

Health Committee

Oral evidence: Work of NHS England and NHS Improvement, HC 430

Tuesday 10 October 2017

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Dr Caroline Johnson; Diana Johnson; Johnny Mercer; Andrew Selous; Maggie Throup; Dr Paul Williams.

Questions 1 - 137

Witnesses

I: Simon Stevens, Chief Executive, NHS England, and Jim Mackey, Chief Executive, NHS Improvement.

Examination of witnesses

Witnesses: Simon Stevens and Jim Mackey.

Q1 Chair: Good afternoon and welcome to the Health Select Committee's first session in this Parliament. Thank you too to Simon Stevens, the chief executive of NHS England, and Jim Mackey, the chief executive of NHS Improvement, in what I think will be your last sitting before the Committee. Thank you very much for coming.

It is an important day: it is World Mental Health Day today. We have also seen the publication of the Care Quality Commission's State of Care report and a report from the Children's Commissioner on children's mental health services in England.

I have asked the Committee staff to give you both the running order of what we will cover this afternoon so that we can avoid repetition as far as possible. Could I open by reflecting from the State of Care report today on the impression that is given of a system under huge pressure, straining at the seams, as it says? We have bed occupancy running at 91.4% from January to March—its highest ever level—and it refers to 4,000 fewer beds in the nursing home sector. Therefore, at a time of increasing demand, reducing bed numbers and pressure for staff, can I start, Simon Stevens, by asking you what is keeping you awake at night?

Simon Stevens: I agree with the independent assessment that the Care Quality Commission has laid out for us today. It makes three important points. The first, which sometimes gets lost in the honest conversation, is that this year's State of Care report "shows that the quality of health and social care has been maintained despite very real challenges. The majority of people are getting good, safe care, and many individual providers have been able to improve." That is the first point we have to acknowledge, and, as it says, that is a huge tribute to staff across the health services working under great pressure, which is the second point. The pressures are genuine and they have rightly identified the fact that in many places now services are beginning to feel that in very tangible ways.

The third point that comes out from what the CQC has said is both that the programme to redesign care—to integrate and join up care, as David Behan has been talking about today—and the programme set out in the Five Year Forward View are needed to future-proof these services, but that cannot be done without proper funding along the way. That shows up clearly in social care—but not just in social care; that is also a live issue in many parts of the national health service.

Q2 Chair: Thank you. Jim, is there anything you want to add to that?

Jim Mackey: No. I think it is a very fair reflection. As Simon said, and as is said in the report, people are working very hard and making progress, but it is very hard; the context is very difficult. You will find in the same



HOUSE OF COMMONS

provider, in the same ward, great challenges but great things happening. I think that is where we are.

Q3 Chair: One issue is that for the first time we have missed all four key performance targets around A&E, elective surgery, cancer and ambulance waiting times. There seems to be a difference in view between NHS England and the Government on how achievable the targets will be. What is your view about how we are going to achieve waiting time targets?

Simon Stevens: We published at the end of March, as we are required to do, our outlook for the year ahead, called "Next Steps on the NHS Five Year Forward View." We were explicit in that about the importance of improving the experience that people have of cancer services, mental health services, GP services and the importance of short waits for A&E care, cancer care and indeed for routine surgery. However, faced with the combination of pressures on the national health service in 2017-18, we took the view—with support, I would say—that, if something had to give, this was not the year when mental health services should take the hit in order to sustain other parts of the programme of what the NHS offers.

We are all very committed to short waits for routine surgery; that was one of the huge achievements of the national health service during the course of the 2000s, and waiting times are still very low compared with what they had been for most of the post-war period. The amount of routine surgery going on is going up. The number of operations is up over the first four months of this year compared with a year ago, but it is not growing fast enough to maintain the 92% RTT waiting time standard, and we felt the need, in all honesty, to say that.

Q4 Chair: You feel that that standard will slip.

Simon Stevens: It clearly will slip during the course of this year. Prospects for next year and the year after will be determined by the budget for the NHS in those years.

Q5 Chair: Thank you. A final point for me is on the issue of bed occupancy, as I said, now running at 91.4%. Is the NHS going to cope this winter with occupancy rates running that high?

Jim Mackey: Things are running very tight and we have a huge effort going on across the country to try to create extra capacity by freeing up beds. You have heard of all the work people are doing on the DTOC front, in trying to find every avenue, shortening length of stays and ambulatory care and so on. It is true that we are running tighter than any of us would really want to and we have not had the impact from the social care investment this year that we had hoped for; so, it will be difficult—it will be very tight—over winter.

Q6 Chair: A lot of people are commenting that there are bed closures going on as an ongoing point at the same time as bed occupancy rates are running at record highs and we are losing beds in the community. Is there something that you are planning to do about that?



HOUSE OF COMMONS

Jim Mackey: We made pretty strong statements last year about preventing unnecessary bed closures and we have a lot of collective effort going on this year to make sure that we have sight in every system of what is happening; that there are not going to be unplanned closures; if closures do happen, they have been risk-assessed and so on. Providers' plans indicate that we will have slightly more beds going into this winter than last, but, as has already been indicated, that is not completely staying in tune with demand and we needed a DTOC reduction this year to create the capacity that we would like.

Chair: I am going to move on now to the first of our themes, which will be around workforce. Then we are going to come on to finance. Starting on the theme around workforce, Caroline is going to lead off on the questions.

Q7 **Dr Caroline Johnson:** One of you rightly said that the staff are a major asset to the NHS. We are not going to focus so much on nursing staff this time because we are shortly going to do a specific investigation into nursing numbers, but how many medical staff vacancies do you have at the moment and what are you doing to recruit more and retain the staff that you have?

Simon Stevens: How many medical staff agencies, was that?

Dr Caroline Johnson: How many medical staff vacancies.

Simon Stevens: Shall I start with what is happening on the medical workforce in the round? We have had a rising number of patients whom we are looking after, but we have seen large increases in the number of hospital consultants—not only over the last 15 years but even over the last year. The number of hospital consultants is up, and the pressures are being experienced particularly in some specialties and in some hospitals.

There is an issue particularly around so-called middle-grade doctors. We have to choose our vocabulary carefully, looking at the story on the front page of *The Times* today, certainly not saying “junior doctors” for experienced doctors who are still receiving training. So, fundamentally, we need to increase the number of doctors in training. That will not produce immediate relief, but it will produce a benefit to the national health service over seven, 10 or 12 years.

The 25% increase in medical school places, which is now coming on line, is going to be an important part of that. That 25% increase is 1,500 medical school places, of which 500 will be in place during this next year and then another 1,000 the year after. HEE is at the moment in the decision process as to which parts of the country and which universities should get those roles, and there may be some new medical schools that are created on the back of this.

As it does that, it will be very important that it pays attention to—and it is—the particular need we have for GPs and psychiatrists. So, explicitly, one of the criteria that HEE is using will be looking at universities and



curricula that have a good track record of generating doctors who want to go on to train in general practice and psychiatry.

If you think about the intake into medical school, there are some positive signs and expansion in the undergraduate number of places; the UCAS applicant numbers for medicine and dentistry are up this past year, whereas some other subjects have seen a decline. That is on the positive side.

The concerns are particularly around GPs where, unlike hospital consultants, we have seen flat to negative numbers over the last decade or so. We have a big programme to try to turn that around that we could talk about in more detail, and, as I say, there are particular pressures in individual specialties—for example, in A&E departments. Without stealing their thunder, later this week NHS England, NHS Improvement, Health Education England and the Royal College of Emergency Medicine will set out a very ambitious plan around expansion of A&E and ED consultants for the next several years. So, we are looking at where the pressures are and seeking not just to apply short-term relief but also long-term solutions.

Q8 Dr Caroline Johnson: You mentioned the middle-grade staff—the training-grade doctors. Shortages in some specialties are particularly acute; I know that my local A&E department is currently closed overnight because there have not been sufficient medical middle-grade staff to fill the training posts to accommodate that. When medical middle-grade training staff are allocated, it is done centrally in the regions. For the hospitals in Lincolnshire, who gets which posts filled is decided by a training doctor base over a Nottinghamshire-wide area. To what extent is there oversight to make sure that that is done fairly, particularly in recognition that it is easier for a large hospital to have a few vacancies than it is for a small hospital to backfill that work?

Simon Stevens: You make a very important point, which is that this is a particular challenge in some geographies—Lincolnshire is definitely one—for small and medium-sized hospitals. The work that NHS Improvement and Health Education England are doing with us is going to require a re-look at the way in which decisions are made around where training places are allocated and the way in which training rotas work.

From the point of view of doctors themselves that is not working optimally, with short—four-month plus—placements in individual locations, sometimes working a long way away from your partner, if they happen to be a doctor, and the kind of destruction, in effect, of the “firm” structure, or the team base, inside hospital medicine and the preponderance of specialty rather than generalist acute medicine. All these are on the agenda. I think HEE, the Royal Colleges and ourselves are well aware of that now, and we need to see some significant changes in that area over the next two or three years.

Q9 Dr Caroline Johnson: On a slightly different note, I noticed from the



HOUSE OF COMMONS

figures we were given that the number of public health and community medical staff has fallen by 42%. Was that done as a specific policy change or has it happened for another reason?

Simon Stevens: Excuse me—public health and what?

Dr Caroline Johnson: The public and community health is the figure we have been given.

Simon Stevens: Are you talking about public health doctors?

Q10 **Dr Caroline Johnson:** Medical. The figures we have been given are medical staff working in public and community health. I know from my own practice that there is significant demand for community paediatric services; I am not so familiar with the adult services. But has this fallen as a result of specific Government policy or for other reasons, and what are you doing to ensure, particularly with the issues on delayed discharges, that there are enough medical staff in the community to meet the demand?

Simon Stevens: We would have to look very specifically at the public health numbers that you reference, because, as you know, employment of public health doctors has moved from the NHS to local government. Directors of public health and their teams are now in local government, not showing up in the NHS. We still capture some of those numbers but we need to make sure there is not a statistical artefact going on there.

More generally, obviously, we need strong community care of the elderly services, geriatric services and rehabilitation services, but I personally think that the old categorisations between what is in primary care, community medicine, hospital outpatients and what is a consultant working for in-patients is a time-expired way of thinking about how we look after groups of patients with long-term needs. I suspect that the sort of statistical series you are describing may not completely capture that.

Q11 **Dr Caroline Johnson:** You alluded to the particular challenge faced by GPs. The Government have committed to providing more GPs, but currently one in five is 55 or older and one in five training posts for general practice is unfilled. The GPs themselves are being asked to see more patients, and increasingly complicated patients, and to extend their hours not just for emergency care but for routine care, evenings and weekends. In that context, what are you doing to ensure that GP as a specialism is an attractive one and to retain the staff that we have?

Simon Stevens: We are now doing a lot. There is complete clarity and agreement on the fact that the GP part of the system had been eroding for a number of years, and the GP Forward View, which was published in concert with the Royal College of GPs with support from the General Practitioners committee of the BMA, laid out a very practical set of actions on workforce expansions in general practice around building a multidisciplinary team, relieving some of the workload pressures that are experienced in practice, and, on all of those fronts, underpinned by a



HOUSE OF COMMONS

significant pivot or inflexion point and investment in general practice. We are seeing that the tide is turning.

What is the evidence for that statement? Now, for four years in a row, we have seen an increase in the number of new doctors choosing to go into GP training, and all the signs are that this year's numbers in the GP training scheme will be the highest ever. We are seeing a significant turnaround in the investment going into general practice, and, again, for the last three or four years, we have seen real-terms increases compared with real-terms decreases in the three or four years prior to that.

The figures that NHS Digital has just published for last year, for 2016-17, show a real-terms increase in GP investment of 3.2%. We are £80 million ahead of the investment profile that was in the GP Forward View. Therefore, on that front, there are some real practical reasons for optimism.

The flip side is that there are real concerns about the early retirement rate, driven by pressures on practices, concerns about indemnity and changes to pensions. The Secretary of State will be talking to the Royal College of GPs later this week, and we will be in a position to set out some further action on measures that I hope GPs will welcome on some of those other points.

Q12 Dr Caroline Johnson: The second area that you highlighted was psychiatry. From the figures we have been given, since 2010 there has been a 2% reduction in the number of medical staff in psychiatry, a 24% reduction in nurses in psychiatry, an 11% reduction in community nurses, and a 17% reduction in school nursing. In that context and given the Government's commitment to ensuring that within the health service mental health and physical health have parity, how are you going to ensure that demand is met?

Simon Stevens: That is a completely fair description of what has been happening in the mental health workforce, and that is why in July all the national leadership bodies of the NHS convened by Health Education England published this detailed plan as to how they would seek to—

Q13 Chair: Could you say what it is for the record?

Simon Stevens: This is the delightfully titled "Stepping Forward to 2021: Mental Health Workforce Plan for England" report from Health Education England to support the delivery of the Five Year Forward View on mental health. In it, you will see chapter and verse on how the workforce expansion is intended to be secured over the next five years, including a very detailed waterfall chart showing the functions around the new joiners, extra staff, retention pressures, retirements and so on. If you are doing a separate inquiry on workforce or nursing, that would be a good place to start, I would say.

Q14 Dr Caroline Johnson: Finally from me, because of the challenges around medical and nursing staffing, there has been an increased number



HOUSE OF COMMONS

of different types of roles. It started with nurse practitioners and now we have nursing associates and physician associates. With doctors and nurses, we very clearly have a form of regulation through the GMC and the NMC. How are the nursing and physician associates regulated and going to be registered?

Simon Stevens: You should await upcoming announcements from the Secretary of State on that topic.

Q15 **Chair:** We can expect something imminently, can we?

Simon Stevens: I believe so.

Chair: Thank you. That is helpful. Now we are going to move on to the issue of Brexit and the key issue of finances. Ben is going to lead on that.

Q16 **Mr Bradshaw:** On the workforce issue, Mr Stevens, how worried are you about the potential impact of Brexit on your pre-existing workforce challenges?

Simon Stevens: As we have discussed before, we have a superb contribution from staff who have trained and come from the rest of the European Union in many parts of the national health service. It is about 9% of our doctors and about 5% of NHS staff overall. In some parts of the country, that is a higher proportion; it is particularly true in London and in some London hospitals. At Great Ormond Street, for example, there would be a much higher proportion of staff from the rest of the European Union. For that reason, we greatly welcome the assurances that have now been given to staff from the rest of the European Union about their ongoing welcome in this country, because that surely is what the national health service needs.

Q17 **Mr Bradshaw:** That is of course assuming there is a deal. Have you been asked by your political masters to prepare contingencies for a no-deal scenario, which is what the Prime Minister was talking about yesterday?

Simon Stevens: We have not, but I do not detect any disagreement with the proposition that in addition to continuing to grow our locally trained staff here—the 25% increase in doctors and 25% increase in nursing places—we will continue to rely on our international staff. That has been true for the 69 years of the NHS and I do not detect any dissent from that proposition.

Q18 **Mr Bradshaw:** You have not done any work on a no-deal scenario and the impact on the ability for people to move across borders or to move medicines or other equipment across borders.

Simon Stevens: Those are two slightly separate issues, are they not? I do not really want to speculate; this is a matter for the Department of Health and for other parts of Government. But, even in a no-deal scenario, it seems to me that, if we are in control of our immigration policy, given the public support for continuing to be able to recruit not just in the UK but internationally, there is no reason why we should not



HOUSE OF COMMONS

continue to roll out a big welcome for highly trained professionals with great English language skills coming to help look after patients here.

- Q19 **Chair:** Can I just ask this though? It is not just about highly trained professionals if you look at the number of people working in support roles in the NHS. Are you concerned about the future, not just about the staff who are currently here but how easy it is going to be? I am sorry, Ben, to cut across that, but I wanted to clarify.

Simon Stevens: That is particularly an issue, as you know, Dr Wollaston, in social care in some parts of the country with care assistants. Across the social care sector, there are more people who are working from elsewhere in the European Union, and so that needs to be factored in as we think about home care and care homes well.

- Q20 **Chair:** Have you made allowances for those who are working in roles such as portering, the kitchen and other support staff throughout the NHS?

Simon Stevens: They are all included in the 60,000 or so people who are working in the NHS from the rest of the European Union among our 1.3 million staff. So, yes, they make an important contribution, but I think other parts of the care sector and probably the UK economy are more exposed to these kinds of questions than the NHS.

Chair: I am sorry to interrupt.

- Q21 **Mr Bradshaw:** Going back to the money and its impact on overall performance, I am slightly confused by what you said earlier, because on the one hand in response to the Chair's question you quoted the CQC report today about having maintained the quality of services, but then you acknowledged in response to her question that the targets had all slipped. It is not just the main targets; trolley waits and delayed discharges are up hugely. Which is it? Has quality been maintained in spite of the financial situation, or are quality and the service that patients are experiencing slipping?

Simon Stevens: The CQC is unequivocal in its overall assessment, which is that quality has been maintained, but in some areas it reports—and we agree—that the pressures that you describe have intensified. The number of organisations providing care that are good or outstanding has gone up, but none of that detracts from the fact that when you think about the extra patients who are being looked after in A&E departments, or the extra quick cancer diagnoses that we need to offer, we have a system that really is, as they have described, full. That is how it feels from the point of view of front-line nurses, doctors and therapists.

- Q22 **Mr Bradshaw:** You also said in response to the Chair's question that whether the performance continued to slip in the years ahead would depend on the money, but—correct me if I am wrong—for the next few years the money in this Parliament has been front-loaded. Your increase was 1.8% in this financial year; it is 0.7% next year, 0.2% and 0.1%.



HOUSE OF COMMONS

These are already by far the lowest increases in the NHS's history and represent real-terms cuts per head. How can the public not expect the quality and level of service to deteriorate further given what you said earlier and given that financial situation?

Simon Stevens: Let me answer that in two parts. As we set out in the "next steps" document, on stroke care, cancer care, heart attack care and indeed—we will come on to talk about it—I believe on mental health services, the range and quality of care that the NHS is providing now is better than it was three, five or 10 years ago. But, looking forward, it is no secret—and I am not saying anything I have not previously said—that the budget position, the currently pencilled-in funding for the national health service for next year and the year after, looks extremely challenging, and, if not amended, it is going to be very hard for the NHS to do all that is being asked of it over the course of the next year and the year beyond.

The welcome news is that there are statements that the Government have made that they understand that this needs to be looked at. So, it is just a practical fact to say that the prospects for the kinds of measures that you are talking about for next year depend on decisions that are made on 22 November.

Q23 Mr Bradshaw: You say it would be very hard for the NHS to do what is being asked of it in future years, but you have already announced, as I understand it from the *Health Service Journal* over the summer, these 14 areas that are the subject of what is called a capped expenditure process, which include most of the south-west of England, incidentally, where you have asked the NHS to think the unthinkable, including closing services, stopping treatment, scrapping choice and extending waiting times. The financial impact on the quality of services is happening now.

Simon Stevens: It is right that Parliament decides what the NHS budget will be and then we use our best endeavours to get fair shares of that budget to different parts of the country. The objectivity and the fairness by which the NHS budget is divvied up is the highest it has ever been—I can justify that statement if asked—since 1976, when we tried to start doing fair shares around different parts of the country. Once that budget has been set locally, it is for individual areas to live within the money that Parliament has allocated; if they do not, in effect, they are unfairly taking money from some other part of the country given that we are living within a fixed pot in any given year.

Q24 Mr Bradshaw: But that system is going to involve the most unprecedented level of postcode lottery, is it not? There will be parts of the country where you just do not get access to treatments that you do elsewhere.

Simon Stevens: It is not a postcode lottery if it is a fair division of the budget, but I agree that in some of those areas people are having to make very difficult choices. I would say that it is right in a democratically



HOUSE OF COMMONS

controlled national health service that the elected Government decide what the NHS budget should be. All we can say, whether it is we, NHS England, NHS Improvement or the Care Quality Commission, is that those decisions have consequences, and decisions that are taken on 22 November will determine the shape of the national health service next year and the year after; of course they will.

- Q25 **Mr Bradshaw:** Mr Mackey, you said earlier that you did not think that the extra money the Government had announced in a fanfare earlier this year for social care had had any or much of an impact. Could you elaborate on that?

Jim Mackey: Our expectation was that we would see a significant reduction in delayed transfers of care, and the evidence is that that has not happened. There is still time to make an impact on that; people are working very hard. There is an awful lot of discussion going on in local systems to do that, but as at the end of month five there has not been a material improvement in delayed transfers, which is clearly our—

- Q26 **Mr Bradshaw:** What is your explanation for that? Is the money not being delivered to local authorities? Are the local authorities not spending it in the right way to deliver the care packages to help address the problem? What is going on?

Jim Mackey: It is a complex situation and it is different in different parts of the country. In some places they have to recreate a market, for home care, for example, where there has not been a market or a vibrant market for very long, and that takes time. Councils are still very strapped for cash. There are interactions between the bodies to try to agree how the money is spent, and so on. What some councils say to me, and I am sure to Simon and others, is that they feel the money is non-recurrent, so it is very hard to plan for the future. From our point of view, we argued hard for the extra money and for it to be spent in social care, and we rightly expect to see an impact from that.

- Q27 **Mr Bradshaw:** If the independent pay review body recommends a pay rise for NHS staff of more than the 1% cap, that is going to have a massive impact on the already very fragile financial situation in the NHS, is it not? What kind of impact will it have on everything that you have just said you want to do in the next few years?

Jim Mackey: If that sort of thing does happen, it is my view—and I am sure Simon's view as well—that that needs to be funded. The NHS is generating serious levels of efficiency. It is very hard to imagine how that sort of pay award could be internally financed.

- Q28 **Mr Bradshaw:** There would need to be extra money on top of the extra money that you think there will need to be in the budget just to stop a further slippage in quality of services. If health service workers are going to get a 2% pay rise, that will have to be funded on top of that.



Simon Stevens: As I understand it, the Secretary of State has said earlier today that in a sense the pay cap has been lifted and so the review bodies presumably will be asked to give their advice, but ultimately public sector pay policy, including the national health service, is set by Government rather than by the NHS. But, as Jim says, yes, we said from the get go that over time it will be necessary for NHS staff to get rates of pay that are consistent with that and the rest of the economy. It is not reasonable indefinitely to expect people to take the kind of net pay cuts that they have seen, but that does need to be funded.

Q29 **Mr Bradshaw:** Finally, Chair, some people have suggested that we could save some money by merging your two organisations and that you do not get along, not personally, but I think the quote was that relations are as strained as ever and you had a row over the provision of bariatric surgery, or your organisations did, according to the *HSJ* of course.

Simon Stevens: Bariatric surgery is a subject I am interested in because I tend to believe we should put more money into obesity prevention rather than bariatric surgery, and I have had this argument with the bariatric surgeons, but I am not sure that is anything Jim and I have had a row about.

Q30 **Mr Bradshaw:** We are going to talk about obesity and public health later. Seriously, do you think there would be merit in this world of integration if your two organisations were merged?

Simon Stevens: I think there would be merit in more fusing of our functions and teams and, of course, as you know, Ben, that has now happened in your part of the country. The regional director for the south-west works for both Jim and me, and we are doing the same in the south-east, testing that proposition. I think we will see more of that. We each want to take further significant administrative savings out of the overhead of the national health service, modest as it is by international standards at 2p in the pound relative to 5p or 6p in Germany and France, just for the record. We do want to do that, but actual full-blown merger would require an Act of Parliament. Unless you are going to tell us that that is what you guys have in mind, that is probably not on the cards for the next several years.

Q31 **Mr Bradshaw:** Do you agree?

Jim Mackey: I would agree with that. There is an awful lot more we could do to simplify. We should seriously reduce our overhead, as Simon has already outlined, and I am instinctively a devolution person. So, I think we should be looking, wherever possible, to push things into the local system—simplify the architecture—but to formally merge requires a change in the law.

Mr Bradshaw: The obstacle, once again, is the 2012 Health and Social Care Act. Thank you, Chair.



HOUSE OF COMMONS

Chair: Thank you. Luciana has a follow-up question on the Better Care Fund.

Q32 Luciana Berger: Thank you. I want to come back to the point about the Better Care Fund and the specific point raised by Ben about the delayed transfers of care. I will give you one specific example. NHS England has, as I understand it, so far chosen to reject Liverpool's Better Care Fund plan because it will not sign up to some unachievable targets that have been set by NHS England. They will not sign up to those targets because NHS England has said, first, that it will seek to claw back the money and now to financially penalise them if they do not agree to these targets. While that has happened, at the same time NHS England fully supports all the projects that have been put forward by Liverpool on which it intends to spend that Better Care Fund money. How does it make sense to withhold the very same cash that will essentially reduce those delayed transfers of care, and is not NHS England by withholding that Better Care Fund money turning a possible winter crisis in my city into an inevitability and in other parts of the country that have also chosen to reject that unachievable target?

Simon Stevens: No, definitely not, and you have been badly briefed on the backstory on this. The Government have, in my view rightly, said that one condition by which the Better Care Fund transfers from NHS budgets to councils should take place this year is that councils will agree to meeting the unmet social care needs of your constituents, your frail older residents who are stuck in hospital across Liverpool waiting to go home. One hundred and twenty-one of 141 councils have said that they will do that. Liverpool is not one of them, and, therefore, under the requirements that were set for the approval of the Better Care Fund transfers from NHS money to local government this year, we are required to put Liverpool into escalation. That is what we have done.

We want that money spent in Liverpool on the unmet social care needs of really vulnerable people who are stuck in hospital. The reason we want that is not only because, as the Care Quality Commission has shown, it is so bad for the future recovery of 6,000 old people to be stuck in hospital at any one time, but that it is also having a terrible impact on the safety of A&E departments, which then cannot admit emergency patients arriving in the A&E department to a hospital bed where they need to be. It is not plausible to say, "Why don't we just open up a whole load more beds to compensate for the fact that we have these 6,000 beds out of action?", because the nurses are not there to do that.

We really have to make the hand-offs between health and social care work and we have to deploy at least some of the £1 billion extra that the Government have put into adult social care this year—perhaps about a third of it—to buy more social care packages for that group of people. Social care funding is not the only call on local councils; we know there are pressures around the national living wage and learning disability



HOUSE OF COMMONS

services, but around a third of it needs to be used for that purpose. That needs to be true in Liverpool just as it is in the majority of the country.

- Q33 **Dr Cameron:** You spoke earlier about Brexit and issues in social care. If Brexit has this adverse impact upon social care provision, surely that is going to have a significant knock-on effect on NHS provision, particularly on waiting times and bed blockages—all the issues that we already struggle with. Therefore, on integration, how are you working together on a way forward for that rather than segmenting it into something being a social care problem instead of an NHS one?

Simon Stevens: What is happening across England—and I cannot speak for other parts of the UK—is that for the most part people are working together quite effectively, and in fact CCGs are transferring more than they are required to of NHS funds into a shared budget with their colleagues from local government. That is happening in many parts of the country. The net required transfer of money from NHS to social care was £1.6 billion this year with a £5.1 billion mandatory pooling, but instead of £5.1 billion we are at £7.3 billion. So, people are doing that in most of the country, but there are some parts of the country where that is not working well, and that is one reason why the Care Quality Commission has been asked to go in and do 12 reviews in those geographies to get to the bottom of what is going on.

- Q34 **Dr Cameron:** Is it not the case then that Brexit has the capacity to undermine much of that good work? If social care falls foul of staffing shortages, much of that working together could itself fall foul.

Simon Stevens: We have to deal with the world as we find it. There are a whole range of pressures to which we have to respond and we need to take account of those ones as well.

- Q35 **Chair:** Can I return briefly to one of your previous points and bring in the Care Quality Commission again? They spoke last year about social care being at a tipping point; there is ongoing fragility, increasing loss, with 4,000 fewer nursing home beds in the care sector. Are you aware of and supporting any research that is looking at how we can best support the provider sector so that it is in a position to look after the people who need delayed transfers of care? There seems to be very little work being done about how the money is being used. Does that concern you?

Simon Stevens: One important reform that is happening in nursing, as I think we may briefly have talked about in the past, will have a beneficial effect for the workforce and social care. That is that the new nursing associate grade, which is between a care assistant and a registered graduate nurse, will provide career ladders for people who begin work as care assistants to progress to nursing associates, and then, on the apprenticeship-based model, to graduate nursing. Given that we have about a million care assistants and about half a million registered nurses across the country, providing ways that enable people to learn and earn



rather than having to take three years out to go back to college, real help with the career ladders in social care—

- Q36 **Chair:** Forgive me for interrupting. I agree, and we are going to be looking in detail at those kinds of things in our nursing workforce inquiry. My question was more about the funding—how the money is getting to the frontline in a way that prevents provider collapse. Are you yourself looking at what is the best way to support the provider sector through the use of the Better Care Fund? You have referred to social care packages and nursing packages through that funding, but my question was more about whether we are looking at the best way for that money to be spent and how it is getting to the frontline to achieve its purpose.

Simon Stevens: Statutorily, that is a responsibility that sits with local authorities, and to some degree with the CQC rather than with local CCGs, but in many parts of the country people are working together on this. We know there are real pressures in parts of the south-west and in parts of the north-east, and there are places where, frankly, there is brilliant work that the NHS has chosen to step up and lead in care homes. The CQC report today references the work that is going on in Sutton, for example, where GPs and clinical pharmacists are working directly with care homes. There is a lot more that can be done directly between the NHS and care homes, but the way, as we all know, that adult social care statutorily works is that the NHS does not have that lead responsibility for managing the market, as it were, for the supply of care homes and home care.

I would make one final point on this, which is that in those places where, ultimately, we are not able to deploy NHS resources through the BCF route, it will be very important that hospitals directly use that funding to buy social packages or care home places for their residents.

Chair: Thank you. We are going to move on now to STPs and the legislative picture, on which Maggie is going to lead.

- Q37 **Maggie Throup:** It leads in quite nicely, does it not? Are sustainability and transformation partnerships, as they are now called—and I notice we have changed from “plans” to “partnerships”—the silver bullet we have all been searching for?

Simon Stevens: I think we can all say “no” is the answer to that question. Sadly, no, they are not, but they are a means to an end; they are a pragmatic effort to ensure that the different organisations in a geography plan together and integrate services rather than each individual component—be it the hospital, the GPs, the mental health trusts and the social care—ploughing their own furrow and thinking that the net effect of that will be good things happening for patients. Again, the CQC report points out today that that is not what the future needs to look like, so STPs are simply a convenient process for driving that kind of integrated population-oriented planning and care delivery.



Q38 Maggie Throup: Can those proposed changes in the STPs be delivered at scale and pace?

Simon Stevens: We deliberately have not sought to pretend that every part of the country starts in the same position. That is why we recognise that there are eight parts of the country that are able to go much faster on making integration real for patients. There are some parts of the country where there are real structural difficulties, not just financial but also in the care delivery, and they are real conundrums as to how you bring this about. Then, as you would expect, the bulk of the country is somewhere in between.

In July, we produced a baseline assessment of each of the 44 STPs, how well they were doing on the quality of care, the population health and the degree of sustainability and integration, but what a number of them need to succeed is capital investment, because they have proposals to modernise hospital services and to upgrade the out-of-hospital services. We were able to allocate £325 million in July for that purpose to kick-start the process. The Chancellor has indicated that he will make more capital available in November.

Q39 Maggie Throup: That is all well and good, and some of that capital funding is going to one of my local hospitals to rearrange the A&E, but I am more concerned about the changes in the community that are needed that might take quite a while to put in place. We have already talked about care home beds and nursing home beds, and that side of the provision, to make sure people are kept in the community rather than in the acute setting. Do you feel that the changes in the community setting can be put in place in a timely fashion to match the changes in the acute sector, because the change in the acute sector seems to be happening quicker than the change in the community sector?

Simon Stevens: Again, it is a different picture in different parts of the country, but if you look at what has happened to where NHS staff are concentrated, over the course of the last 10 years we have seen much bigger increases in hospital staffing than we have in community health service staffing. So, yes, to some extent people are trying to adjust that, but we have to do both simultaneously.

In March, I set out a fifth test that would be applied to any reconfiguration or service change proposal that was being advanced to make sure that hospital beds do not close before either alternative services are in place, including the appropriate workforce, or, if it is being driven by some new treatment or prevention, we are really clear about what the quantitative impact of that will be—new stroke services prevention, for example—or if it is because a geography has a relatively higher dependency on hospital beds than the national position would suggest is possible.

It is worth recalling that although across England we are very lean in our availability of hospital beds—by international standards and by reference



to our own history, acute beds have gone down by 40% over the last 30 years—the fact is we still have up to a twofold variation in the usage of in-patient beds for emergency patients between different parts of the country, even when you standardise the differences in the population. That tells us there is still opportunity to redesign care in the way that the CQC has been advocating today and the Forward View puts into practice.

Q40 Maggie Throup: Do you think that message is getting to the frontline?

Simon Stevens: Which message—the message about—

Maggie Throup: The message about the way you are changing things.

Simon Stevens: In some parts of the country, yes; in others, no. Let us be clear: in some places there are highly contested service changes, some of which are not being driven simply by the need to redesign and future-proof services; some are being driven by the fact that they do not have the medical staff to safely staff a service, and under those circumstances they need to make often a temporary change. In many other parts of the country, people are really stepping up and doing this.

If you look at what has happened across Dorset, for example, the conversation there is not without controversy, but people are squaring up to the benefits of a more planned approach to how hospital services are arranged as between Poole and Bournemouth, for example, which were famously blocked by the Competition and Markets Authority a few years ago. Now I think we stand a good prospect of bringing about those changes, backed by up to £140 million of capital investment to modernise services for Poole and Bournemouth, even though it is going to mean significant changes for provision in both communities.

Q41 Maggie Throup: What are the gaps in legislation that need to be plugged to ensure that the local leaders can implement the changes required through the STPs?

Simon Stevens: Jim has previously said, and I agree, that we can get eight or nine tenths of the way there through our current means. There will come a point when there will be a tidying-up process to be done around some of the statutory superstructure, but we cannot put the future on hold and wait for that.

Q42 Maggie Throup: Is there anything in particular that springs to mind? Obviously, to get 80% or 90% there is fine, but if we are really going to make these happen, we need to make sure that we plug those gaps.

Jim Mackey: As Simon said, there is a long way we can go yet before we get to that point.

Going back to your earlier point, everywhere you go people accept and want to see patients looked after closer to their home than in the hospital system. We are starting to see a number of systems making an impact on that. I went to Frimley in the summer, for example, where they shifted huge volumes of patients who would have been in hospital into a



community setting. They have done that through the ACS vehicle. If everybody can move a way forward to that sort of degree, we are all in business.

To take the real step into an ACO environment or a fully hybrid environment requires a change in the law. The CCG still has to receive an allocation as described in law; you have the FT mechanics that would have potentially to be changed there to make a single entity, but there are very few places that are at the point where they are ready to do that anyway. I think we should push it as hard as we can and get people adapting what is working in certain parts of the country now, and then take stock to see what really needs to change at that point.

- Q43 **Maggie Throup:** Finally, obviously, there are the different elements that are all coming together for the STPs. Are they all fully up to date and on board with it? I know you have mentioned already some variation, but some messages I am getting are that some of the local authorities and CCGs feel as if they are not being fully informed by the acute sector. Could you comment on that?

Jim Mackey: As has already been said, there is a mix. You can go to some STPs where everybody is very strongly engaged across the board, there is good clinical engagement and good public engagement, and others where it looks like they have barely met. There is a very large rump in the middle who are very open to influence and have big challenges ahead, so I do not think it is as simple as saying there is a problem with communication from one part to the other. The whole point is to start that process of getting people to work together and that is quite a tricky process where people have not done it very well in the past. We can absolutely put more effort into clinical staff engagement generally in public engagement on what the plan is, and in the next year or so that will be a big priority.

- Q44 **Maggie Throup:** Surely it is harder to go back now and restart it than to have got it right in the first place.

Jim Mackey: This is actually an OD process. It is a psychological, behavioural process, and it is often portrayed as a structural thing, but if you are in a system that has had lots of difficulty between bodies, you cannot just leap into this kind of world and expect everybody to behave perfectly collaboratively from day one.

Everywhere you can see progress. You can see absolutely a difference of pace and a difference in the rate of development across the country. I do not think, again, you could say at the beginning, "Everybody must do X." A strong signal was sent and everybody has started off, and we now need to try to lift the bits that are working in certain parts of the country and hopefully spread them and allow everybody to catch up. It is a pretty complex process. If you are in an STP, there are 20-odd organisations. The councils are variably involved and quite nervous about the thing for largely financial reasons. That is a tricky exercise.



Q45 Maggie Throup: The success or failure of STPs is going to be dependent on everybody working together, and, if you are already saying that councils are quite nervous about it, what can be done to get everybody on board?

Jim Mackey: We have to keep helping people talk to each other, work on their plans and see some results. Results is the big thing. Once people start seeing success, they start believing in it and they will put a bit more effort in, and so on.

Again, across the country you can see people trying very hard, but they all started in a different place. Pretty much everywhere has a plan. In some places, they could, obviously, execute it better and quicker—we would like them to get there quicker—but there is a general good will of people wanting to try to work together. But if you are a partner there and you are in surplus and next door has a £20 million deficit, or you have an argument about DTOC, social care and BCF, they are not things that are going to go away overnight. We have to keep working at them.

Simon Stevens: I would agree with that. The only thing I would add maybe as a data point is that, where people are doing integration to the maximum that is set out through the STP-type processes, we see that it has an impact on moderating the emergency demand that flows into hospitals. We published some data on that at the end of March. That trend has continued. So, we have seen, compared with the baseline year, that in those areas where the hospitals, the GP services and the community health services are working in the most joined-up way—our so-called PACS sites—emergency bed days per person are almost flat, up only 0.1% per person compared with the 2014-15 baseline. For those where the GPs and the community nurses are coming together, it is only up 0.3%. For the rest of England, it is up 1.8%. We really are seeing that this is not a silver bullet but it is part of what the future needs to look like.

Q46 Maggie Throup: It comes back to the question about scale and pace. If you are seeing such good results, what can you do more to get those results throughout the country?

Simon Stevens: We are trying to do several things at once. It is no secret, of course, that we are driving this profound redesign agenda, and we are somewhere between a third and halfway through that. We need to have the resolve now to drive that to its conclusion in as many parts of the country as we can, and we need the tools and the backing to do that.

But, also, as well as future-proofing, we are mobilising the whole of the NHS for the real operational pressures that are there right now, including for the winter ahead. There is an enormous amount of work going on to ensure that hospitals are as well prepared as they can be, but also there are the changes we have made to the 111 service; your chances now of being able to talk to a nurse, paramedic or doctor have gone from under a quarter to 36% of calls. There are the changes to the urgent treatment



HOUSE OF COMMONS

centres and to the way ambulances respond. There is a big flu campaign that we will talk more about on Thursday, with some other important changes for winter as well. It is “all of the above”; it is not “either or.”

Chair: Thank you. A number of colleagues want to come in on the sustainability and transformation partnerships and accountable care systems. I have Rosie, Paul and Diane; I start with Rosie.

Q47 **Rosie Cooper:** Thank you. I am now going to ask you both a question that will probably sound like I have not listened to one word of your answers so far, and that is because I rather tire of the flowery words and the good intentions.

When I have had dealings with both your offices and asked questions about accountability problems, your senior officials tell me that the problems lie in the Health and Social Care Act 2012. When you layer on top of that how STPs and then accountable care organisations are going to deal with the legalities of the health service as it is today, as to the accountability gaps—and this is really a question—do rules apply only when they apply to other people and not to you at the centre? How are you as NHS organisations, and indeed political masters, going to deal with the huge accountability issues, or are you just going to use your muscle to make the system do what you want?

It is okay, when you talk about STPs, saying that everyone is working together and it is all really good. The reality is, for example, that your lead in Lancashire wrote to me not a month ago telling me that one issue they are going to be looking at is the sustainability of Southport and Ormskirk hospital. I naturally had a fit. But then when I talked to your person in Cheshire and Merseyside, they say that, no, it is not going to be considered at Lancashire; it is going to be considered in Cheshire and Merseyside.

Who is running the show? Do you guys have any real control? Where is the accountability back to me, to all the associated health bodies and, most of all, to the people who are paying for this?

Simon Stevens: The accountability for any proposed service change is the same on the question of reconfigurations as it was under the 2006 Health Act. So, if a major service change is being proposed, including in your local hospital, then the local overview and scrutiny committee has the ability to refer that to the independent reconfiguration panel. Then, ultimately, the Secretary of State, accountable to Parliament, will make the decision. So, I do not think the accountabilities have changed at all.

Q48 **Rosie Cooper:** Ultimately you are right, but who is making those decisions? Where are the cupboards in which those decisions or plans are being incubated?

Simon Stevens: If that is a contested service change, then the decision will ultimately be made by the Secretary of State.

Q49 **Rosie Cooper:** Are all those documents made public now, because I



HOUSE OF COMMONS

know that people have been threatened in my local area that, if they make public any of their secret documents, there will be, basically, a witch hunt? Tell me how is that in the name of the people?

Simon Stevens: The Freedom of Information Act will cover that situation for you if nothing else does.

Rosie Cooper: I will test it for you this week, because we have already got it.

Simon Stevens: Excellent.

Q50 **Dr Williams:** I understand and support that STPs are around population health change, but what I have seen is that largely the leadership and direction of STPs is being led by acute trusts. Are you satisfied that you have the population health expertise in order to get the transformation part of the STP?

Simon Stevens: We clearly need that. Of the 44 STPs, about half were led by hospital leaders and half were led by a CCG or local government leader, but, by definition, in any STP it is one or the other; somebody is taking that responsibility.

In a way, picking up where Rosie was, these are not statutory bodies. If Parliament chooses to create them as statutory bodies at some point in the future, in a sense that will deal with some of these issues, but for now they are the best endeavours of a group of people in each part of the country and I am not quite sure what the alternative to that really is under the circumstances, other than for everybody to plough their own furrow and wait for you guys to do something.

Q51 **Dr Williams:** Do you have plans to bring in people with data and population health expertise? Do you plan to give public health experts power within STPs in order to be able to get this sort of massive shift towards prevention and away from having to have this conversation about acute demand all the time?

Simon Stevens: Yes. If you look at the places that are most advanced, including the eight that we have talked about, they absolutely are doing that. I do not know, Dr Wollaston, what the Committee's work or touring programme looks like, but, if the opportunity presents itself, it might be worth going to spend a bit of time with some of those eight, and I think you will see they kind of get exactly what you were just saying.

Q52 **Diana Johnson:** If you were starting this process again, would you do exactly what you have done so far? My concern is that there was such a lot of secrecy at the outset and a failure to engage with the public, with elected politicians, that there is a lot of suspicion about what this is really about. While here, I have been listening carefully to what you are saying it is about, but if you were doing this again would you do it in the same way? Would you keep the plans so close to your chest?



HOUSE OF COMMONS

Simon Stevens: I think you make a fair point as to many parts of the country; yes, I do, but also, to be equally frank about this, people are having to manage incredibly pressurised budgets and difficult trade-offs. Doing so in an open way makes sense, but let us not pretend that that would not also have given rise to controversy, that there would not be individual organisations, including in some places councils who chose, for legitimate or political reasons, to oppose the changes that have been talked about. Just being open would not have brought tranquillity to the complexity of the difficult choices that are having to be made all over England.

Diana Johnson: Perhaps you are just storing up problems.

Simon Stevens: In some places, yes, that might be right.

Q53 **Chair:** Before we move on to the next group of questions, one benefit of STPs was supposed to be that we could move away from the purchaser/provider split, endless contracting rounds in the NHS and wasteful transaction costs. What kind of progress do you feel we are making on that side of things?

Simon Stevens: In the eight that are most advanced, I think we are effectively going to enable an integrated delivery system to take responsibility for the fair share in the NHS budget, and so, yes, we will have moved away from an annual contracting cycle and all the transactional costs and hassle that go with that. That is not to say, however, that there is not still going to be a strategic division of labour between planning and funding decisions on the one hand and integrated care delivery on the other.

The reason we still need to be able to make some of those big decisions is that, when we come on to talk about mental health, for example, it is pretty obvious that, if we locked in the current shape and pattern of spending, we would just be reproducing a situation where we were not putting our thumb on the scales for mental health services or we were not doing the sorts of things that Dr Williams was talking about in terms of a move towards a more primary-care-oriented set of services in places such as North and South Tees, which would clearly benefit from that. We still need to be able to make resource allocation decisions that will differ from the status quo, but that is not quite the same as the annual contracting round and the purchaser/provider split as it has arisen since 1991.

Q54 **Chair:** Finally, Jim, I know when we spoke last about greater transparency you were going to discuss having a letter that made it clear to those who are in leadership roles in STPs that there did need to be greater transparency. Are you satisfied that that message has got through?

Jim Mackey: Yes. About two or three weeks ago we had all the STP leaders together. Simon and I were there with lots of other colleagues,



HOUSE OF COMMONS

and we discussed exactly that. A lot of them are now developing plans to start better engagement. Some could have done it better at the beginning but we are where we are. We went from that meeting to a meeting of STP clinical leaders, the first time they had all been together, where again there was a big appetite for people to start having the conversations about what the choices and the options were, and the challenges that people had and so on. I am pretty sure people have got the message and there is a will to do it, but it is very difficult, and, as Simon said, where there is an already antagonistic context with people fighting effectively for one side to win and one to lose, it is really hard for people to do.

Q55 Chair: Would you accept that managers currently feel constrained and fearful of sharing plans because they feel they are being instructed not to make them public? Are you satisfied that you have given a sufficiently clear public voice and, through this Committee hearing today, that they are free to share plans and discuss them with elected representatives?

Jim Mackey: From my point of view, absolutely. We are never going to deliver a plan if we have not engaged on it and we have not had a process of developing the options together. That is never really going to be executed and I think everybody knows that, but you know when you are developing these plans that the first time you go public with them there is a very serious chance you will get shot by the council, a local politician or a neighbouring organisation. There is no easy way of doing this. You learn from the people who have done it effectively. There have been a reasonable number of organisations and systems that have led service change across the country. The evidence internationally is that you have a better chance when you start an early conversation, you listen to people, you modify your plans and then you execute, and you do not just go straight to execution.

Simon Stevens: I agree with that, but maybe I will put one way in which you could be supportive of the processes that are happening locally, which is that, given the difficulty of sometimes balancing budgets in geographies with the fair allocations means, it is not a solution simply to say no to everything that everybody ever comes up with, because they do have an obligation to live within the funds that Parliament collectively has provided. We all understand how difficult that is. Look, we live this every day of the week, but being open and engaging is not the same as saying that you do not also have to help people understand that we are having to operate in very constrained circumstances, which is the consequence of seven years' worth of the NHS budget growing in the zone of 1% compared with our historical rate of 4%. We are spending £23 billion a year less than if we were spending at French or German levels, and there are consequences to that.

Jim Mackey: Just to add to that, our most troubled systems generally have a system problem that has existed for a very long time, and virtually nobody disagrees that there is a problem. What they all disagree



on is what the solution is. As Simon said, when anybody suggests a solution, if the person who suggested it then gets flattened and caught up in a massive political mess, we are just going to drive that down.

Q56 Rosie Cooper: Jim, are we not rowing back from the assurance that managers can be clear, open and transparent with people who are asking them questions? Are we rowing back or is that the situation?

Chair: That is not what I heard, but perhaps—

Simon Stevens: No, I do not think we are rowing back at all, Rosie, but we are saying that, equally, they, as public servants, have a responsibility to live within the money that has been allocated by Parliament, so it would be unfair of you to criticise them for doing so.

Chair: Thank you. I am keen that we should move on to accountability and how we stop people falling through the gaps in commissioning. Paul is going to lead on that.

Q57 Dr Williams: I would like to talk about it from a patient perspective, and I am going to use an illustration in order to ask you some questions about how we can better serve patients who are getting care across multiple organisations. It is an example that comes from my constituency, although it happens in other parts of the country as well, where children with suspected autism are identified by a speech and language therapist or another professional and referred into an autism diagnostic pathway. This is a multiagency pathway; I have been and seen it operate myself. You need an assessment. It can take up to six months' worth of assessment with speech and language therapists, occupational therapists, educational psychologists, sometimes child and adolescent mental health workers, and sometimes paediatricians get involved as well. They are people who are working across multiple different organisations, mental health trusts, acute trusts and community trusts; sometimes they are commissioned by either the local authority or by the clinical commissioning group, so it is a complex pathway. In my constituency, that pathway seems to have broken down.

The NICE guidance is that assessment for a child referred for assessment should begin within three months. We put a freedom of information request in to our local mental health trust and it is 44 months that they have to wait for the assessment of children to even begin, although, interestingly, with the same mental health trust in a neighbouring local authority, a different CCG, it is only six months, and then, within the same CCG area, but again a different local authority, it is nine months.

I am not necessarily asking you to give the reasons why that happens or to solve this particular problem, but who do the parents of these children hold to account? What can they do about what feels like an unacceptable wait for their children?

Simon Stevens: You have put your finger on what is a very blurry set of services and accountabilities, particularly at the interface of the education



HOUSE OF COMMONS

system: the local children's mental health services, which are now the responsibility of councils to commission, and the local specialist mental health services.

The first thing we want to do as far as these autism services are concerned is get an accurate picture across the country as to what the waiting-times experiences are. For that reason, NHS Digital is going to have a national data collection starting from April that will give us that kind of precise picture across England. We may come on to talk about children's mental health services more generally. This is an area where not only do we have to match investment with service expansion but that needs to be underpinned by the availability of the staff to do it. Frankly, staffing in children's mental health services is one of the rate-limiting factors, whatever the budget is, for what the expansion would look like.

Chair: Before going on, there is a gentleman in the audience whom I would like to stop gesticulating, please, or to move. Thank you.

Q58 Dr Williams: I understand the complexity. Who is accountable? When there are multiple commissioners and multiple providers, who is ultimately accountable for making sure that these children in this example get their autism assessment?

Simon Stevens: It will be your local authority and your local CCG together.

Q59 Dr Williams: The other thing that parents have told me of these children is that information sharing across these different organisations is non-existent. Are we doing enough to be able to share patient records between health, social care and education? Of course, we know that the principle we should all be following is that we should share, unless there is a really good reason not to, and it is usually in the patient's interest to share. But the practice is that it is very rare for patients to find that their records are being shared. Should we be legislating in order to ease the sharing of information?

Simon Stevens: That is a very important set of issues that Dame Fiona Caldicott has recently been inquiring into, not just on the sharing of health information but cross-agency with education and social care. There are parts of the country that have one way or another managed to crack this. We are also in procurement at the moment for a new child health information system, which will make it easier for multiagency information sharing, but I would be happy to come back to you, Paul, with more specific thoughts on that if it would be helpful.

Q60 Dr Cameron: As a follow-up to that, there are very specific clinical training courses that staff can go on for autism diagnosis. Do we have an understanding of how many clinicians are trained in that diagnostic process, where they are across the NHS, and if there are gaps in numbers?



Simon Stevens: I can ask Professor Tim Kendall, who is our national clinical director for mental health, to come back to you on that specifically.

Q61 Dr Caroline Johnson: This is not related to autism; it is related to special measures. ULHT, in Lincolnshire, with acute trust services, was put in special measures in October 2013 and came out of special measures in March 2015. It has then gone back into special measures again for clinical services in April 2017 and then back into financial special measures last month. Are many trusts going into special measures having fairly recently come out, and is this a sign that the support that trusts get when they go into special measures is withdrawn too quickly after they come out and causing them to slip back in again?

Jim Mackey: That is a really good point. From memory, there are only two that have gone back in having come out, and nobody would want that to happen. One of them was a very borderline case, and when we made the judgment call we thought, on balance, it would give the trust a better chance to be released from special measures, while recognising there were still lots of challenges there. I think, with hindsight, we probably made that call a little early, so there was still a lot of ongoing support—that was not really withdrawn—but they probably were not quite ready to go at the time the call was made. These things are complex judgments and people made the best judgment they could in the time.

In the part of the world you have described—it goes back to the earlier points on STPs—there will have to be quite serious decisions made about infrastructure, about configuration, about workforce supply, because that system has been trapped in an unsustainable state for 15 or 20 years. The fabric of the buildings is really difficult; the workforce supply and gaps are very difficult; the money is very difficult, and so on. So, we have to help them somehow to find a solution on that. Whatever the solution is, it will not be popular because there will be a lot of people who will be very unhappy with it.

Q62 Dr Caroline Johnson: On the general point of special measures, when a trust comes out of special measures, and when ULHT comes out of special measures, which we hope we will see, will support continue for the trust for a period, and generally around the country, to ensure that people do not slip back?

Jim Mackey: Yes. There is almost always a take-up process. I have actually just left an argument about this in NHSI. You always try to avoid a cliff edge where you have lots of support and then it is withdrawn immediately. Sometimes there is a tension because the people who provide the support are rare people and there are lots of demands on their time. What is more normal is that there is a plan over a period of time where those responsibilities are handed back to the organisation to take control of themselves.

Q63 Dr Caroline Johnson: Where a trust has come in and then out, will that



taper be done more slowly the following time?

Jim Mackey: I think everyone would be very nervous the next time about whether they can. There is a risk there that organisations get trapped in special measures because everybody gets more nervous and the risk thresholds change, so we will have to take a tailored judgment at the right time and support the organisation accordingly.

Q64 **Rosie Cooper:** Following on from my previous question, NHS England oversees the work of CCGs, and I do not need to rehearse the huge failings of the CCG and healthcare in Liverpool. The Kirkup review and the National Audit Office inquiry into the transaction process will do that for me later on. The CCG there was operating with virtually no governance whatsoever and that was not spotted by NHSI or NHSE.

My question takes two strands, the first being, why did it take you so long to do anything about it—to react—and are you ashamed of your organisation's failings? How are you assured that this is not happening in other parts of the country?

The second strand to the question is, who holds you to account? Who holds the regulator to account? Is there any point in having NEDs on NHSI or NHSE when they have not held you to account and obviously are not holding you to account, because this kind of nonsense would not be happening, with people getting away with doing what they did in Liverpool with the CCG—with no governance at all? How do you account for that?

Simon Stevens: First, for those not intimately familiar with the inner workings of Liverpool CCG, the chief officer, the accountable officer and the finance director have resigned from Liverpool CCG following an independent review that we commissioned, because we determined that, inappropriately, there had been increases—

Rosie Cooper: That was after my question to the Prime Minister.

Simon Stevens: With Rosie's advocacy on this point, we determined that back in 2013-14 a decision had been made by their governing body that we did not feel could be supported. Those two individuals have stood down from the CCG. We have looked across England to see whether there are other examples, and where we find them—if we find them—then we will take similar action.

Q65 **Rosie Cooper:** The real question is, why did you not find it? How do you hold CCGs to account? You have been responsible since 2012-2013, whenever it comes. What is your accountability process, how did you miss it and why? Obviously, it is a lot more complex, and you and I both know it and it is all going to come out, but how did that happen under your watch, Simon—

Chair: Rosie, we have a lot to get through today, so can we—

Simon Stevens: Let us get a few facts on the table here.



Rosie Cooper: Everyone else has had one or two goes.

Simon Stevens: First, the legal framework that Parliament has established sets CCGs to determine these matters with the remuneration committee and with external auditors. That is what happened in the case of Liverpool CCG. We have subsequently stepped in and taken a further look at the decision it made, but, frankly, that is not the statutory basis on which CCGs are established. Similar to foundation trusts, these are decisions that CCG boards, with their external auditors overseen by the NAO, need to make. As it happens, this is a unique and certainly a very unusual example, but, having had the matter raised with us, action has been taken.

Q66 **Rosie Cooper:** It took you a long time and you supported those two individuals against the odds, but, anyway, it will all come out in the fullness of time.

Simon Stevens: I am not sure it did take us a long time really. You raised the matter on 22 March and this action had taken place by the summer holidays.

Q67 **Rosie Cooper:** It will all come out.

Simon Stevens: I think it already has. We have published.

Q68 **Rosie Cooper:** Oh no, there is more.

Simon Stevens: Then we look forward to further revelations.

Chair: We are now going to move on to the very important theme of mental health. Luciana is going to lead on this.

Q69 **Luciana Berger:** We meet today on World Mental Health Day. In fact, it was nearly five years ago that parity of esteem was enshrined into law in the Health and Social Care Act. Can I ask you both if you believe that real equality for mental health has been achieved?

Simon Stevens: We have made significant steps, so we are more equal in mental and physical health now than we were three years ago, but I do not think we are all the way on that journey.

Jim Mackey: I agree. We have made a start, and I think under Claire Murdoch's leadership in the last 18 months or so she has raised the profile of mental health, but we are not there yet.

Q70 **Luciana Berger:** I think, particularly today, people would say that it is not just talking about mental health—although that is obviously very important—but it is what we achieve that will make the difference. On that very point, it is in NHS England's planning guidance that every CCG in the country should be increasing their proportion of spend on mental health. I have had to do an FOI of every CCG in the country for the last four years because the information is not readily available of what exactly is spent, and I have found through those FOIs in the last two years that



HOUSE OF COMMONS

more than half of CCGs are not increasing their proportion of spend on mental health. Why is that?

Simon Stevens: It is not true. I understand that is what the 129 responses that you got were, and I understand why at the time that was the information you had available to you—I fully appreciate that—but we actually now publish the annual audited mental health expenditure for England, both by CCGs and nationally. That clearly shows that CCGs increased their mental health expenditure last year in real terms—a £575 million increase in CCG expenditure, up by £1.6 billion over the last three years, and in fact 85% of CCGs increased their mental health spending. That is what happens when you get the data from 207 CCGs audited as against a snapshot fragmented FOI of 129.

Q71 Luciana Berger: Forgive me, but the guidance says it is about the proportion of spend and not the total amount. It is the proportion of spend. I have the proportion, and over the course of the past four years no one has ever disputed my figures.

Simon Stevens: Let me dispute them right now then because they are wrong. The proportion of CCG spending on mental health—mental health spending by CCGs went up by 6.3% last year compared with their programme allocation growth of 3.7%. Likewise for England as a whole—the national health service in England—mental health spending went up by 5.7%, when you take account of specialised services, compared with 3.4% overall growth in the NHS programme budget. So not only did mental health spending go up in real terms but it increased as a proportion of the overall spending.

Q72 Luciana Berger: We will no doubt take those very specific points forward and further after this session, but the only thing I would say in response to that is that I have done this activity over the last four years, and the response that has come from the Department of Health has never echoed the points that you have just made.

Simon Stevens: It is precisely because we are committed to transparency as a precursor to getting parity of esteem that we are now publishing all these data. I would urge parliamentarians for all parts of Parliament not just to rely on fragmented snapshot FOIs, because we had another one, by the way, which was equally inaccurate, that a different group put out, which was based on just 50 responses from CCGs. The claim was that half of local NHS bodies cut their spending on children's mental health in real terms last year. That is not true either. Children's mental health spending went up last year and the majority—two thirds—of CCGs increased their children and young people's mental health services. It is really important that we are fact-based in these kinds of moments.

Chair: Perhaps, if Luciana submits her data to you, could you provide us with a detailed response?

Luciana Berger: I am very happy to make the data available.



Simon Stevens: Yes, absolutely. These data are all published on our website now, but they are obviously returns from 207 CCGs rather than from 50 or 129, and they take account of the year-end audited positions as well as the national spending on mental health in addition to the local spending as well.

Q73 **Luciana Berger:** The reports coming from right across the country—and I have been on physical visits across the country and engage on social media—and also from speaking to leaders themselves, clinicians, and leaders of the mental health trusts, are that the facts on the ground and what people are actually experiencing is a far cry from the case that you have just made. We heard yesterday from the Children's Commissioner about the state of young people's mental health services, in particular that 75% to 80% of children are not receiving the help that they need and there is a failure to set expectations in delivery and monitor outcomes. I do not know if you want to respond specifically to the Children's Commissioner report that we had yesterday.

Simon Stevens: Yes. If the Children's Commissioner had come to us before publishing their report in draft, we would have been able to correct some of the factual errors that were contained in it, and it is regrettable that that opportunity was not provided. For example, there is a conflation of NHS spending and local government spending in some of the areas. It strangely does not talk about the fact that there were 21,000 extra children and young people being treated in NHS mental health services last year. It does not describe the fact that, as facts on the ground, we have 70 new eating disorder services across the country; the waiting times for eating disorder services are coming down; there are new mother and baby unit services being commissioned in four parts of the country; and there are 120,000 additional people getting specialist NHS mental health services now compared with three years ago. Frankly, I have the detail for each of your constituencies—I can describe for you some of the stuff that is happening in each of your constituencies—so it really is just not true that nothing is happening in mental health services.

Q74 **Luciana Berger:** In my own constituency in Liverpool we have just seen cuts to our young people's mental health services of over 70%; it is £750,000. I have constituents literally emailing me on a daily basis who are waiting to access those services who have been on the waiting list for over six months just to get an initial assessment. I do not think that is an indication of money coming forward.

Simon Stevens: Let us be clear about what I am saying. I am not saying that all is well in mental health services or that it is mission accomplished in the journey on which we have embarked. In the mental health taskforce that was, after all, drawn up by Paul Farmer from Mind, with support from the Royal College of Psychiatrists and patients' groups, we said we need a pragmatic set of improvement goals that we can fund over the next three or four years. I am confident that we are delivering against that trajectory. We also said that, given the funding and the workforce challenges, even by 2020, rather than looking after one in four



HOUSE OF COMMONS

young people who had a mental health problem, we would probably get that to one in three. We are not claiming that there is not massive unmet need in children and young people's mental health services. We are saying, however, that it does everybody in mental health services a disservice to pretend that somehow progress is not being made.

Q75 Luciana Berger: The Government committed £1.4 billion to the Five Year Forward View per year for mental health and £1.25 billion per year to "Future in mind," which was specific funds for young people's mental health. Are you confident that all that money is reaching mental health services?

Simon Stevens: We have increased mental health spending by more than that over the last three years.

Luciana Berger: That was not my question.

Simon Stevens: Children and young people's mental health services are up by £100 million over the course of the last year. I understand the campaign that says we should ring-fence mental health funding separate from physical health funding, and there are some reasons why that might be an attractive thing to do, but there are also some quite significant downsides to doing that. Let me give you a couple of examples.

If we are, as we are, investing in putting crisis mental health services in A&E departments across the country, are we to define those as mental health spending or as A&E spending? If we are investing in the physical health of people with severe and enduring mental health problems to cut what is one of the biggest inequalities that exist, namely the 15-to-20-year premature death rate, is that mental health spending or is that physical health spending?

If we are boosting integrated models down in Taunton, as I was last week, where the community health services, the mental health services and Musgrove Park hospital are coming together as a single organisation with integrated teams, then are we really asking accountants to go round putting time and motion studies on every patient encounter that those individuals have? One could do that, but, unless one is clear about the foundational level of spending and what the integrated opportunity needs to look like, it would be a massive paper chase rather than actually improving the targeting of money.

Q76 Luciana Berger: In a response to a parliamentary question about the number of areas that have signed up for the mental health investment standard, of those that had come forward, 32 CCGs said they had not met the mental health investment standard for the last financial year. What are the repercussions for those areas that do not meet the mental health investment standard?

Simon Stevens: There is not a requirement on every single CCG to meet the mental health investment standard. The requirement is that, across England in aggregate, we meet the mental health investment standard



HOUSE OF COMMONS

and our expectation is that the vast majority of CCGs should do so. Eighty-five per cent did last year, but we recognise that there may be particular circumstances where, for example, a CCG is already spending more than the national average on mental health, or where, frankly, it is struggling in the round to balance its budget. In those circumstances, it must not make disproportionate cuts in mental health services relative to anything else, but none of this trumps the overall responsibility to live within the total funding available for a geography.

Q77 Luciana Berger: On page 4 of the GP Forward View it says that NHS England has undertaken to introduce 3,000 new, fully funded mental health workers. Throughout that document it uses the word “new” and refers to the word “extra” 3,000 mental health workers. Can you clarify that that is still the case, because reports have come out from people working in NHS England that these will not be new mental health workers? In fact, they will be existing IAPT workers rebadged.

Simon Stevens: They cannot be that because we are going to expand the proportion of the population getting access to IAPT from 15% to 25%; so, that big population increase obviously requires more people to provide those services.

Q78 Luciana Berger: It says 3,000 additional mental health workers.

Simon Stevens: Yes. The mental health workforce plan from HEE, as I said, lays this out as well and we are directly funding these as part of the mental health taskforce implementation.

Q79 Luciana Berger: They are new and additional staff.

Simon Stevens: That is my understanding. I will pull out the chapter of the HEE report, but, yes, this is targeted investment to expand IAPT. By the way, sometimes it is useful to see ourselves as others see us. *The New York Times* recently described our talking therapies expansion programme as the world’s most ambitious effort to expand mental health services for anxiety disorder and other common mental health problems, and they were right.

Q80 Luciana Berger: I am awfully sorry, but there was a correction to that article that I submitted at the end of August, and it is actually listed on *The New York Times* website, because the initial article said how many people in the community needed help rather than how many people were actually getting help. It wrongly said how many people were getting support, so it got—

Simon Stevens: No, but I challenge you to find another western country or another country, full stop, that is doing this scale of expansion of mental health services for common disorders, particularly embedded in primary care as we are doing.

Chair: I am very conscious that we have a lot to get through. I know that you have to leave at 5.30, and Lisa wanted to come in with a



supplementary on mental health before we move on to primary care. Did you have one final point, Luciana, before we go on?

- Q81 **Luciana Berger:** I have one quick and final point about learning disabilities. We learned just the other week that London University has cancelled its learning disability nursing course due to a lack of suitable applicants. I know we are going to discuss more broadly the issue about nursing, but how do you believe the shortages of learning disability nurses is going to impact on the safe implementation of transforming care for people with a learning disability?

Simon Stevens: Just to remind people about the transforming care programme, this is identifying those individuals who currently are being looked after in an institutional setting who should, instead, get access in a more homely environment or indeed in their own home. That programme is on track for a 30% to 50% reduction in the number of people who are in in-patient settings who should not be over the course of the next several years. In order to do that, we certainly need learning disability nurses, but not just learning disability nurses; it has to be said there is obviously a strong social work and psychology aspect to this as well. That is the kind of preamble.

We are concerned about learning disability nursing and the recruitment prospects there. One approach we are just testing is the nursing equivalent of Teach First, so a fast-track programme on to a nursing qualification for graduates of other disciplines that has worked well in teaching, and we are earmarking the first Nurse First opportunities for learning disability nursing and for mental health nursing. Over and above that—and this goes into a broader question about pay policy—is there an argument for differentially targeting extra pay for disciplines where we are having a particular difficulty in recruiting and retaining people? Probably there is.

Chair: Thank you. I am very sorry to rush you, but I have been reminded that it is actually five o'clock by which you have to leave, so I am keen that we should try to get through. Lisa, you have a very quick supplementary and then we are going to go on to primary care.

- Q82 **Dr Cameron:** As to mental health services in particular, when children reach the age where they are moving on to adult services, there have been difficulties in the past with children falling through gaps, there being delays in transition and streamlining of the care pathway. What has been done to improve that and what progress has been made so far?

Simon Stevens: You are quite right. Part of this is about ensuring that we have teams in place for some of the conditions that we know particularly affect teenagers and young adults, one reason being that, after 25 years of only having waiting time standards for surgical procedures, we have now introduced waiting time standards for the first three or four mental health services. One of those three is focused on what is called, as you know, early-intervention psychosis services, which



HOUSE OF COMMONS

typically are for people in their late teens or early 20s, and we know that effective early intervention there has not only a positive impact at the time but also over the course of those transitions and the rest of people's lives. The good news on that is that we set a waiting time standard that 60% of people would get that within two weeks. Actually, we are now finding that three quarters of people are getting that within two weeks.

Also, recognising the big pressures that have been building in young people's eating disorder services as part of funding the 70 new eating disorder teams across the country, we have introduced waiting time standards for eating disorder services. The position a year ago was that two thirds of people who needed an urgent appointment were being seen within a week. That is now around three quarters. Likewise, the figure for people who just needed routine eating disorder appointments was two thirds getting them within a month a year ago and now that is 79%. I think we are seeing the benefits for the kind of conditions that particularly affect young people and people in their early 20s, but those transitions between children and young people's services and adult services are being tackled in ways such as you see in Birmingham where they have designed a 0 to 25 service that integrates physical and mental health services for children rather than having a clinically arbitrary hand-off at age 18.

Q83 Dr Cameron: Is that a pilot that is going to be rolled out? That sounds like a way forward potentially that could impact people outwith Birmingham as well as those lucky enough to be in Birmingham.

Simon Stevens: Certainly we need to learn the lessons from that. There are some particular circumstances in Birmingham that made that a more straightforward change than in some other parts of the country.

Chair: Thank you. We are going to move on to primary care now with Johnny.

Q84 Johnny Mercer: Hello. This is my first time on this Committee and it has been a real education. Clearly, your job in fighting against the various campaigns and so on, with the reality as it is, is really important, particularly in what we are trying to do in Plymouth. We have a few challenges around GPs at the moment in places like Plymouth, and I do not want to use that particularly, but it is the same generally in deprived communities. To give you an idea, we have seen many providers handing back their contracts. One big thing raised with me is the difficulty in dealing with the indemnity. Down in Plymouth, NHS England has decided to take that burden on. Is that something you would look to do more broadly? Is that something that could be rolled out further across the country to improve perhaps the problems around recruitment and things like that?

Simon Stevens: You are completely right that the indemnity question is one of the huge clouds over GPs' prospects. We have said that in the immediate term for this winter we will extend the winter indemnity



HOUSE OF COMMONS

scheme that we ran last year so that, for GPs taking on extra sessions and out of hours over the very busy pressurised period for the NHS, that will be paid for separately. We have also said that for this year the extra costs of indemnity overall were covered off in the GP contract that we agreed with the BMA. Then looking out for next year and the year after, there is this particular issue around the changes to the discount rate that are affecting the medical defence organisations that provide indemnity. That is something that Jeremy Hunt is going to be addressing explicitly later this week.

Q85 Johnny Mercer: On recruitment, I heard what you said earlier that, for the fourth year, recruitment of GPs is increasing.

Simon Stevens: That is recruitment into GP training.

Q86 Johnny Mercer: That is increasing, which is great. In Plymouth and areas like that, which are more deprived, I often get told that the recruitment of them is particularly difficult; it is particularly acute. Why is that, and what are we specifically doing around deprived areas in the UK to make sure that it is still attractive for GPs to go and work there?

Simon Stevens: You say it accurately and well. We are identifying parts of the country where, traditionally, it has been hard to fill places on the GP training scheme. Frankly, we are, among other things, paying a bonus for trainees who choose to go and work there. We are paying bonuses that already have benefited 120 through all parts of the country that had previously not had GP trainees in recent memory. We think we will get that up to 200 fairly shortly—next year in fact. Some of it is about the attractiveness of GP training and some is about recognising that general practice itself needs to adapt and evolve. There are enormous strengths in British general practice around continuity of care and list-based general practice, but there are some downsides, particularly around individual practices sometimes struggling in isolation from their neighbours. So there need to be much more networked approaches to working with other practices so that collectively they are looking after 30,000 to 50,000 people. Then you can put in place the mental health therapists alongside the GPs, the clinical pharmacists that we are directly funding, the practice nurses and so on.

Q87 Johnny Mercer: For you, the forward view of GP care is these bigger practices where you can get more specialised help.

Simon Stevens: Yes, or it would be smaller practices networked together.

Q88 Johnny Mercer: Yes. We have had four surgeries shut and the provider has handed back the contract. We have three seeking another provider and three who need a new provider by March next year. Constituents are saying to me, and I am sure colleagues across the country, that that gives the impression that the GP system is in crisis, essentially, that no one wants to be part of it. You think it is very much in flux, moving from one model of care to another, do you?



Simon Stevens: I do, but also I think was probably the first person doing my job to say outright, 18 months ago, that I did not feel GPs were crying wolf; I thought they had a point. You see in the CQC report today actually the number of whole-time equivalent GPs per thousand population had been going down. We are about flat to slightly negative in whole-time equivalent GP numbers at the moment, and that is why it is so important, as well as expanding intake, dealing with indemnity questions and changing the design of services, that we also need to do some tactical things. One that I announced in August was that we were going to go, all guns blazing, on a GP international recruitment programme over the next three years, aiming to recruit up to 2,000 additional GPs from either the rest of the European Union or places like Australia. We will be matching them with parts of the country that have particularly struggled to fill vacant GP training places or practices.

Q89 **Johnny Mercer:** Finally, what do you understand by the military covenant in this country and how that applies to servicemen and women accessing healthcare?

Simon Stevens: Yes. There are two sides to this equation, as it were. One is that the military covenant is ensuring that service personnel and veterans get proper access to the care that they need, and there are some specialist services for that; but there is also a priority that needs, rightly, to be accorded to members of the armed forces or former members of the armed forces. The flip side is that the NHS, as an employer, also has reservists among our workforce, and we recognise that there are sometimes difficult judgments about being able to free people up for that. But employers who do it find that it is tremendously beneficial for the calibre of the training and the opportunities it gives for their staff. The NHS is both a supporter of reservists and a provider of care under the military covenant for serving and previously served personnel.

Q90 **Johnny Mercer:** Does the NHS, as a system, believe that those who have been injured on operations in service should be entitled to priority care or not?

Simon Stevens: As you say, the military covenant specifies the circumstances under which that would be appropriate. In a sense, this is not a new principle. This principle goes back to just after the second world war, and one of the founding deals of the NHS was that we would pay particular attention to the needs of those injured in conflict. But, obviously, our fundamental aim is to provide high-quality care for everyone who needs it regardless of their circumstances.

Chair: Thank you. We are going to move on to the wider theme of efficiency variation and getting it right first time. Andrew is going to lead on that.

Q91 **Andrew Selous:** I want to ask you about a number of variations in clinical outcomes and what you are doing about them, starting with



surgical site infections, where we know there is a twentyfivefold variation in outcome, and bearing in mind that an infected joint can cost £100,000 to put right. What are you doing to reduce that twentyfivefold variation?

Jim Mackey: That is at the heart of the GIRFT programme—the work that Tim Briggs, with others, is leading. He has first of all shone a light on it, so it has made the data available to show the level of variation by individual organisation and within the organisation as well. We are encouraging people to look at individual clinical practice and also signposting from those organisations that have made the most impact what has worked in those places, what is good practice and sharing it effectively. That is one area where there has been most impact initially with very strong clinical engagement, determining what good practice was, what good expectations are and what works, and sharing that across the country.

Q92 **Andrew Selous:** If we look at return to theatre within 30 days for hip fractures, again the variation goes from 0% to 7%. The average is 2.3%. We know that active rehabilitation significantly improves results, yet only 50% of patients are getting physio. You have a system at the moment where you will pay for that revision operation with a tariff—no questions asked; you pay the money out—yet there is not the money there for the physio, which we know would reduce the number of revision operations. That is a bit of a nonsense, is it not? What are you doing to translate that one?

Jim Mackey: Again, we are working with providers. Once you have highlighted that that is an issue in a particular provider, we will help them make the business case to make the sensible investment in the physio, OT or whatever it is that reduces that variation and uses the money most wisely.

Q93 **Andrew Selous:** This needs a real culture change to drive it through, though, does it not, and I know it is early days with the data?

Jim Mackey: It is hugely labour-intensive. Going back to the earlier points about the amount of pressure the system is under, one price potentially of being under that sort of pressure is that you do not have the time to spend. The management team and the clinical staff do not have the time to get into this sort of stuff in a lot of detail. It takes a lot of time.

Q94 **Andrew Selous:** Given that budgets are tight, it clearly makes sense to do it. Moving on, we know again from the data on the national registry that, for over-65-year-olds having hip replacements, simple cement joints are producing excellent long-term results, yet only 40% of patients are getting them. Looking from site to site, the variation is from 5% to 95%, and these cemented implants cost a lot less as well. Again, specifically on that variation, for the over-65s and cemented hip joints, can you give us some detail on what you are doing about that?



Jim Mackey: It is the same as the earlier answer. The data is now available and it highlights the variation. It is very clear what good practice is. Tim Briggs and colleagues are going around the country and working with clinical teams to determine what needs to change, what has worked elsewhere and so on, and we will then hold organisations to account and make the progress on those things.

Q95 **Andrew Selous:** On the cost of implants, again the cemented ones with better results cost less, between £600 and £850 roughly, yet you are paying up to nearly £3,700 for implants. I am just looking for a bit of confidence that there is some real management focus at the top that we are not paying more than we need for implants for which we now have less good outcomes.

Jim Mackey: Another part of the operational productivity team is working on procurement and standardising procurement methodology, the range of products, the price that is paid and so on, and making data available so that price comparisons are easy to see, so that boards or a non-exec could see, for example, what their organisation is paying compared with the organisation next door. Again, we are holding organisations to account to reduce the variation in those price differentials over time and have selected a small number of products that procure nationally under a different mechanism and mandate a process that delivers that.

I have one word of caution. A case was highlighted a few weeks ago where we had legitimately pursued a price reduction but we were at risk then of creating a monopoly supply, which would, long term, not be in our interests. These things are not always as simple as just going straight after the shorter term. You have to have a bit of a long-term game as well.

Q96 **Andrew Selous:** Moving on to a slightly different angle on this, again we know from the data that high numbers of operations done by a particular surgeon tend to produce better results. The figure of 35 a year, I think, is the one that the evidence supports. We know the average number of hip replacements that the surgeon does is one a week—52 a year—yet we know a quarter do 10 or less and 16% are doing five or less. Is it not the case that a lone orthopaedic consultant at a smallish district general hospital is something we should be concerned about, and what are you doing specifically on these numbers of operations, again, where the data shows clearly you are getting better results? It is partly an organisational issue, obviously.

Jim Mackey: Yes. Again—and it is part of the Tim Briggs process—in an organisation I know well, in Northumbria, 20-odd orthopaedic surgeons over 10 or 15 years or so have been routinely concentrating and sharing procedures and specialist skills, and using exactly the things you have described, where if you are not doing a certain number of something you would expect a colleague to be able to do them and you would concentrate on other things. That is very logical and obvious unless you



HOUSE OF COMMONS

are in a hospital that has a very small number of surgeons and quite a fragile system.

Going back to your earlier point, there are choices about whether those things can continue, and if there is a compromise in quality and outcome for those patients we will be shining a light on it and helping people make decisions about it.

Q97 Andrew Selous: On a more positive light, I note that orthopaedic litigation costs rose in 2013-14 but have fallen in 2014-15 and 2015-16. Do you think that the getting it right first programme is a key part of that or to what would you attribute that fall in litigation costs?

Jim Mackey: It is part of that. It is one of the disciplines that has more data and the data is often more tangible; it is easier to have an argument because a hip in place A is similar to a hip in place B, as opposed to a patient with dementia or a functional mental illness or whatever, where it is harder to make the comparison. To be fair, orthopaedic surgeons are naturally competitive beings. Once they know that they do not compare well with a colleague, they will often take that on. Tim Briggs and Jeremy Marlow's process will support that and we will continue to hold organisations to account on it.

Q98 Andrew Selous: Finally, can you give us some assurance that there is enough management focus at the top of NHS Improvement to make sure these lessons are learned and that we do follow the data very carefully to see what is working?

Jim Mackey: Yes. We have about 10% to 12% of our staff in NHSI tied up on the operational productivity. As to "work," we are going through a process now, when the new chief exec arrives, where I would expect them to go through a process of recalibrating that. There is an ongoing discussion as to what extent these things get normalised and mainstreamed into our regional teams. It should be the first tool in the box for which our team reaches, but the data is being built. We are at the early stages. Orthopaedics is the best developed. We need to do this across the board.

Chair: Thank you very much. We are now coming on to specialised commissioning and then on to drug costs, particularly around specialised drug costs, leading out with Rosie on specialised commissioning.

Q99 Rosie Cooper: I am going to concentrate on a couple of areas. Whereas with CCGs you have oversight responsibility, here, for example, in prison services NHSE commissions the prison healthcare directly. How is the budget for prison health decided on and allocated, and what are the steps NHS England takes to assure itself that that budget can actually provide health services to meet the needs of the prison population?

Simon Stevens: As you say, we took on responsibility for commissioning healthcare in prisons in April 2013. When we did so, we found ourselves inheriting 114 contracts from multiple sources—the National Offender



HOUSE OF COMMONS

Management Service, local authorities and PCTs, with a wide variety of NHS organisations, voluntary, private sector and so forth. We have now consolidated the oversight of this into 10 health and justice regional teams, and they have been much clearer about the health needs assessment that is undertaken in individual prisons, working with governors, and then, as these contracts come up for renewal, going ahead and procuring them. That involves a variety of new approaches, including particularly around mental health services, but not just mental health services, recognising, however, that what is happening in prisons means that there are real pressures on a lot of those prison health services.

I myself a fortnight ago, for example, was at the category A prison Belmarsh in south London talking with some of the country's highest secure prisoners. For the teams working in Belmarsh and the governor these are very difficult circumstances, but by and large the staff involved do an incredible job.

Q100 Rosie Cooper: Does the NHS Constitution apply to prisoners, and how do you think the principle of equivalence is working? When was the effectiveness of the equivalence principle last audited in prison healthcare contracts? A separate part of this is, do you know whether it is possible for prison healthcare contracts to be top-sliced at a regional level?

Simon Stevens: Can you explain the last point a bit more, Rosie?

Rosie Cooper: Basically, you might allocate £100 million that goes into the north-west, or whatever, and your regional lead could take, say, £10 million, put it aside and use that.

Simon Stevens: Obviously, these contracts are let for particular prisons and services.

Q101 Rosie Cooper: Do you know of that?

Simon Stevens: We are spending about £500 million a year on our health and justice programme across the country, of which about £400 million is in adult prisons. I might add that, as you will know, the Public Accounts Committee has a particular inquiry on mental health in prisons that I will have the opportunity to appear before in a fortnight or three weeks' time where we will be getting into some of this as well.

Q102 Rosie Cooper: To go back, the NHS Constitution applies to prisoners surely. Have you audited the principle of equivalence, and do you know whether regional teams—areas—actually top-slice the amount of money that you allocate for prison healthcare contracts?

Simon Stevens: I am not quite sure on this top-slice point because, of course, we do have to top-slice some money. We run liaison and diversion services across the courts systems. We have responsibility for sexual assault referral centres; we have other costs, including immigration removal centres and so on. So, we do not just allocate the



HOUSE OF COMMONS

budget straight out to individual prisons, if that is what you are saying, but as part of the reforms that were proposed by Michael Gove at the time there was a suggestion that governors would take more of a responsibility for commissioning or co-commissioning the health support they get in their own prisons. That is a conversation we are still having with the Prison Service as to what their current proposition on that is. Having, for example, also visited HM Prison Preston, which is a different set-up from Belmarsh, I know they have benefited greatly from the involvement of the Lancashire mental health services and the acute trust directly in the prison itself.

Q103 Rosie Cooper: I will write to you about those three things because I think it is really important to ensure that top-slicing and any such action does not actually corrupt—I am giving you the benefit of the doubt—your good intention. You obviously have not spelt out the budgets, but we can do that another time.

I am really concerned about the state of the prison at HMP Liverpool. You commission the services directly. Do you know how many people came to harm or committed suicide in the past week, month, six months or year? Do you know that?

Simon Stevens: I have not brought the Liverpool prison figures with me today, but I am sure Kate Davies, who leads our prison health team, will have those available and would be happy to meet with you to discuss them.

Rosie Cooper: You might assume that I have a fair idea what it is. If this was a CCG, you would be demanding to know what they were doing to reduce the levels and using NHSE's—

Chair: Rosie, rather than trying to focus individually, would it be possible for you to correspond directly, because we have a number of other issues to get to today?

Rosie Cooper: Absolutely, but, forgive me, I need to make a point. I am either here to do this or not.

Chair: That is fine. It is just that we do not want to focus too much on individual cases.

Rosie Cooper: You actually talk about reducing avoidable self-inflicted death. Is that the same as suicide? Why are you trying to sanitise the most desperate of acts by using that phrase? I will give you some examples. Because the contract is so poor in Liverpool, Lancashire Care was allowed to low-ball it. The staffing levels are awful. People are getting the wrong medication; people with the same surnames get the wrong medication. The whole thing is dreadful. An epileptic man fell from a top bunk at 1.10 am, was seen by a band 5 nurse, no doctor was called, the prisoner was put back to bed with painkillers, and in the morning was found to have C1-C2 life-changing injuries. That is not healthcare that is really on top of it. That is not equivalence. We also



HOUSE OF COMMONS

have cases—

Chair: Rosie, I am sorry, but we are going to have to have a question because we have several subjects to get through.

Q104 **Rosie Cooper:** The question is, why are you not demanding to know about the people you have providing these services? Why is it me or whistleblowers who have to tell you about this? Answer me a simple question: why, in your world of equivalence, can the NHSE not get desperately, physically and mentally ill men to appropriate services inside or outside prison appropriate to their needs?

Simon Stevens: Are you talking about mental health specifically now?

Q105 **Rosie Cooper:** No, I am not talking about mental health. I am talking about physically and mentally ill. I am not obsessed by mental health. Illness will do me.

Simon Stevens: There are all kinds of operational issues. As you know, we have issues around the transport for prisoners from prisons to hospital when they need it, which can sometimes put an operational pressure on governors when they are short-staffed. We have an ageing inmate population so that in many prisons—including Preston, I might add—they are developing end-of-life and palliative care services. We have an ageing of the lower secure prison population, so the whole nature of the health service that has to be provided there is shifting quite dramatically. We have had issues with a lot of prisoner movement between individual prisons, which means it is sometimes hard to track where people have come from and the health circumstances that they are facing.

You are right to raise the fact that there are real pressures and issues in some prisons and across the prison health service as a whole, but it would be wrong to imply that there are not a group of people who are intensively focused on this and would be happy to talk to you about the action they are taking.

Q106 **Rosie Cooper:** Do you think moving the governor of the prison and putting somebody in who is going to last six weeks, and moving, I understand, a commissioner to the north-east, is the answer to this problem? It takes me back to where I started: how do you evaluate that those contracts are actually the right figures providing the right service? I have to tell you that I understand the person who let this contract to Lancashire Care went on to be employed by Lancashire Care; it's funny, that.

Simon Stevens: If it was a question that was in search of an answer, perhaps I could give you the answer, which is that we evaluate with a very detailed set of metrics the performance around GP appointments, primary health dental services, substance misuse attendance rates, the mental health uptake and a whole series of measures around the care-programme approach that prisoners are on. There are also transfer time



HOUSE OF COMMONS

delays and the impact of various other physical health measures that would be applied in the rest of the NHS. This happens to be the Belmarsh report, but the same would be true for HMP Liverpool as well, I am sure.

Q107 **Rosie Cooper:** Absolutely. So, loads of worthy—

Simon Stevens: We agree, therefore, that they are monitoring.

Rosie Cooper: Loads of worthy documents are totally meaningless in the face of the fact that prison deaths are escalating and people are suffering serious injury in hospital. A low-balling, letting a contract go to the lowest common denominator, will cause—

Chair: Rosie, I am afraid that—

Q108 **Rosie Cooper:** Let me ask you the question. Is it not predictable that low-balling of this type will result in more prisoners committing suicide—yes or no?

Simon Stevens: There is a premise to the question, which is that you believe you know what the right contract value for this procured contract should be in a way that nobody else does. I do not know whether that is true or not.

Q109 **Rosie Cooper:** Believe me, I don't; you are paid to.

Simon Stevens: If you are using the phrase "low-ball," that implies you think you do.

Rosie Cooper: No. The evidence suggests—the outcome suggests—that it is not right.

Chair: Rosie, we do have a lot of areas to cover, and I know that both Lisa and Paul want to come in on this issue.

Q110 **Dr Cameron:** Thank you. It is a question about transition again, when people leave the Prison Service and have a recognised mental health difficulty. When I worked in forensic mental health services, often people would leave prison and the mental health services at times perhaps did not know until the following week and so on. What is happening to ensure that transition is smooth so that when people leave prison they have adequate care in the community from forensic mental health services at the time they need it?

Simon Stevens: That depends again on the nature of the prison, how long somebody has been in prison and, therefore, how easy it is to have done the discharge planning. Where you have a lot of churn between individual prisons, which unfortunately we do see for a variety of reasons—and I think that has been the subject of national conversation even within the last several days—it is much harder to put in place those kinds of processes, but, by and large, that is what mental health teams in prison are trying to do. As I say, we are going to be discussing this in, no



HOUSE OF COMMONS

doubt, great detail at the Public Accounts Committee in a few weeks' time when we will have all this material for your colleagues.

Chair: Indeed, correct. Paul, do you have a follow-up question?

Q111 **Dr Williams:** There are a lot of missed appointments for prisoners in hospital. HM Inspectorate of Prisons looked at this and found that in some prisons up to 40% of hospital appointments were being missed, and it was often, as you have said, because of staff shortages to be able to accompany them. Clearly, that is bad for the hospitals but also bad for the patients. We talk a lot about mental health in prisons, but I am also interested in the long-term condition management as we have an ageing population and timely diagnosis of cancer, for example. I asked the Ministry of Justice to talk to NHS England, but can you make sure you are talking to the Ministry of Justice to ensure that we are doing everything we can to minimise the number of missed appointments for prisoners?

Simon Stevens: Yes, you are quite right. When you go round and talk to governors and health teams in prisons, it is one of the real operational issues. There are some answers to this that are being developed. In some places, if you can embed more health services directly in the prison itself, if it is a large enough prison, that reduces the need for transport.

Also, we are going to take a look at some alternative approaches, such as, where we have the concentration of prisoners who require dialysis, maybe they can be dialysed in the prison estate rather than having to travel to hospital. It is not straightforward because you do not necessarily have the concentration of prisoners needing dialysis in the same prison. If they are scattered around different geographies, what does that look like? That is actually a conversation I personally kicked off with the folks in the prison system within the last few weeks.

Chair: Thank you. We are moving on to the area of high drug costs and rationing. Diana is going to lead on this section.

Q112 **Diana Johnson:** I have four questions, and I will try to be brief. The first question I wanted you to set out was that NHS England had previously told the Public Accounts Committee that the pharmaceutical price regulation scheme is now a bit leaky around the boundaries. Could you say what changes you would like to see for that to operate better?

Simon Stevens: The Government have acted on some of that leakiness. The particular leakiness in question was that, given that the PPRS is a voluntary scheme, it had historically been open to companies who chose not to be members of the PPRS nevertheless to start offering or seeking to sell their drugs to the NHS. That expenditure would not have been counted into the overall PPRS envelope, which was part of the collective agreement between the Government and the pharmaceutical industry. So, the Government are acting to ensure that the statutory PPRS acts as a kind of safety net on that so that people who would otherwise have



been circumventing the voluntary agreement can be covered by the statutory scheme.

Q113 **Diana Johnson:** Everyone has to opt in to the scheme. You cannot circumvent it.

Simon Stevens: There are various other aspects of what being in the voluntary scheme consists of, but on this particular point there is now a way of dealing with free riders, if you like, of the overall scheme. There will need to be a successor to the PPRS when it expires in a year or so's time, but that will no doubt evolve as it has done since 1957 when it was first introduced, I think.

Q114 **Diana Johnson:** I want to move on to the specific arrangement that has been entered into with NICE and NHS England from April this year so that, with drugs that are expensive, which are going to cost more than £20 million in the first three years, there is an allowance to not prescribe them, not to use them. Particularly, I want to ask about the new hepatitis C drugs that have come on line. As I understand it, there are 160,000 people with chronic hepatitis C in England. I want to check with you what the plan is in dealing with that group of 160,000 on the decisions that are made about how you ration that drug, because obviously people could die if they do not receive this cure. I understand this new brand of hepatitis C drugs is far more effective than previous ones.

Simon Stevens: This is an unsung but enormous success story for the national health service over the last 18 months in that we have invested around £200 million a year, which we are sustaining in this new class of treatment for hepatitis C. As a consequence, over that period of time, since we have done so, we have cut the death rate for those most severely ill by 10% and reduced the need for transplants by 50%.

How have we done that? We have done it by following the approach that NICE rightly laid out, which is that you should start with focusing on the very people, the patients that you are describing, those people most at real urgent clinical risk. Those are people on whom to focus the initial efforts. That has been done and has produced the benefits that I have described. We are now rolling out the treatments to a wider group of people, many of whom have it as a sort of chronic background condition that might have no clinical impact for many years.

We have been aided in our ability to do this by the procurement approach that we have taken and I make no apology for driving quite a hard bargain on behalf of taxpayers and patients in the approach that we have taken. We have run six-monthly periodic regional procurements for this. As a result, we have seen over time, as more competition has come between individual companies, the price per treated patient coming down, and we are going to be able to increase the patient numbers treated within that by north of 25% over the course of the coming year. This has been a really successful, managed introduction of a new treatment, but if in an unplanned way we had just let rip it could



HOUSE OF COMMONS

potentially have cost £1 billion or £2 billion last year, which would have meant drastic cuts in other services. The phased approach is, as recommended by NICE, the right approach.

Q115 Diana Johnson: How long will it take for the 16,000 people who have hepatitis C to receive this treatment—how many years?

Simon Stevens: That is partly going to be a function of price reductions, and already, even within the genotype for which there was not clinical therapeutic competition, which I think was genotype 3, from memory, we are now seeing clinical competition there. We expect to see that competitive effect mean that the prices are coming down and we will be able to treat even more people for the £200 million extra that the country is investing in hepatitis C services.

Q116 Diana Johnson: I am glad you have mentioned prices because I want to ask you about that. I am new to the Committee as well so I am trying to get my head round this. I was told that the cost that the NHS was paying for the hepatitis C drug was around £39,000 per patient. I was given some information that, in Italy, the cost they pay is €900 per patient and, in Spain, it is €12,000. Could you explain to me how come it is so much cheaper in Italy and Spain for this drug?

Simon Stevens: I am not sure you should necessarily take those numbers at face value.

Q117 Diana Johnson: Could you tell me what the figures are and why we pay so much?

Simon Stevens: No, because that would weaken our commercial negotiating position. We run competitive procurements with companies and get best prices when we do not reveal the deal we are getting relative to the Italians or the Germans. When we do so, that inhibits our ability to get good deals for NHS patients.

Q118 Diana Johnson: The problem for me as an elected politician is that you are saying to me this is going to be incredibly expensive and it is going to cost over £20 million. That is why it is not being rolled out completely and it will have to be done incrementally—

Simon Stevens: No, but they are separate, because with this one we did: we put £200 million in, not £20 million, in the first year.

Q119 Diana Johnson: Perhaps I have misunderstood that, but then I do not understand, if you have put in £200 million, why it is that the 160,000 are not being treated, because you are paying a much higher price for the treatment per patient. That must be right.

Simon Stevens: The cost of treating all 160,000 at the original price, including at that point the genotype patient subgroup, for which there was not therapeutic competition, would have been north of £1 billion.

Q120 Diana Johnson: It was only a fifth of what you needed—the £200



HOUSE OF COMMONS

million.

Simon Stevens: NICE convened a clinical panel and asked whether it was sensible to do this on a phased basis or should we try to do it all at once. Their recommendation to the NHS was to do it on a phased basis, starting with the patients who have the most acute condition. That is what doctors have done. That is how we have cut the death rate by 10%.

Q121 **Diana Johnson:** We only have a little time and I know you have to go, but I want to be clear: do you think, from the figures I have been given from other European countries, that we are paying over the odds? Are we paying too much taxpayers' money for these drugs in the UK? That is what I am asking you.

Simon Stevens: We are paying the best prices we can get using the competition available to us, given that these are in-patent products.

Q122 **Diana Johnson:** What I am told is that, in Italy, they categorised hepatitis C as a life-threatening disease, which nullified patents, and then companies could compete at a lower price. Perhaps you could look at that and let me know whether that is something you recognise.

Simon Stevens: We have not broken the patent on these or other equivalent medicines and we would be subject to infringement action in the European courts if we did.

Diana Johnson: We are leaving, aren't we?

Q123 **Mr Bradshaw:** Why has Italy not been the subject of patent infringement then?

Simon Stevens: I think we should take what we are hearing about Italy under advisement.

Q124 **Diana Johnson:** Perhaps you could write to me about this, because I think it would be quite interesting to see the cost, if that is possible.

Simon Stevens: Sure.

Q125 **Chair:** Can I just ask whether you have a bit of flexibility in your timetable to talk about prevention?

Simon Stevens: Let me consult. Yes.

Chair: Super, thank you, because obviously this is a key area for the NHS and patients. Andrew is going to lead on that.

Q126 **Andrew Selous:** Thank you so much. I will be as quick as I can and I hope you do not think that we think it is unimportant because we have left it until last. We think it is incredibly important. In view of time, I want to focus on childhood obesity because it is such a big issue; it is such a big social justice issue as well, particularly as we know that poorer children at the age of 11 are likely to be three times more likely to be obese than their least deprived peers. I understand that we are spending approaching 10% of the NHS budget on this, £6 billion a year on obesity



HOUSE OF COMMONS

and some £9 billion on type 2 diabetes. The numbers are large.

Starting internationally, I am not sure if you are aware that there has now been an evaluation of the Amsterdam healthy weight programme. We have four years of data, which has seen an 18% reduction in obesity among the most deprived children. Is this on your radar and is it something you think we should emulate here?

Simon Stevens: Yes. Those kinds of programmes are certainly on our radar. As you know, Professor Jonathan Valabhji, our national director for diabetes and obesity, has taken a hard look at international models. The one that we felt was most promising for at least initial introduction across England was the diabetes-prevention programme, which originated in a randomised control trial in the *New England Journal of Medicine* back in 2002, I think it was. The DPP showed that a well-structured programme of lifestyle change to reduce obesity was associated, I think, with a 58% reduction in the conversion from prediabetes to type 2 diabetes.

In real-world settings, the impact is being reported as slightly less than that but, nevertheless, clearly clinically significant. That is the reason why NHS England with Public Health England are now funding the national roll-out of a diabetes-prevention programme, and Professor Jonathan Valabhji will be reporting very shortly. I have seen the draft manuscript of the research paper showing the impact that we are getting from that. The DPP, in partnership with Diabetes UK, is one of our big initiatives in this area.

But, over and above that, I was with folks in Greater Manchester a few weeks ago looking at the fantastic child health measurement data linkage that now exists across the children subset of the 2.8 million across Greater Manchester, which is really going to be able to track other interventions and whether we can get the kind of gains that Amsterdam or others are seeing. Some of this, of course, is not the work of the health service. A lot of this needs to be the broader obesogenic environment, using the sorts of interventions that Public Health England's evidence review set out for action.

Q127 **Andrew Selous:** The last part of your answer leads me on to my next question, which is, would you like to see more cross-departmental work, working with local authorities, with CLG, with city mayors, and you mentioned Manchester, or even the Cabinet Office, because again my understanding of what happened in Amsterdam was that it was multi-sectoral and multi-departmental? Do you think there is more scope to join up here to make further progress?

Simon Stevens: I do. If we cast our minds back 18 months when there was a conversation about what the childhood obesity strategy should look like in the round, and then a year ago a decision to proceed with several elements of that but to wait to see whether that was having the desired impact on reductions in childhood obesity before deciding whether further reinforcement was needed, my hunch is that further reinforcement will be



needed. On a day when we are rightly talking about race and ethnic disparities in this country, if we are serious about those we have to be serious about the fact that, among four and five-year-old children in this country, 22% of white British children are overweight, but 31% of black African children are, rising to 46% of black African children by the time they are 10 or 11 years old. There is an inequalities aspect to this that is both around deprivation and around race, and to will the end is to will the means.

Q128 Andrew Selous: Moving on to labelling information, do you think that nutritional information should be universally applied on food and drink products?

Simon Stevens: We are seeing positive signs, with regard to the reformulation particularly of added sugar in drinks that was anticipated on the back of the sugar tax, that manufacturers are now recognising that that is a real thing, not just in this country but in many other countries, and they are beginning to take action. Across the NHS, we are kicking junk food out of hospitals and changing the NHS standard contract so that sugary and fizzy drinks—

Q129 Andrew Selous: I want to press you a bit on consumer information. If I go into a supermarket to buy some breakfast cereal, should it not just be really easy for me to see how much sugar is in each product on a traffic-light system?

Simon Stevens: I think so, yes, although I do not even think a traffic-light system is the answer. The Jamie Oliver proposition around the printed number of spoonsful of white sugar should be printed on the side of the pack and then you can really get it—"Blimey! There are five spoons of white sugar in this bar or this sugary drink." I think parents would be stunned to realise that.

Q130 Andrew Selous: That was going to be my next question and I am pleased you have mentioned that. In a lot of schools I go into, in reception there is a brilliant display of the number of sugar lumps in each sugary drink, which I think is incredibly powerful, so I am pleased you are advocating that.

Staying with schools, have you had any thoughts on whether the current sports premium could be adapted to more of a child health premium to tie in with health educational needs assessments? There is a line of thought that the current way we do this with the sports premium will benefit the sporty kids, but we perhaps need to have a little bit more focus on those who need some specific attention. Have you looked at the school area? I know it is outside your specific remit.

Simon Stevens: You are ahead of me on that and no, I have not, is the honest answer, but I do know that where, in parts of the country, our vanguard programme is working with primary schools in particular, it is really beginning to have success in the mile-a-day run-around, which is



HOUSE OF COMMONS

part of the answer there; but whether that gets to the point you are making I am not sure, so I am happy to discuss that.

Q131 **Andrew Selous:** Would you like to see it be mandatory that that happened, the 60 minutes of exercise—

Simon Stevens: I would need to educate myself more on the proposition before—

Q132 **Andrew Selous:** I think it would be helpful to have the authority of NHS England looking at these issues, because many of us are keen that the NHS is not overwhelmed with future demands. I know it is outside your direct brief, but, personally, as a Committee member, I would welcome that.

Simon Stevens: Unusually, I think, on that point, both the *Daily Mail* and *The Guardian* are agreed on this, going by their front pages today, and rightly so.

Andrew Selous: Go for it.

Chair: Can I bring Ben in with a supplementary?

Q133 **Mr Bradshaw:** I am very pleased that I think you said further reinforcement of the Government's anti-obesity strategy would be necessary, because, of course, one of the first acts of the new Prime Minister when she came in last year was to significantly water down the even relatively weak anti-obesity strategy that had been announced by her predecessor David Cameron. Were you consulted on that decision?

Simon Stevens: No.

Q134 **Mr Bradshaw:** Were you disappointed by it?

Simon Stevens: I took from that that for the first time we had quantified goals for childhood obesity reduction against which we could judge whether any particular package of measures was having an impact, and if it turns out that they are not having the desired impact—and PHE will be independently reporting on this—that will strengthen the case very considerably.

Q135 **Mr Bradshaw:** When can we expect these reinforcements?

Simon Stevens: I think PHE is doing an annual report, is it not, on the impact on calorie content and childhood obesity? So, once a year we will all have a chance to see whether we think progress is occurring.

Chair: I hope we will have the opportunity to follow that up in March. Thank you.

Q136 **Andrew Selous:** Would you agree that there is a sense of urgency on this issue?

Simon Stevens: From those with whom we have spent time together, yes. From the get go, I have been pointing out that there is something



HOUSE OF COMMONS

extraordinary about the fact that we appear to be spending more on obesity-related conditions in the national health service than we are on the police, the fire service and prisons put together, notwithstanding our conversation about prison health. So, yes, this is a clear and pressing matter.

Q137 **Chair:** In saying goodbye and thank you very much for coming, Jim, before we finish, do you have any advice for your successor?

Jim Mackey: In these national jobs, it is easy to forget the people whom you look after and to whom we are here to be responsible, so my advice to them would be to find mechanisms so that you connect with the service regularly to keep in contact with that.

Chair: Thank you. We would all sign up to that. Thank you very much indeed, both of you, for coming and, Jim, thank you for all that you have contributed to NHS Improvement.