Simon is describing.

Q121 Karin Smyth: Absolutely, although some of those variables around social care and public health might have been differently managed—

Sir Amyas Morse: One thing that would be very helpful as you produced that plan would be to understand in some detail the assumptions you are making about growth in demand. I sometimes wonder whether we are not whistling in the dark a bit about that, making the assumption that various interventions will somehow arrest growth in demand when we have a background of an ageing population and less spending on health than a lot of other advanced countries. It would be really interesting—

Chris Wormald: Sorry, I missed what you said.

Sir Amyas Morse: We are spending less on health—per cent. of the population—than some other advanced countries. If there is an underlying growth in demand, it would be helpful to understand what assumptions you are making about it.

Simon Stevens: We can tell you now. The underlying assumption is that, across a range of activity, demand growth is going to be in the 2.5% to 3% zone, which is kind of what we have seen this year. It is a consequence of a growing and ageing population, so—

Q122 Chair: Mr Stevens, I think it averages about a 1.3% growth rate.

Simon Stevens: There is a demographic element to this, and then there is the fact that for the NHS our single biggest investment this past year was £200 million on new drugs for treating hepatitis C—treatment that did



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not exist three years ago. It is the fact that 2,400 people were alive with their families this Christmas, having survived cancer care in the NHS, who would not have been so a year ago. These are the benefits over and above the pure demographic change, and those need to be factored in too. In a sense what the NHS is being asked to do is to reverse engineer from a sum of money that Parliament has voted for it, to say, "All right then, what are you going to do?" We cannot change the aging of Britain, but our demands are quite different from, say, the criminal justice system.

Q123 **Chair:** I think we already understand that. Sir Amyas.

Sir Amyas Morse: What I wanted to ask was, to have the factors isolated, not necessarily just constrained by the ability to meet the demand, what the underlying demand trends are. That would be informative for everyone, and I do not think it would be a difficult thing. It would be very interesting to see that.

Chris Wormald: Yes. I just wanted to come back on the international comparison. Actually our total spending is roughly on the OECD average, and on the EU15 average it is not correct that we spend significantly less. There are some countries that spend considerably more, such as the United States, but we are around the average. While we are on international comparisons, the work that the OECD published yesterday on waste is very important.

Simon Stevens: I hate ever to disagree with Chris, but that is one lens on it. The OECD has an important set of comparisons that includes countries such as Mexico. If you look at the countries we would normally compare ourselves with—France, Germany, the Netherlands, Sweden and so forth—on a per capita basis we are spending substantially less.

Chair: We spend less. Lies, damned lies and statistics.

Simon Stevens: That is a choice that we have made. We are spending 30% less per person on our health services than the Germans are.

Sir Amyas Morse: My only reason for asking that question was not so much to make an invidious comparison, although they do seem to be supported by the figures, but more to say that it shows there may be a lot of unmet demand still out there. If you say that other countries, which are quite comparable with ours, manage to spend a lot more, there is a question mark. What is the explanation for that? I simply invite you to share a reconciliation.

Simon Stevens: It is partly that we are much more efficient. I genuinely believe the NHS is more efficient than a number of those other countries. I think the *Daily Mail* got this right in November when it pointed out that the NHS trails the rest of Europe in what we spend on doctors, beds and scanners. That is a correct reflection of the relative efficiency of our system.

Chair: It will be the headline in tomorrow's newspaper, Mr Stevens, as is your wont.



Q124 Karin Smyth: Before we leave this subject, I want to come back on the STPs. In your next iteration, will you still be focusing on the protection, as far as is possible, of primary care?

Simon Stevens: Yes. We have talked previously about the fact that over the course of 10 years, for reasons we understand, a big mistake has been made in the NHS, which is that the rate of growth of hospital specialties has been three times faster than that of GPs—not what anybody would have said was the smart choice a decade ago, but that is what has happened. If you think about the relativities of the 300 million GP appointments versus the 23 million A&E appointments, it is pretty obvious that if you find it harder to go and see your GP, some of that will show up as extra pressure in A&E departments. We have got to do what we said in the GP forward view, which is not just to invest but to make some big changes to the way general practice works, because the old isolated corner shop model of general practice in many places now is not what GPs themselves are saying is required. Bringing together groups of practices so that we can get extra staff services and expanded access is clearly vital not just to what patients experience, but also for the sustainability of the NHS.

Karin Smyth: If patients are going to be discouraged from turning up in A&E with minor complaints, they will have to go somewhere, so it is important to build stability.

Q125 Caroline Flint: Following up on the changes to primary care and GP practices and how they operate, I totally agree with what you have said, Mr Stevens, but what worries me after nearly 20 years as an MP and 10 years since I was a public health Minister is that in my own constituency, and across Doncaster and the country, we did look at regrouping single-handed practices into health centres.

We created massive health centres—I still have one of the biggest in the country—in order to bring those GPs together to share good practice, to do minor ops, and to bring more services out of hospitals. Earlier on you talked about using capital money to create more such centres. Why are we not using the centres that we have built and invested in already to do exactly what you say? I don't see it happening in the centres that we already have.

Simon Stevens: That is right in some parts of the country. I believe that GPs' own views on this have changed quite a lot over the course of the last five or 10 years. Because GPs' backs are against the wall—I genuinely think that for the most part they are—they are now willing to consider those kinds of changes. When they were described as “polyclinics”, which sounded vaguely Cuban or Soviet, they ran a mile. You can kind of understand that.

Q126 Caroline Flint: Have you or will you do some scoping of existing GP and health centre provision to see how the current resource is being used in our communities and ask questions about why in those circumstances more hospital services are not happening in those centres?



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Simon Stevens: Definitely. There is a big efficiency to be had. There is another point that we have not dwelt on enough so far, which is that, although we are a very efficient health system overall, there are still waste and efficiency opportunities in the National Health Service. The fact is that we will have delivered around £3.2 billion of efficiency this year— 2016-17—if we can end the year where we expect to, with more to come in future. That is also part of the headroom for the new things the health service wants to do.

Q127 **Philip Boswell:** Mr Stevens, this is very much an English NHS issue. Scotland saw 93.5% treated within four hours in the Christmas week at hospital A&Es; if you include minor injuries, the figure was up to 96.1% being treated within four hours. Are the measures you are taking likely to catch up with the Scottish NHS figures, which are at least 10% better?

Simon Stevens: The north of the border advertorial is duly noted. The fact is there is a lot of scope for learning between what Scotland is doing and what England is doing. As I understand it, there were substantial A&E pressures in Scotland's largest hospital and in fact measured A&E performance was rather below the aggregate number, so this is not unique. It is true that across England there are also differences between different hospitals under greater pressure than others. I understand the spirit in which the question was asked. We will always learn from practice north of the border.

Q128 **Chair:** Do you talk to your Scottish counterpart?

Jim Mackey: I am meeting Scottish colleagues on Friday, and this week we had some conversations. A few weeks ago, I went up there in the autumn and I will have a session on Friday to talk about this specifically.

Simon Stevens: Anne-Marie Trevelyan has left, but you would expect Berwick-upon-Tweed to be the nexus of good practice exchange.

Chair: Northumberland is a very handy meeting for you, Mr Mackey.

Q129 **Philip Boswell:** To follow on from something you said earlier, Mr Stevens, the four-hour target pressures NHS staff to admit patients to hospital in three hours, 59 minutes and into attendance to hit delivery targets, but as NHS England has more than halved the number of beds since the late '80s and cut the social care budget by £5 billion, that is obviously a social care budget designed to capture or to treat or deal with those patients in the no-longer-existing beds. Is this the real reason why NHS England is in crisis?

Simon Stevens: No. It isn't, because all industrialised countries have reduced their acute hospital beds over the course of 15 or 20 years and part of the reason is that medical practice has changed. If you look at the practice of surgery, the combination of minimally invasive surgery and fast-acting anaesthetics means that operations that previously meant people would be in hospital for several days are now being done as day cases. If you look at changes in the way heart attack and stroke patients



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are looked after and those with many different clinical conditions, you can see there have been, for legitimate reasons, reductions in beds.

Interestingly, however, when you look at the number of beds being used for emergency patients, over the course of 15 years in England we have seen a 52% increase in the number of emergency medical admissions, but the number of emergency bed days has essentially been flat. In other words, those beds have been used much more intensively and that is part of the big productivity gain that the NHS has delivered over that period. The relevant question is: can that continue or are we at some kind inflexion point?

Philip Boswell: I need to stop you. That is not the question I asked.

Simon Stevens: Your question was "look back", so I have answered "look back".

Q130 **Philip Boswell:** You are cutting the beds, but you are also cutting the social care support that is supposed to deal with—

Chair: To be fair, that is not for Mr Stevens.

Simon Stevens: I have been running a little campaign against doing that.

Philip Boswell: But is cutting—

Chair: He is giving you an open goal on social care, Mr Stevens.

Philip Boswell: Social care is being cut. I take your point about beds, modern societies, evolved societies and healthcare reducing the number of beds, but surely that is because of the increase in the support they get in the community. If you are cutting social care, what else will you get but a crisis?

Simon Stevens: To put some facts around your point, which is an important one, for every acute hospital bed in England there are more than four care home beds, so what is happening in the care home sector for frail old people obviously has a direct read across to what is happening in hospitals.

In a typical hospital in England—it is probably true in Scotland as well—two thirds of in-patients at any one time are over the age of 65 and more than a quarter have got dementia. The patients that, quite rightly, the NHS needs to look after with dignity and quality of care are for the most part older people with multiple conditions. Those are conditions that don't just neatly partition between what the NHS does and the help that people need in care homes, rehab and home care support. That is why, in my opinion at least, we have got to have a three-step journey to sort this out.

First, we have to ensure that there is a tactical funding response to stabilise the availability of social care pretty quickly. Secondly, over the course of the next three or four years, we have got to ensure that different parts of the health and social services are working more closely



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together in different parts of England, although I don't think that will be a single model.

Thirdly, post 2020, I think there is a suggestion for Parliament and others that there is a debate to be had around what is the structure of spending and support for retirees in the round. There are three steps. In my opinion, you can't just do one or two without doing three.

Chris Wormald: Just on social care, obviously there has been a lot of political debate around that. The Prime Minister wrote to you, Chair, and your fellow Chairs, today, answering your letter of 6 January. We accept that there are pressures in this sector. The Government are taking a series of immediate steps to release up to £900 million from the precepting that Simon mentioned earlier and the new homes bonus, and also to confirm that they want to look at how this works for the longer term so that it becomes stable.

However, as you know and will have heard from the Government before, money is not the only question here. There is a lot of variability between local authorities that we need to deal with. We need—I think someone said this—better integration between the health and social care systems and that is more advanced in some places than others. The Government's position is set out in the Prime Minister's letter—

Q131 **Chair:** We will be talking at the end of this session very briefly about discharging older people and your response to that Report. It is just important to put on the record that we did identify in that Report that there were, Mr Stevens, issues around the medical end as well. I think in that session you said that it was two-thirds the problem of the NHS and a third that of social care, for some of those delayed discharge issues.

Simon Stevens: If we are going to come on to talk about it, I actually think that that underestimates exactly what is going on, given the flow into community health services, but the point that Chris makes and that indeed the Prime Minister has made, quite rightly, is that there are big differences in the efficiency with which this interface works across the country.

Q132 **Chair:** Absolutely. We covered that in a previous Report, so I do not want to go into that now.

Mr Wormald, you have just given a proper Whitehall loyalist defence—of course, as it is your job—of the extra money going in, but I think it would be fair to say that that is not a sustainable income. It is bits of money for the short term. You did acknowledge that and I am glad about that. We are going to move straight on to Anne Marie Morris on sustainable transformation plans.

Chris Wormald: The Government accept that there are pressures in this area. The Government have taken action, but it is not purely a money question.

Q133 **Chair:** As you know, the three Chairs—the Chairs of the Health Select Committee, the Communities and Local Government Select Committee



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and myself—have written to the Prime Minister.

Chris Wormald: As you will have seen, I was quoting from the response.

Chair: There is a lot of activity, as you know, in this area.

Anne Marie Morris, over to you. I should say we are aiming to finish this section around 5 pm or just after, which gives you some good time to get in, and then I will just cover the issues on discharging older people at the very end.

Q134 **Anne Marie Morris:** What we have discussed so far, particularly some of the integration issues between health and social care, leads us neatly into the STPs.

The STPs are seen—I think by one and all—as the right vision, which is trying to integrate health and social care across the country on a geographic basis. As I understand it, we now have 44 quite divergent STP plans. Some are quite detailed and thorough and others are—shall we just put it kindly?—a little bit scrappy. How are you, Mr Mackey, going to mark the homework of those 44? Clearly, it is quite important, if this is going to be the solution for the future, that you get that right.

Jim Mackey: There is an ongoing process that NHS Improvement and NHS England are doing together. They are working actively with each STP and their footprint on an every-week basis. Simon and I will get all the leaders together in a week or so's time to take stock and decide where we need to go at the next stage, what kind of tailored support is required at an aggregate level and what specific things are needed for each STP.

It is one of those things where it isn't possible to say, "There's this thing that we're going to do right across the country," because they are quite different, but we have a commitment—a deal with the STP leaders—that they will ask us what they think they need from us, we will have an exchange with them, we will challenge them on their assumptions, and we will agree a support package for the year ahead over the next few weeks.

Q135 **Anne Marie Morris:** Clearly there has to be a timeline to this, because at some point you have to implement, and some of those plans are pretty scratchy. As you said earlier, we hear about delivering the quality at the same time as the financial sustainability.

Some of those plans are going to have aspirations, and you are going to look at the money they have actually got and say, "Hold on a minute, there is no mismatch," and then you are going to say, "There's no more money." How are you going to square the circle between getting those plans right and delivering the quality that you and I passionately care about within the existing budget?

Jim Mackey: There is a link here between the operational plans and the contracting process, as Simon mentioned earlier. It looks like there will be fewer than 10 contracts that we might have to arbitrate on, out of however many there are—250 or so across the country; quite a large number. They have translated themselves into operational plans, so from



the provider point of view we are assessing them—Simon is doing that for NHS England—and then we need to connect them with the STP to make sure we have not got a grand plan that is not grounded in reality.

In a few weeks' time, we will be able to say that we have got this overall plan—the STP—and that it is underpinned by contracts and detailed institutional operational plans. Within a few weeks, we will be in a much stronger position to determine risk, and to determine where people have made heroic assumptions and are not going to be able to deliver them, given your point, Sir Amyas, about actual growth versus planned growth, and aspiration versus reality. Then we will tailor our efforts appropriately to those plans, given the evidence we have got at the time.

Q136 Anne Marie Morris: What will you do if you can't match the quality and the money?

Jim Mackey: There are things across the country that have solved pretty much every problem. Our problem is that they are not being solved everywhere at the same rate, with the same vigour and the same skill.

I was reading just yesterday about progress with the vanguards, for example. It is early days, and the evidence is new and fresh, but if we rolled that out in the country and everybody adopted it, it would have a serious impact. If an STP has a plan that is miles off what we think is deliverable, we will connect it with other STPs and bring in specialists if it needs specialist support to target efforts to help it catch up.

Q137 Anne Marie Morris: But don't we have a timeline problem here? The vanguards are still in early days, as you say. There are other activities looking at new models of care, but they are still very embryonic. Most of the STPs are not aware of what is in those vanguards because very little has been published. In a sense, the exam question that you set for the STPs was almost impossible to answer, because they don't have the information and the detail of what the new models of care might be, yet they are having to put together a plan that is deliverable.

Jim Mackey: I am not sure about that point. I'm not sure whether the vanguard processes have actually published anything, but it is very easy to find a vanguard, go see them and have a sharing of what they have made progress on and what they haven't. They talk at conferences all the time, so I think that is an active discussion in the NHS.

Q138 Anne Marie Morris: I would love to agree with you, but I have spoken to STP leads—we have just had two CCGs in here—and I asked them, "What do you see as the future for your new models of care?" They are effectively waiting for what is coming out. You are expecting them proactively to go and look. I'm telling you that my experience is that they aren't looking; they are just desperate to meet your exam question, which they think is a financial one. It seems to me that, without a bit more guidance from both NHS England and you, we could end up with something that simply can't work.



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Jim Mackey: There is a spectrum, as we said earlier on. There is a handful of STPs who frankly are getting on with things. It is not a stop-start process; they are getting on and they are doing what they need to do. There is a handful at the other end who are really struggling, and we do need to give them serious help to speed up.

I think our big issue in the NHS is always that there is a very large proportion of the NHS in the middle that we can influence and help share best practice more quickly and adopt things more quickly when they are found to work, so we will be doing that. Frankly, I would be seriously disappointed if you were talking to people who said, "I wish I could find out what's happening in Nottingham," because we all know where Nottingham is and we could pop up and have a chat with them.

Q139 **Anne Marie Morris:** I would love to think that you are right. Unfortunately, my experience does not match yours. Perhaps, Mr Stevens, because you are closer to this, you could give me your thoughts on where we are with these new models of care.

We cannot have a financially sustainable system without these new models of care. These new models of care are effectively moving from looking at roles to looking at activity, which is a very good step forward. My only comment would be that we have moved to outputs, but we haven't yet moved to outcomes. One of my concerns is that these models of care may not be flexible enough to enable the regulators and others to accept them, which gives us a knock-on problem further up the regulatory food chain.

Simon Stevens: That is a very sophisticated line of inquiry, and you make some very important points there. Your premise was that STPs are going to be tough because they don't know enough about how new care models are going to develop. I think STPs are going to be tough, but not for that reason. I think STPs are going to be tough just because it is a really tough job to try to square the circle with the things that we know we need to do, given the pressures that are in the system.

We are two years into the vanguard programme. The vanguards were designed to be the kind of intense end of the spectrum to blow up a lot of the historical divisions that existed, which we have spoken about previously. The divisions between general practice, community health services and hospital outpatients and specialist departments goes back to 1911. It is Lloyd George we have to thank for that one, not Nye Bevan. This is quite profound redesign—changing the funding flows and the rest of it.

Q140 **Chair:** How many Prime Ministers are in your firing line?

Simon Stevens: He was learning off Bismarck, so actually it was the Germans in 1883, just to clarify that point.

What we are going to be doing over the course of the next year and two years through this delivery plan we have talked about is not getting every part of the country to do the full-blown integration of hospitals and the GP



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service and the rest of it, because that is a journey and that is going to take time. But there are no-regrets moves that actually out of the STP conversations most people are saying, "We need to do this."

If I could just give you one very straightforward example: of the 300 million patients who see a GP each year, somewhere between 86 million and 105 million of them see the GP the same day for an urgent condition. That obviously is four or five times more than the number of people who go to an A&E department. What GPs are saying is that they need to, as it were, stream between the same-day urgent care that they have to offer versus the ongoing looking after people with long-term conditions—heart conditions, diabetes and so on—but each individual practice cannot offer the full primary urgent care service.

What the NHS has done historically over the past 10 years is add in some other stuff, but it is not joined up. So, yes, we have had walk-in centres, we have had minor injuries units and we have had urgent care centres as well as people going to see their GP, but it is a really confusing maze for most people, who do not know what these things are, when they are open, whether you can take your child, whether you can go in the evening and so forth.

What all the STPs are really saying is that we have to bring together same-day urgent GP care with these other centres that are going on, share the records, have the equivalent of a duty rota for a town or a part of a city—you have to have more flexible arrangements in rural areas—and then be very clear for the public as to what that looks like. The good news is that that is already happening in big parts of the country. Big swathes of London are going to be doing that by the middle of this year. In most boroughs now, there are primary care hubs. You could call that a new care model—if you want to put lingo on it, it is a primary care home—but that is the concrete action that has to happen over the next 12 months and 24 months; it is not the fancy stuff around redoing Lloyd George.

Q141 Chair: Mr Stevens, you talk about clarity for the public, but I think most of the public have no idea what an STP is delivering for their benefit. At the moment, first, it is a very structural discussion, and secondly, the STPs are not doing a very good job of communicating what the benefit will be to Mr Smith in Hackney or Mr Jones in Devon.

Simon Stevens: I apologise if I am not making it clear. That is not the issue. At the moment in south-west London, on the side of bus shelters and in train stations, posters are now up saying, "If you need to see a GP in this area, 8 to 8, seven days a week, here's how you do it."

Chair: Well good for south-west London, but—

Simon Stevens: And you go to one of four clinical hubs and you get it. I know because my daughter—

Chair: That is fantastic for south-west London.

Simon Stevens: That is what we have to roll out across the country. You



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cannot do it at an individual practice level, because there are not enough GPs. You have to phase it in as GPs expand.

Chair: I am pointing out that the STPs are not doing a very good job of communicating what on earth in this structural change will benefit patients, as Anne Marie Morris has said.

Q142 **Anne Marie Morris:** That is right. There is a communication issue regarding what is happening about new models of care to those tasked as STPs to come up with something, and to the general public, in terms of them understanding what they are going to get. That takes us back to the 44 plans. If we do not get it right and make the wrong assumptions—a word we seem almost to have overused today—and if the individuals who have to deliver STPs have not used the right assumptions based upon knowledge, we are going find that it does not work.

Let me move the debate on and ask how you are then going to measure against the plans. Will you have some key performance indicators? How are you going to apply them, and when are you going to start applying them so that you can be sure that this is not going to go—forgive me—tits up before we even get six months down the line?

Simon Stevens: This is why we brought forward the contracting round and made it a two-year contracting round, which kind of answers these practical questions in each geography. This is not a philosophical conversation about what five or 10 years looks like. It is about how we are going to make services better and make the money work to the best of our ability over the next two years. That is then the conversation we are now having with the 44 STPs, bringing in the outcome of the contracting round that we want to memorialise or distil at the end of March in this delivery look for the next two years.

Q143 **Anne Marie Morris:** Okay, but that is not exactly a KPI. Then you have the issues about the measures that the CCGs have and how you combine or change that so that it actually fits, or so they fit together as one model.

Simon Stevens: Yes. On KPIs—ways of measuring whether care is getting better and we are using our money well, to paraphrase the acronym—we have published what is called the CCG scorecard, which says, for mental health services, cancer services, maternity services and so on, that these are things that we are going to track to see whether or not services are improving. We were talking earlier about one KPI—that is, the A&E four-hour performance—and there are other KPIs as well. We have those measures. The problem in the national health service is not that we have a shortage of measurements. If anything, it is that we do not distil them and make them intelligible and actionable.

Q144 **Anne Marie Morris:** Agreed, but the STPs are not just covering the NHS, are they? So you have to look at a set of KPIs, if we are looking at this model—to integrate across health and social care some KPIs that work for the whole piece.

Simon Stevens: Yes, and in particular some of the interface points between the two systems, of which the ability to get people the support that they need when they are leaving hospital is a pretty good one.

Q145 **Anne Marie Morris:** Run by me how these key performance indicators are going to be put in place and when. I appreciate that you are from NHS England rather than, if you like, social care, and that we do not have your equivalent looking at that piece. But on the assumption that you two are working together, I presume the pair of you have come up with some thinking by now, because if not, it is a bit late.

Simon Stevens: Yes, so from April, we will be tracking and publishing measures of this broader set of indicators, some of which relate to the NHS and some of which are social care as well. As it happens, we have some for social care, particularly through the way in which the better care fund has been incentivised, but I don't think they have been fantastic, frankly, as kind of a mechanism for focusing on the things that we really want people to get right. So that is what we have to bring together.

Q146 **Anne Marie Morris:** So you are going to review that ASAP.

Simon Stevens: We've been having this discussion. This is not a new thing that we are going to start tomorrow; this work has been ongoing.

Q147 **Anne Marie Morris:** Will you publish those indicators sometime soon?

Simon Stevens: As you know, we publish shedloads of indicators.

Anne Marie Morris: Yes, but STP indicators, rather than—

Simon Stevens: Yes.

Q148 **Anne Marie Morris:** And when do you expect to do that—in weeks or months?

Simon Stevens: From April we will start publishing a lot of these measures at STP level, as well as by institution or by CCG.

Q149 **Anne Marie Morris:** Are you going to communicate earlier than that with the STPs themselves, so that they can deliver against them? It is one thing having measures, but we need some lead time to meet them.

Simon Stevens: Yes. I don't think that anything that will be measured is going to be a surprise to STPs.

Q150 **Anne Marie Morris:** Okay. Are you worried that there is no allowance for transitional double working? As I understand it, all the STPs have been asked to make the change within their existing budget, which means that there is no spare cash to do double running. I am quite concerned. Good project management does not normally say, "You switch off the light bulb in room A and switch it on in room B, and hey presto, everything's wonderful." Realistically, how is this going to happen? Does this not keep you awake at night?

Simon Stevens: Sometimes my dog keeps me awake at night, but not this particular question, although of course it is a concern. The issue is



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that we have been given a figure of money by Parliament, and that is what the NHS has to work to. If there were funding available for double running and the kind of transitional support you described, would the NHS welcome it and use it well? Sure we would, but it is not apparent that it is.

Q151 Anne Marie Morris: The cart seems to me to be driving the horse. If we want something that is sustainable and will work long-term, simply saying, "That's the pot of money, and even if there's a problem turning on the light bulb in B after turning it off in A, tough." It seems to me that that will cost more.

Simon Stevens: We have got some funding to lubricate some of these changes. The changes that are happening in primary and urgent care, for example, will drive efficiency for us as much as they will require big new double running costs. I think we have to be quite nuanced in our understanding of the changes that each geography is looking to bring about.

Q152 Anne Marie Morris: Mr Wormald, one of the things that is very clear is that if you are looking at the financial sustainability of a system, you have to look at the totality of that system. Health and social care is quite broad. We are looking at social care. Quite a chunk is committed by the voluntary sector, God love them, as well as the NHS, and then we have other pieces of local government—housing and the rest of it—that relate to this whole piece. Yet in terms of measuring the inputs, the outputs and the outcomes, we do not align that as Government. We talked a little about some of the NHS measures such as four hours and so on. If we do not look at what the input is—that is easier, because it is an amount of money—or at what we are getting for our money and what the outputs are in all of the pieces, we cannot be surprised if the system falls down.

Mr Stevens, when you say that one of the challenges for A&E is the lack of investment in social care, isn't that in large part because we do not measure social care in the same way that we measure the NHS? If we had a better understanding of the inputs, outputs and outcomes, we would have something truly sustainable. At the moment, we just look at what happens in the NHS, and if that improves, we assume that it's all going to be fine, whereas in fact the pressure is felt elsewhere. Mr Wormald, how is the Government going to do a better job of pulling this together and properly measuring across the whole system?

Chris Wormald: The first thing to say is that obviously, that is a widely debated question and has been for some time. We work within the statutory framework that we have, which runs these systems in very different ways. That is just built into the legislation: one is a local government service funded by local government financing, and the other is a national service run under its own legislation.

That drives a number of the behaviours that you describe, and it is something that we live with. What we work on is, given that statutory framework and the fact that these systems are run on very different bases—one is means-tested and the other is universal—how do we make them work better together? Simon's STP process is very important in that.



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I think it is actually the first time that local government and the NHS have sat down in those sorts of environment and even discussed those issues in that way. That in itself is a very big step forward. The better care fund, which Simon has mentioned already, creates a framework for looking at these issues. Some areas are much more advanced than others.

I cannot disagree with what you are describing, because that is the statutory position and the different finance position. I do think—and Simon may want to comment, too—that we have made a lot of progress on how you make these things work together operationally. But there is clearly a considerable way to go, first to get that absolutely right and secondly to get it consistent across the country. I don't know if you share that view, Simon.

Simon Stevens: Completely. You know the Greater Manchester experience. That, in a sense, is the first advance around this, but there are individual local authorities and parts of the NHS that are doing important different things. I think I have now appointed three CCG accounting officers, who are actually the chief executives of the local authority as well. We have models in Plymouth, Northumberland, Salford, Tameside—there is definitely progress.

Q153 John Pugh: The issue of systems management is one that I am absolutely fascinated by. I am not making this up: an hour before this session started I was phoned by a constituent, or somebody who had used the local hospital. She was a nurse. She had gone to the local hospital feeling that she was seriously ill. She had phoned 111 and she had been delivered there by the ambulance service. There was then a significant delay before she was handed over to the A&E department, who were worried that the clock was ticking against them. Of course, they have the problem that in order to admit the person—and they did have to admit the person at the end of the day—they have to find a bed. That means that at the other end they have to have somebody out of a bed and released through adult social care. When she got to the ward, she found herself surrounded by a number of patients from nursing homes who were suffering with dementia but could not go back to their nursing home because the nursing home was risk-averse, because it was not well supported by the GP sector.

So you have a number of different organisations in play with regard to this woman's care: the GP sector, the hospital, the ambulance service, 111 and so on. The experience was clearly deeply unsatisfactory from her point of view. I believe that she spent something like 19 hours on a trolley. People apologised for that, and it did not end up too disastrously, but what we are looking at is not a failure because of poor management at any one particular point. There are managers in the ambulance service, managers in the hospital system, managers in the nursing home who do their own risk assessments, and GPs, who obviously have their own practice managers and so on. What you are lacking in the piece is any kind of systems management.



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Simon Stevens: Exactly. I think you have fantastically illustrated the point. Indeed, there were very powerful articles in *The Sun* yesterday and *The Times* the day before, in which a woman described her mother's experience over the Christmas period, which was rather similar to what you described. Each piece of the system, under great pressure, was doing the right thing, but the combined effect was not a good experience for the individual involved, this woman's mum.

Q154 **John Pugh:** Do you need to reinvent the regional health authorities, to be that system presence?

Simon Stevens: No, what we need to do goes to the question that Karin Smyth was asking. When we talk about redesigning services and getting this right over the next two years, this will be the litmus test of whether or not it is real. It is these kind of changes that we have to bring about. They are not changes that are going to cost an enormous amount; they are changes that are going to produce better outcomes for a given sum of money. There is going to be a rise in demand, of course there is, but this is actually one of our efficiency opportunities as well as one of our quality improvement opportunities.

Chris Wormald: Can I just add one thing to that? I agree with everything Simon said, but the one thing I would add is that if you look at the history of this, structural and legislative changes to the system have rarely been the answer. I looked at this from a local government perspective when I was accounting officer for the local government budget, and whenever you see this work well, it is actually about the individual relations between the people who manage those services—it is about them sitting down and having deeply sensible conversations about how you work in the system, as opposed to big structural changes. I think our focus in this is built into Simon's STP process: "How do you get those conversations?" as opposed to "Can we invent a new business model?"

Q155 **John Pugh:** We can see what is desirable, but we have, to some extent, stripped out some of the elements of systems management that used to exist. Look at the Health and Social Care Bill that went through in the last Parliament, which I am deeply familiar with and which I served on the Bill Committee for. The general philosophy there was to consider individual parts of the NHS as cost units that functioned independently—throwable or not, depending on circumstances and so on.

Simon Stevens: That is right, but I don't think your constituent would have had the integrated experience they need prior to 2012. I don't think it is something that was there and suddenly went away. The point Chris is making is that this is not going to be achieved by boards, headed notepaper and administrative superstructures. This is achieved by sharing information; getting people access to paramedics; increasing the proportion of calls in the 111 service that are being handled by a nurse, paramedic or doctor; and giving them the ability to book you into a GP appointment, rather than sending you to A&E—those very practical things are what will, over the next 12 to 24 months, make the difference.

Chair: You are almost making a pledge there, so we will hold you to that.

Q156 **Kevin Foster:** It has been interesting to hear what been said about integrating health and social care. You will be aware that Torbay has what is seen as quite an innovative integrated care organisation. We are talking about targets across the piece. We have heard news in the past couple of days that the trust will need to look to renegotiate the risk share agreement, because the way the control totals are done individually to the CCG does not work very well at all with the integrated structure, which could, if there were a system-wide control total, have accommodated and still delivered the sustainability and transformation fund objectives. Is that something you are looking at?

Simon Stevens: I am sure Jim will come in, but this was brought to my attention last night. I am, with Jim, very keen to have a look at what is going on there. He and I have both said we will create a shared control total for providers and commissioners in a given geography, as long as people understand that as different ways of divvying up the money that there is; it does not, in itself, magic up more money.

Q157 **Kevin Foster:** That is the key point—that we understand it is not about more money, even though that would be lovely, but about how it is divvied up.

Simon Stevens: Exactly. We will have a very careful look at that. Indeed, I know this has been raised by Dr Wollaston as well. We want to really understand the moving parts. As I understand it, in any event this would not take effect for 12 months or so, and I don't think it would have any direct impact on patients—just to be clear about that.

Q158 **Kevin Foster:** Without dwelling too much on this, one concern is that if those areas that do look to integrate start running up against this type of problem, that will be a deterrent to integrating, which is exactly what we want. Secondly, while it would not take effect for 12 months—

Chair: We don't want to deter people from integration—just to be clear.

Kevin Foster: No; we want integration, clearly. Secondly, while you say 12 months, we would not want wasted work over the next 12 months—arguing a new risk share arrangement, and then a couple of days before, saying, "Actually, on second thoughts, we'll go with what was suggested in the first place."

Jim Mackey: I completely agree on the principle. This example—as Simon said, we found out about it yesterday—looks like it has not been calibrated appropriately. So it's not that the model doesn't work. It just looks like risk has been disproportionately shared on one party. We need to work together to make sure it is adequately shared and that those who can influence the risk are able to. It is a really good case study for how we do this for the rest.

Chair: Anne Marie Morris will come back to risk, but Karin Smyth has a brief intervention.



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Q159 **Karin Smyth:** I accept the point about not wanting another reorganisation. My own health economy only has 15 organisations involved in coming together. Other colleagues have much, much more than that.

Simon Stevens: We might be prepared to make an exception for Bristol, South Gloucestershire and North Somerset.

Q160 **Karin Smyth:** There are three different community care providers and three different local authorities, which don't always get on. That is a huge task, and is it about having somebody to take that particular responsibility—not these emerging leaders or whoever is Buggins' turn having to make it work. What are your thoughts now on formalising the arrangements so that there is a degree of accountability locally and you have a bit of a better grip?

Simon Stevens: Even if we bring together the NHS bodies in Bristol, South Gloucestershire and North Somerset, I don't suppose that will give rise to a corresponding local government reorganisation. As I understand it, some of the sub-optimal decision processes in your area are because of the hotch-potch of organisations on both sides of the equation. We are concerned about the fragmented decision making that has existed in your part of the country.

Q161 **Karin Smyth:** But it is not unique. Mr Bacon was talking about—

Simon Stevens: It is not unique, but it is sufficiently concerning to be on my radar anyway.

Karin Smyth: I know.

Chair: We will touch on governance briefly at the end, if we have time.

Q162 **Anne Marie Morris:** I think the point that Mr Foster made is spot on; that issue affects my constituency as well, so it is a point very well made. However, looking at the whole risk issue going forward, it seems to me that there are a number of risks that we face. Mr Wormald, although he agreed with my conceptual point, said that there was parliamentary constraint in what could be done to try to help this sharing, if you like, of pots—

Chris Wormald: I was simply observing, just as a statement of fact, that the NHS operates under a very, very different legislative framework from the one for adult social care, and under a very different financial framework. That goes to some of the issues I was just describing.

Clearly, there are things we can do within the NHS budget to address these questions, and when you are talking about how you put together the local government budget with the NHS budget, this Committee rightly expects the accounting officers here to be focused on the money you vote us, and we also expect councillors to be directly responsible for their resources. When you are looking at some of these integrated approaches, that gives you an accountability set of questions. I am merely observing that as a fact; I am not proposing to change that fact.



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So the question that has gone to a lot of the examples that Simon has given is this: given those facts, how do you best work across those boundaries? It won't be neat and perfect, and there won't be a single accountability framework or whatever, but there are things that we can do to make it easier for the NHS and local authorities to be able to gear that properly while recognising the separate accountabilities and separate budgets.

Anne Marie Morris: Point taken—that is exam question 1. The challenge with that is—

Simon Stevens: Was it a pass or fail?

Q163 **Anne Marie Morris:** Mr Stevens, I think you have been quoted as saying that this is something you can't impose by statute, and that it is something that people have to find a way of working towards. While at one level you are absolutely right, the kick up the backside might make a difference. So my question is probably to Mr Wormald, who may not be able to answer it, and to Mr Stevens, who probably will be able to. Clearly, as Ms Smyth said, we cannot have a reorganisation, because none of us are up for that. However, there has to be a way of reorganising that financing pot, if you like—regulation and statutory underpinning to add a bit more weight to what you're trying to get people to do on a voluntary basis. That is exam question 2.

Chris Wormald: That is exam question 2? I will answer your question. Quite clearly, there are things that we can do within the NHS budget, of the type that Jim and Simon were describing, which make these things easier, and there are also things that make it easier for local government and the NHS to work together. There are some very simple things, like coterminosity, which we have built into the sustainability and transformation plan process and which actually makes quite a lot of difference.

What I'm saying is that there is a statutory line, which we can't cross, between the NHS and local government, because we expect different people to be accountable for specific sums of money and how that money is spent.

Now, we cannot address that question—it is a question for parliamentarians and not a question for civil servants—but I don't think that at the moment anyone is suggesting that they wish to legislate across that question, because it raises all sorts of confusion, as I was saying. Therefore, our focus is on how we make it easiest for those systems to work together, recognising that we can't make it perfect.

Chair: I am aware of time, so we definitely need to make sure that wherever this debate goes, we are keeping it tight. So, Mr Stevens?

Simon Stevens: I agree.

Chair: You agree? Well, there we go.



Q164 Anne Marie Morris: I think that you have passed question 1; on question 2, I think you passed the buck back to us, and that is actually very fair. What I was looking at was any advice from—dare I say?—civil servants and others as to how parliamentarians might look at this issue, because one of the real political challenges that parliamentarians face is, if you like, a resistance to change.

While I understand and agree with Mr Stevens's point, which is that it needs to come rather than to be thrust upon them, there are some bits of tinkering within the system that maybe a civil servant cannot tell me as a parliamentarian might be good practice—but at some point I think parliamentarians could do with a bit of guidance as to the art of the possible, because otherwise the cart is going to be dragging the horse.

Chris Wormald: Of course we don't just address these questions from your Committee in these situations; they arise in other sectors, not just in health and social care. There is the big point but the whole economic development piece in local government and how we do city development plans—those things—raise a lot of the same issues. As has been demonstrated in those cases, there are things you can do, both legislatively with secondary legislation and in terms of administrative practice, that make those things work better.

My ex-colleague Jon Rouse, who has given evidence, now works for Simon in Manchester, addressing exactly these things and is making a lot of progress. I don't want to give the impression that nothing can be done, but it has to be done within that legislative framework that we all understand.

Chair: Anne Marie Morris?

Anne Marie Morris: I look forward to it. That's plenty, thank you.

Q165 Chair: The risk-sharing agreement came up and, Mr Mackey, you highlighted that you thought there was an error in calibration. How are you looking at these things? What analysis are you doing? It has been quite a rush to get the STPs in place. I imagine that this would be one of the biggest sticking points for STPs—we know it is. The Devon one, the Torbay one, was unbalanced. How can you be sure that the others are fairly spreading the risk? How will it work in actual practice when something goes wrong in the system?

Jim Mackey: There is quite a lot all over the country anyway. People have been using risk-sharing mechanisms for the past few years, so there is a sort of muscle memory developing around them. We are working with those that have worked and those that haven't.

A lot of them are now embedded in contracts for the next two years and our teams from both sides have been involved in the assessment of those, ensuring that they have got balanced risk and that there is a decent management plan for them. On the broader system control total thing, we will see what comes out of the sessions this time and see how they work.



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Q166 **Chair:** The key thing is that patients are at the centre of this. If something goes wrong, the last thing you want is different organisations arguing over who was responsible. Are you confident that the risk sharing is robust enough so that the patient is not suffering?

Jim Mackey: I think most of those we have now are progress on what we had before. There is not anywhere that has got it right yet. Going back to the earlier points, that is because people are having to do a very difficult job. They are trying to balance all of these risks together. The proof is going to be in the eating.

Q167 **Chair:** How are you analysing it? You are looking at the best practice; you are helping others come up to that.

Jim Mackey: Yes, we are looking at volume trends. We are looking at who is actually able to influence decisions, how people hold themselves together in governance arrangements, which data they use, how they engage with patients and clinicians.

Q168 **Chair:** Do you do dummy runs to see if something has gone catastrophically wrong? Are you doing tests?

Jim Mackey: There has been some small simulation in some of them to test. There are some decent simulation tools now you can use to test scenarios: what if this goes wrong or that goes wrong?

Q169 **Chair:** If this bit of it goes wrong, it could be catastrophic for the whole approach.

Briefly on the issue of STP governance, I was interested to discover that my STP has a chair but I do not know how he was appointed. Some of us have discovered that we have chairs of our STPs, some don't. How are the chairs or convenors—as we discovered with our previous panel of witnesses—appointed? Are they appointed locally or do you have a say nationally? Is that for you to answer, Mr Mackey?

Jim Mackey: Ideally, we wanted everybody to do it locally and many did. Some did with our help and some had a gap and couldn't find leaders locally. So we have helped find them leaders from other parts of the country.

Q170 **Chair:** Were they advertised locally? A lot of us seemed to have it if that was the case.

Jim Mackey: I think it is a mixed model, so some did act locally. There was not a standard template.

Q171 **Chair:** So some people emerged, were discovered, given second jobs?

Simon Stevens: Let's look at what these roles are. This has been an informal convening process to get the right people together to begin phase one of an important conversation, to develop a set of proposals. Those proposals are now being turned into plans.

Q172 **Chair:** We know that bit. Some of them are independent people. I won't name the person because that is not fair as I haven't told him I will, but



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mine is from outside the health sector. He has nothing to do with and does not run any of the health organisations. Others have come from within the bodies that are in a supporting or neighbouring area. What is the rhyme or reason behind it and are they being paid?

Simon Stevens: For the rhyme or reason behind it, we could take Karin Smyth's example. There are a lot of different bodies and the chief execs and leaders of each of those have got day jobs and responsibilities, so this is somebody who can reach out.

Q173 **Chair:** Are they being paid?

Simon Stevens: One way or another, yes. Either they are being paid because they are taking some time out from their existing responsibilities, or they are being compensated sessionally, I would imagine, where you have got independent chairs. But these are time-limited roles for the most part to get us to where we are now.

Chair: Time-limited. Right, okay.

Simon Stevens: The question we will be discussing with the STP convenors and the constituent bodies in the first part of this year is how they now want to evolve their governance and leadership support. To the extent that that becomes a more durable part of what they're doing, there will need to be transparency about the processes used for those appointments.

Q174 **Chair:** At the moment, it seems that it is not very transparent. My own was willing to provide me with a link to publish the plans at an early stage, but a lot of colleagues across the house have found it very difficult to get hold of their STPs. We know they are now public.

Simon Stevens: All 44 STPs are published and available on our website. We have been nothing other than fully transparent.

Chair: This was a process of iteration. It is quite understandable that members of the public might have wanted to have an input into them as they were being formulated. Some were being very secretive; some were being very open.

Q175 **Karin Smyth:** The accountability issue is really important for building trust in the plan. We know that we rely on a lot of interim management in the system and we are short of people taking on some of the large roles. Bringing together 15, 20 or 10 organisations with competing incentives in a financially constrained Department is a very difficult task. We don't really want to take the people who are doing well in places and running good institutions off their day job, do we? That takes the eye off that ball. It is important to give an assurance of grip in the system as well as accountability. That is why we're interested, as a Committee.

Simon Stevens: Of the 44 conveners or chairs for this first stage of the journey, half are from provider trusts and half are from CCGs—or just under half for both, because we have four local authority executives and



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leaders who help as well. We are discussing with them now what support they need as they crystallise their plans for next year and the year after.

Part of what we're trying to do is to give them the ability to pull together different teams of people who are working in different bits of your local health and social care service and actually create a combined—

Q176 **Chair:** So you are effectively creating new bodies here, in some way?

Simon Stevens: We are aligning effort, at the very least.

Chair: I love the sophistry; there must be a whole dictionary, Mr Stevens, of your—

Q177 **John Pugh:** Who decides the footprint of the STPs? In the Merseyside scenario, there is the central cluster, which is one STP, and there is a sort of ring that goes around Merseyside that represents another. I have not been able to find out why it has been done like that. You could have done the whole of Merseyside, or you could have sliced Merseyside down the middle or created a north and south or whatever.

Simon Stevens: They were decided locally and organically as a pragmatic judgment. Nobody is saying, "These are the lines in the sand." The reality is that there are decisions that have to be more local and decisions that have to be cross-regional. If people want to change what their boundary looks like—these do not, in themselves, constitute statutory organisations. The accountabilities are with the statutory organisations. People are pooling sovereignty and decision rights and we are in a live discussion with them about whether they formalise their governance partnerships where they've got a clear plan of action that they now want to take forward.

Q178 **Chair:** Talking about the plan of action, they all produced their plans on 23 December. I understand NHS England has assured all of them?

Simon Stevens: We have certainly worked with the STPs, particularly in the context of what they're doing for their 2017-18 and 2018-19 contracting round.

Q179 **Chair:** But you have gone through them to see that they stack up, to some degree?

Simon Stevens: Yes. It is an iterative process, and we said to concentrate on the next several years, rather than on—

Q180 **Chair:** So somebody at NHS England has had a look at them and checked that they have ticked the boxes and done what they are supposed to do? You are content that all 44 have delivered, on paper at least?

Simon Stevens: Well, they're along the spectrum. I don't want to say that everybody is declaring peace in our time to 2020.

Q181 **Chair:** Mr Stevens, perhaps I am not being clear: has NHS England done a checklist? Have you done a cumulative financial analysis of what their financial needs will be?



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Simon Stevens: We have looked at all 44, yes. We have said that the financial period we want people to focus on most is 2017-18 to 2018-19, linked to the contracting round that, as I said, is just in the process of successfully concluding. We need to be clear ahead of time, before people get concerned or carried away: some of the staffing projections within individual STPs will now need to be refined.

To nip one potential future controversy in the bud here this afternoon, I think it is certain that we are going to need more qualified nurses in the national health service in five years' time than now. Anybody who looks at some kind of Excel spreadsheet and infers, "Oh blimey, there is about to be big reduction" is wrong. When it comes to hospital beds—

Q182 **Chair:** Mr Stevens, could you stop a minute and answer my question? It is very early days to have done this, and if you haven't, tell us by when you will: have you done a cumulative analysis? These 44 STPs—sustainability and transformation plans—are contributing towards the £22 billion efficiency gap in the NHS. That is one of the main reasons.

There should be a win in patient services, efficiency and the effectiveness of the NHS. Unless you have done that financial analysis cumulatively, you will not know how much it is contributing to that. So have you done a cumulative financial analysis of what those STPs will cost and will generate in savings over the two-year period you have asked them to focus on?

Simon Stevens: We have done it several times and it is iterative. That is the reality. Folks had a first go in the summer and refined it in October. There were a further set of deliberations at the end of December.

Q183 **Chair:** So you know how much this will save.

Simon Stevens: Yes. We know that for next year and the year after in aggregate we are gunning for around about £3.5 billion to £4 billion of efficiency each year, building on the £3.2 billion of efficiency that we will have delivered this year.

Q184 **Chair:** So there will be savings made year on year—not just spending and then a projected saving in years four or five.

Simon Stevens: Absolutely. Some of that is hardwired into the way in which the reimbursement formula is set: the tariff efficiencies.

Q185 **Chair:** And if they do not deliver the savings that you have projected?

Simon Stevens: Actually, it is worth saying that the national health service has got a very strong track record on this. In a little noticed publication a fortnight ago, the Office for National Statistics showed 2.3% productivity gains in 2014.

Q186 **Chair:** Mr Stevens, I simply want answers to my questions. At this late hour, we could be here quite a long time if you keep giving me adverts about everything that is going on. Please answer my specific questions.

Simon Stevens: Where people are doing well it is important to encourage and congratulate them.

Q187 **Chair:** At 10 minutes past 5, when you have already been sitting here for a couple of hours, it might be to the benefit of all of us if we cut to the chase. So, if they do not work and do not deliver the savings—when they start motoring through and they don't work—what is plan B? Will another STP have to fill the gap?

Simon Stevens: That is no different from the situation this year or last year.

Q188 **Chair:** What is plan B?

Simon Stevens: The practical reality is that Jim's folks and my folks locally, together with leaders in different parts of the NHS, are structuring the best operating plans that they can for next year and the year after, and we will keep them under constant review as the year unfolds. It looks as if this year—a tough year—we will have cut the hospital deficit by two thirds and will be on track to balance the NHS budget, which will be a substantial improvement on the position last year. We know increasingly what the battle rhythm needs to be in order to do that.

Q189 **Chair:** We will hold you to that. Mr Mackey, going back to the issue around the control totals that was raised earlier: there are many organisations, as Ms Smyth highlighted, in STPs. Some are weaker than others. If one is not doing very well, will the others bail that one out? That is effectively what happens.

Jim Mackey: That is what happens by default. There is no contingency, no headroom anywhere, so if anybody does go adrift, they are spending somebody else's money. We need to use that more as a lever.

Q190 **Chair:** That is all very well if you are in a multi-borough area, as they are in London. If another borough a long way from me—a long way is about four boroughs over in my case in Hackney—is overspending, it might be my constituents and my local services bailing it out.

Simon Stevens: We want to get everybody to balance. We are trying very hard to do that.

Q191 **Chair:** We need to come back to that. The Comptroller and Auditor General is next.

Sir Amyas Morse: Just so that I am following the story, this is the year when we have an accelerated budget sum, so when we say we have reduced the deficit, we have reduced the deficit against the front-end accelerated budget. Is that right? Just to be fair about it.

Simon Stevens: Compared with last year.

Sir Amyas Morse: I am not saying it's bad. I'm just trying to clarify.

Simon Stevens: If your point is that the budget increase was greater this year than last year, it was. Deliberately so, because we had to absorb

another £1 billion of pensions/national insurance costs in 2016-17 that we did not have in 2015-16. That was part of the reason for saying we needed a front-loaded funding settlement.

Sir Amyas Morse: I understand that, but are you saying we should regard the reduction in the deficit as what I call new achievement, rather than attributable to the budget?

Simon Stevens: It is a combination.

Q192 **Chair:** I have a couple of questions before I go to Phil Boswell, who will ask a few quick ones about leaving the European Union, which is obviously of concern at every hearing we have at the moment. Mr Mackey, what level of efficiency do you expect in 2017-18 and 2018-19? Will it be more than 4%? Or will it be higher or lower than that?

Jim Mackey: The efficiency embedded in the tariffs—about 2%—it looks like providers will generate that and, for the first group of plans, it looks like they are planning to generate around the 4% mark.

Q193 **Chair:** In the past, you have sat here in this Committee and candidly told us that 4% was what caused the problems that we are in at the moment. How can these new plans deliver a 4% efficiency saving and not create the problems that we have had?

Jim Mackey: Yes, I would rather it was 2%; I would rather it was the lower figure, but the reality is that that is what the aggregation of plans is in order to deliver what they need to deliver. In this year they will have delivered three and a bit per cent.—close to 4%.

Q194 **Chair:** So if we keep delivering at 4%, what is your view about the sustainability of these plans?

Jim Mackey: We won't be able to do it forever. There is no question that we can do it forever. We are creating new evidence. There is no system in the world that has done this. It is certainly not possible forever, but this time last year most people wouldn't have thought this was possible, what people have achieved this year.

Q195 **Chair:** And going back to what I was asking Mr Stevens about, I have talked about the cumulative cash financial side of it, but what about the cash flow? It tends to be, with these transformation things, as Ms Morris has highlighted, that you need early money in to transform something.

Jim Mackey: There is a lot of work going on around cash flow and cash management. I have a slightly different view on the pump-priming thing; in my experience in the NHS I have never seen anybody receive transformation money and wash its face—pay the money back through the actual change. I think you have got a much better chance when you have actually got some skin in the game. I am not in the place where I think you should just throw money at new things. I think if people really believe in it as a business case they will engage—

Q196 **Chair:** It is refreshingly honest of you to say that transformation money



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goes in and we never get the savings. That seems to us one of the problems. We will be watching the 4%, because it is very concerning. When will you be able to publish detailed financial information about your analysis of these 44 plans, so that we can see the cumulative—

Jim Mackey: Probably around March, I would have thought.

Chair: Presumably it will not be in the Budget, because it will be projected costs.

Q197 **Karin Smyth:** Is that what we established earlier in the sitting—that we will see this at the end of March, and be able to look at the choices that need to be made?

Simon Stevens: Yes, for '17-'18 and into '19. I do not think, in the spirit of what we are realistically asking people to do, that there is any point in, in eight weeks' time, getting people to pick numbers out of the air for the end of the decade.

Q198 **Chair:** Finally—well, it depends what your answer is, Mr Mackey—are you on target this year to reduce the agency costs that we have talked about in this Committee before?

Jim Mackey: We are forecasting around £2.8 billion to £2.9 billion now, versus last year's £3.7 billion. The only caution in that is that the last few weeks have been really pressured, so there might be a little bit of a bounce out of that, but they are huge results—we have hit record levels of spend in terms of reduction over the last few months.

Q199 **Chair:** And what is being done apart from reducing the hourly rate of pay through agencies, which is a small part of the problem relative to the volume? What else are you doing to get that down?

Jim Mackey: There is a range of things. There is more transparency on data and rates of pay. Providers are working together and holding a line more, now, on making sure they are not played off against each other. They are establishing collaborative banks. Some specialist organisations have emerged, who have got fantastic data that can be used to help drive costs down. Now we need a really big, concerted effort on the medical locum. It has largely been in nursing, to be fair, so the next big push is on the medical locum side. We have had some early discussions with the Royal College of Emergency Medicine and a couple of others about whether we can work together to translate that temporary workforce into a more substantive workforce on NHS pay, terms and conditions.

Q200 **John Pugh:** To be absolutely clear, in figure 9 of the NAO Report, the figure for agency and contract staff as a percentage of total staff expenditure is now 7.6%. What will that look like when it is for 2016-17? You are targeting what?

Jim Mackey: This year we had about £2.7 billion to £2.8 billion, so I am not sure what that is as a percentage. I have not got those papers in front of me.

Q201 **Chair:** I think we are comparing apples and pears, there. Our concern, of



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course, was about the volume. You talk about the conversations with the Royal College of Emergency Medicine on making a more permanent workforce, but of course the pension cap has been a big issue for senior medics leaving—both GPs and consultants. Is that something that any of you are raising with the Treasury? Mr Wormald, your predecessor sat here and said it wasn't an issue, but now we know it is.

Simon Stevens: I don't think that is what is going on with A&E locums per se, because some of these are younger doctors. I do not think it is principally the pension issue there.

Chair: It's not, okay. I am going to ask Phil Boswell quickly to come in on Brexit, then I have to talk to Mr Wormald about your responses to our discharging older people inquiry. I am afraid we will be going until at least 5.30 pm; it depends on how fast we manage questions and answers.

Q202 **Philip Boswell:** I have a couple of questions around Brexit and how it affects the respective Departments—the Department of Health and the NHS. We have had about six months to think about how Brexit will impact our Departments. This line of questioning is going to be a recurring theme. It has been already. Every time you come back, we will be testing what you have said and, to be honest, what a reasonably competent professional should have known about the impact on the Department as well. Assuming that we trigger article 50 by the end of March 2017 and the UK leaves the EU with a hard Brexit, as is perhaps likely, in April 2019, what are your main concerns about the impact of hard Brexit on your respective Departments? The Department of Health first, Mr Wormald.

Chris Wormald: Obviously, the effects are dependent upon the terms on which we leave, so there is a lot of variability around that. As I think I have said to this Committee before, there are issues for the Department of Health raised by leaving the European Union, but we are not in the category of Departments where it dominates our business. There are three main issues that we are looking at. One is workforce, as you would expect, across the NHS. As you know, a considerable amount of our workforce comes from the European Union, and we look at that as an in-the-round question alongside all our workforce questions. There is a set of questions around drug regulation, which is currently done on a pan-European basis. Indeed, European drugs regulation is actually done from the UK at the moment—it is based here. The third issue, which I have also discussed with this Committee before, is mutual recognition of health costs and EHIC. Those are the three big issues that we are looking at. As I have also said to this Committee, and I am sure you have heard repeatedly from pretty much everyone, we do not give a running commentary on where we are on those issues, but those are the three things that the Department is looking at.

Philip Boswell: Thank you. Mr Stevens, please.

Simon Stevens: I think Chris has laid it out well. From the point of view of the NHS, about a quarter of our NHS doctors are foreign nationals and



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something over a third qualified internationally—but not solely or even principally within the European Union; in other countries as well. We have a slight advantage relative to other industrialised countries in terms of the retirement wave, in that we have one of the lowest proportions of hospital doctors aged 55 and over. That gives us some time to expand our own domestic medical undergraduate training places. The Government's announcement of another 1,500 medical school places in England on top of the 6,000 we have will over time obviously be extremely helpful, but I do not think we should kid ourselves that we are not going to need to continue to retain and recruit high-calibre international staff alongside locally trained NHS staff. That has been true since 1948 and is not about not to be true.

Q203 Philip Boswell: You say that about a quarter of doctors are foreign nationals; doctors are mostly young, which is a positive; and there are 1,500 places on top of the 6,000—so 7,500—but there are around 55,000 nurses and doctors from the EU and about 80,000 social care workers in direct labour. If we have the hardest of hard Brexit and we lose those people, bearing in mind it takes four years to train a nurse, five years for a basic doctor, 10 years for a GP and 14 years for a surgeon, your 7,500 training places ain't going to cut it.

Simon Stevens: I must admit that I haven't completely got my head around what is meant by the term "hard Brexit," but to the extent it is a conversation about continuing participation in the single market or the customs union, that per se doesn't mean that just because we're controlling our own immigration, we can't make decisions about who stays and who we bring in. I don't think that the Brexit lens on that per se constrains the choices that the British Government will have post-Brexit.

Chris Wormald: Just to be clear about the additional doctors we are training, what we said was not about what the balance of UK doctors versus foreign doctors ought to be or anything like that. It was a very simple point that a rich country like the UK ought to be a net contributor to the world's supply of doctors, not a net importer from countries that are not as well-off as us.

Chair: Which is a long-standing principle.

Chris Wormald: Yes. Well, except we haven't been doing it.

Simon Stevens: We are willing to take the Australians, the Canadians and the New Zealanders—

Chris Wormald: Exactly. UK doctors will continue to want to work abroad, and some of those doctors will want to work here, but overall we ought to be a net contributor.

Q204 Chair: So what are you doing, Mr Wormald, as the head of the Department of Health, to make sure this voice is being heard in Whitehall?



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Chris Wormald: Like every Department, we are in discussion with our colleagues in the Department for Exiting the European Union. I don't think there is anything different about the Department of Health from all those other Departments. We discuss these issues a lot and, as I say, we have identified what we believe to be the key issues. There will be, I am sure, a lot of other minor issues, but we are pretty clear that those are the big things that we need to look at.

What we have not done—I wrote to you on this subject—is to establish, “Here is the unit that will do all these things.” We have a set of people who work with their colleagues in NHS England on the future of the workforce nationally, crucially with higher education in England. We look across the workforce and ask ourselves the question, “How do we ensure that we have the workforce we need going forward?”, of which this question is a subset, but by no means the biggest component. We look at it in the way that Simon described—in the round.

Chair: I think Mr Boswell has another question.

Q205 **Philip Boswell:** Just a final point on the EMA, which was mentioned earlier, Mr Stevens. The European Medicines Agency, which has its headquarters in London, will have to move. Currently we have one licensing process for 28 EU countries, which is very efficient. The UK being out of the EU will mean that the pharmaceutical companies will want their products licensed in the larger markets before the smaller ones, as happens in the States, Canada, etc., so the UK's 60 million won't get their drugs launched as timeously as the 450 million in the rest of the EU. What impact will the EMA leaving the UK have on, first, the research it drives into rare diseases in the UK; secondly, the UK pharmaceutical industry, which is critical to our economy; and, thirdly, the later or delayed launch of new drugs and investment in research and development?

Chris Wormald: You are not going to like my answer. We are looking at all those issues and we are not going to give you a running commentary on the situation.

Simon Stevens: But just to reassure you, it is most likely that the EMA will relocate, but that doesn't mean that there are not choices that the Government will have in terms of mutual recognition or participation in European licensing processes. I think that is what Chris is saying. We are not giving a running commentary. We are in discussion with the life sciences industry about what the right way of squaring that circle is. It is possible that on the back of that we can generate some comparative advantage for the UK, given that more regulatory freedoms are there. By the way, I think that could also apply—

Q206 **Philip Boswell:** Advantages such as?

Simon Stevens: In terms of the way the licencing process work.

Q207 **Philip Boswell:** To deregulate, then?



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Simon Stevens: I think that if you had Mike Rawlins and MHRA here, they would talk you through some of that. In addition, there are some regulatory flexibilities that it would be good to get through this process, around public procurement and some of the benefits that the Royal College of Surgeons has talked about, in terms of getting control over language recognition tests across Europe, which they say could improve patient safety. There are a number of moving parts here, and I think we should be objective about what we are gunning for.

Chris Wormald: I fully agree with that. I just want to make the point that, in our considerations, we are not just looking at the risks, which you have noted. We are also looking at the opportunities here, as you would expect.

On the drugs industry specifically, the UK has a very important pharmaceutical industry. It is here for a lot of reasons, but particularly because we have excellent universities that work in this area. We have a lot of competitive advantages around that, and I am sure life sciences will be an important part of the Government's industrial strategy. When you look at drugs regulation, although we are currently part of the EU system, of course there has to be a level of alignment between all major Administrations, because drugs companies serve a number of markets and wish to work in the US, Europe, the far east and so on. It is not a simple set of things, and we will still be part of a world drugs system with other industrialised countries because that is the nature of how the system is, regardless of our EU position.

Chair: We need to finish on this.

Q208 **Philip Boswell:** Thank you, gentlemen. It sounds very much like the only advantage is to turn UK citizens into guinea pigs through deregulation, but—

Simon Stevens: To be absolutely clear, that is not what I am saying, and in any event that would be a decision for Government, not the NHS or NHS England.

Q209 **Chair:** I think that Mr Boswell has made his points and concerns known. We now need to spend 10 minutes—I ask Committee members to indulge us, as we need at least a quorum for this—to cover the concerns we had about the Treasury minute responses that you did to our discharging older people from hospital report.

Chris Wormald: Yes, and I have now written to you—

Chair: Our first recommendation was that basically you have a metric—a way of measuring the cost of keeping someone who is medically fit in hospital when they need to be discharged. You said that rather than having data the way that we suggested, you wanted to introduce a stranded patient measure, after consultation with various professional bodies. That would measure patients unnecessarily delayed, which is those who had been in hospital for seven days or more. That is the measure.



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Chris Wormald: I am acting on the advice of the two organisations whose representatives are sat to my left.

Chair: Yes, that's fine. Perhaps Mr Mackey or Mr Stevens—

Chris Wormald: Just to be clear on what we are saying, we agree with what the Committee recommended. What we do not want to do is introduce a new—

Chair: We never seek to create huge new bureaucracies or bureaucratic systems, but—

Chris Wormald: So what we are looking at—

Q210 **Chair:** Sorry, I am just aware of the time. We are briefed on this, so we know what we are talking about and do not need to go into the detail on the record because we have got it in our Report. We have got the Treasury minute, it is all written down and we do not need to have it all read out.

The concern with that stranded patient measure is that somebody could finish their medical treatment at four or five days and would not be counted as a stranded patient. It is not measuring the additional cost of having someone in hospital for say, three days, if they could be discharged at four.

Chris Wormald: These are the kinds of technical issues that we need to come back on. We are clear, on the advice of my colleagues, that we want to amend the data collection that we already do to get at the issue—

Q211 **Chair:** If you are in hospital for eight or nine days and are still receiving treatment, you have hit the seven days so would you be counted as a stranded patient—I hate the phrase “stranded patient”.

Chris Wormald: The health service monitors all patients who are in for longer than seven days because, as I understand it, that causes you to ask questions about whether this has been done right. Some of those people will be there because their treatment takes longer and some will be there for other reasons. NHSE and NHSI wanted to come back to us on what the best technical way is, within this overall measure that you want to have for the good running of hospitals, to identify the category of patients that the Committee was interested in, or whether we think a low-burden way would—

Q212 **Chair:** Perhaps I could ask Simon Stevens how this measure will be used to capture the trust cost of an older patient who is no longer benefiting from acute care. It is a very blunt measure.

Simon Stevens: You have got a sort of J-curve in terms of the distribution of bed days. So a smaller proportion of people who stay in for very long periods of time account for a high proportion—on the Pareto principle—of the overall number of blocked bed days. If you are using this as a measure, you are tracking a lot of that. Since we are having a technical conversation, we are running this up against the HES data to



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look at what the dispersion of lengths of stay are by different category of care to answer the question, will this do the job? We want something that is fairly straightforward for practising ward nurses and social care staff to get their heads around, as opposed to the system at the moment, which has got all kinds of definitional ambiguities that the NAO pointed out originally—

Chair: Which is why we made the recommendation.

Simon Stevens: And we have a system anyway where we reimburse by docking off what are called the HRG trim points for a number of conditions in the tariff system. They are then paid as separate, per-day payments. So it is quite an overly complex system that we have got right now, and that is why we are trying to find something that is more intuitively usable.

Q213 **Chair:** A lot of it is for us and you, I hope, to assess the cost of this—where the cost should fall and whether it is cost-shunting. I think that in the evidence session in October, when you talked to us, we asked you to estimate the cost of delayed discharges and you estimated it being somewhere between £0 and £640 million. Do you have a better estimate now of the rising cost of this?

Simon Stevens: Yes. If you remember the discussion—I remember it vividly—the NAO number was £820 million gross, and that was then offset by £180 million of the replacement costs on community and social care, but that excluded some of the extra primary care costs that would probably be being incurred. It assumed the HRG trim point was £303 a day, but it could actually have been between £190 and £225. Look, we can have a replay of that conversation, but that would take longer than five minutes.

Chair: No, we don't need to do that. Absolutely.

Simon Stevens: This is all what we are looking at in the context of getting a single measure that, as Anne Marie Morris said, we can layer into the STPs as well as the day job of helping patients get home when they need to.

Q214 **Chair:** Mr Wormald, in your letter to me of 9 January, you say, "The likely burden of collecting this data is hard to justify". We don't want to create burdens, but we do want to be reassured that you and Mr Stevens and Mr Mackey and all those running the health service are doing everything you can to have an accurate picture, not just because of the cost but because of the cost to patients. We looked last time at muscle wastage issues and the loss of independence for people. It is just not good for people to be in hospital at length, for any longer than they should be.

Chris Wormald: And we were agreeing with the Committee's recommendation. What we were saying is that we want to see if we can achieve what you want by adapting existing measures that hospitals will find easy to implement, as opposed to creating a new measure that people need to collect. That was the only point that we were making that was different from your recommendation.



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Q215 Chair: We never want systems to be set up brand-new, but we think that often the data and information that should be being collected isn't, or is being collected, but could just be calibrated in a different way. We are not asking necessarily for much more form filling. It is just good practice.

Chris Wormald: Yes; this is why we wanted the technical assessment, because we want something that is both easy to collect and robust. Some of our existing methods—

Q216 Chair: The point that we can't quite understand is that if you are a sister, or matron, or whatever we call people these days running wards—a senior practitioner on the ward or the ward manager—if you are good at your job, you will know who has been in what bed for how long, whether they should have been discharged and whether they have ongoing medical needs. You will probably have an assessment of where there are delays in the hospital and departments that are slow at dealing with things. That will hopefully be at the forefront of a good manager's mind locally. You need a way of capturing that local data so that you are enhancing both the benefit to the patient and the cost to the taxpayer.

Chris Wormald: And of course, you want that to be low-burden and you want it to be consistent between hospitals.

Simon Stevens: Organisations.

Chris Wormald: That is why we need this piece of technical work to ensure that the number we get is actually telling a truthful picture.

Q217 Chair: I expect you could find somebody in Shoreditch who could provide an app to the ward manager. There's an idea.

I want to quickly move on to the issue of the social care market. That is a big concern for us on the Committee, and not just through the hearing we had with you on that occasion. You have decided not to issue a national market position statement on the adult social care market, yet since we met it has been under even greater stress. What information do you collect to make sure that you have a really clear oversight for the adult social care market? If it fails, it is catastrophic for the NHS.

Chris Wormald: I think I had better check and write to you on that subject.

Q218 Chair: Okay. Is the markets hub up and running now?

Chris Wormald: I will collect your questions and write to you on that. This is not something that I have particularly come with, is it, David?

David Williams: No.

Q219 Chair: I think we gave notice that we were going to be asking about this. Forgive me if somehow in the new year break that didn't happen. We are just concerned that the fragility of the adult social care market, which is only worse, not better, since we met you, is having a big impact on hospitals' ability to discharge patients. You are the steward. You have the role in your Department of being the steward of this marketplace, which



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is largely, in many parts of the country, private. So it is difficult. You don't control it completely, but you have to ensure that there is an operating set of facilities out there that will support and provide care and nursing care in cases of people leaving hospital.

Chris Wormald: Yes, that is correct. We share that responsibility with my colleagues at the Department for Communities and Local Government and we discuss these issues with them and the Local Government Association a lot. I will write to you with the exact detail.

Chair: And I will make sure that I write to you with a detailed laying out of our concerns, rather than delaying us any longer.

Nine minutes since I said 10 more minutes, we have now completed our session. It was a bit of marathon because we were in effect covering three issues today, with a second panel as well. You know our concerns in this area; I won't repeat them. We will watch closely what will be happening to your accounts this year and we are hoping to have a debate in Parliament as well. If they don't balance, we will of course be calling you in very early to find out why—Mr Williams, you can look forward to that.

Chris Wormald: I am sure we will of course be watching closely as well.

Q220 **Chair:** The point is that in the middle of this, as we talk the jargon, we tend to forget that patients will suffer if we do not have a long-term sustainable model for funding the NHS. We have heard from Mr Mackey some real concerns about that ongoing 4% efficiency savings. If the STPs are seen as a mask for cuts, that will be a disaster for proper long-term transformation of the system. I think that is an abiding concern.

Chris Wormald: I hope that what you have seen from both the previous panel and this panel is that we do think about all of those things simultaneously. That is the thing we discuss: how do you keep in balance those things, remembering that the purpose of all this is the patient? That is hard-wired into all the discussions that we have. As I say, I hope you saw from the pre-hearing that that is then replicated at local level. That leads to some tough conversations of the types that we have.

Chair: There may be some more tough conversations coming up, but for today, our conversation is over. Thank you very much.

Chris Wormald: Thank you very much.