

Public Accounts Committee

Oral evidence: Sustainability and transformation in the NHS, HC 793

Monday 5 March 2018

Ordered by the House of Commons to be published on 5 March 2018.

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Members present: Meg Hillier (Chair); Sir Geoffrey Clifton-Brown; Chris Evans; Caroline Flint; Gillian Keegan; Anne Marie Morris; Bridget Phillipson; Gareth Snell.

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

Questions 1-145

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, David Williams, Director General of Finance, Department of Health and Social Care, Simon Stevens, Chief Executive, NHS England, and Sir Ian Dalton, Chief Executive, NHS Improvement.

Reports by the Comptroller and Auditor General:

- [Sustainability and Transformation in the NHS](#) (HC 719)
- [Financial sustainability of the NHS](#) (HC 785, session 2016–17)
- [Sustainability and financial performance of acute hospital trusts](#) (HC 611, session 2015–16)
- [The financial sustainability of NHS bodies](#) (HC 722, session 2014–15)

Examination of witnesses

Witnesses: Sir Chris Wormald, David Williams, Simon Stevens and Sir Ian Dalton.

Q1 Chair: Good afternoon and welcome to the Public Accounts Committee on Monday 5 March 2018. We are here today to look at sustainability and transformation in the NHS, on the back of a National Audit Office Report on the subject.

Sadly, this is a subject that we return to perennially as a Committee. Last year, we were very critical of the short-term measures used to balance the NHS budget. The trust sector reported a deficit of nearly £800 million last year, and it forecast a deficit of over £900 million this year, so the system still has a long way to go before it is sustainable. As the NAO Report highlights, and as the Committee has said before, the NHS is still very much focused on survival, with growing demand that budgets are not keeping pace with. The transformation funding that is going on seems to be propping up the system rather than achieving the transformation intended. In that system, there are clear winners and losers because of how the budget is formulated.

We have spent some time talking to finance directors and are working with colleagues around the House to do that. Two concerns came out from them on trusts: the issue around staffing, and the concern that they are getting mixed messages from the top. We will be probing some of that as well today.

Let me introduce our witnesses, starting from my left: David Williams, director general of finance at the Department of Health and Social Care; Sir Chris Wormald, permanent secretary at the Department of Health and Social Care; Simon Stevens, chief executive of NHS England—not yet of social care, but I am sure that will come; and Ian Dalton, the new chief executive of NHS Improvement. Ian replaces Jim Mackey, who retired last Christmas. I think this is your first time in front of us, Ian.

Sir Ian Dalton: It is.

Q2 Chair: Welcome. The hashtag today is #NHS.

Before we get into the main session, I want to ask both Sir Chris Wormald, as permanent secretary, and Simon Stevens about the NHS winter crisis funding. It was provided to trusts that bid for it and met certain criteria last year, and by our reckoning it would probably have arrived with trusts in about November. I wonder whether you have any indication of how that has been spent—maybe David Williams is the one to ask, because I can see the permanent secretary looking to him. I want to know how it has been spent, whether it has been spent and how you are monitoring that at a central level. Shall I start with you, David Williams, and then see what Simon Stevens has got to say?

David Williams: Yes. I can set out how the additional funding was allocated and planned to be spent, and then you may want to hear from NHS colleagues how it has been deployed into the system in practice. The



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Chancellor announced £337 million of additional funding at the Budget in the autumn last year. £150 million of that has flowed straight through to providers to cover costs and pressures that they had already incurred or forecast. £137 million was put into the system to buy additional capacity; some of that was around additional beds in acute trusts, and some was for increased access to GPs, particularly over the Christmas holiday period, as well as resources for mental health services, ambulance trusts and NHS 111 services. We retained £50 million of that additional money centrally, against the point where winter was over, which is a point that I think we have not yet reached—

Chair: The Department predicts that now, does it?

David Williams: —and we are currently in discussion with the NHS about how best to release it.

Q3 **Chair:** Just be clear, is that money for this financial year? Does the winter have to be over by 31 March in Department of Health land, come what may?

David Williams: We were hoping there might be some opportunity to put a bit of investment towards the end of February and March into elective care, but in practice the continuing high levels of flu and bad weather have meant that the focus has necessarily been more heavily on A&E performance.

Q4 **Chair:** Just to be clear, does the £50 million that you have held back centrally have to be spent by 31 March? Presumably, you have to spend it. As the finance director, David Williams, you might not want it spent.

David Williams: It has been voted to the Department through supplementary estimates and we have put it into the mandate, so there is a question about whether there is anything sensible that we can do with it over the next four weeks or whether, in practice, it is simply a relief to the bottom line.

Q5 **Chair:** Simon Stevens, from your perspective, has the money been spent well? Have you been keeping track of it?

Simon Stevens: It has been allocated in the way that David has described—

Chair: At short notice.

Simon Stevens: It has been allocated to trusts and also a small amount to GPs. For the first time in terms of winter funding, the mental health trusts also received funding to enable them to put additional support into crisis mental health services and A&Es over the winter period. That has collectively helped the NHS perform under demanding circumstances over the December and January period. The key fact to have in your mind is that we looked after 130,000 more people within the four-hour A&E target in December and January this year than we did in December and January the year before.



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- Q6 **Chair:** Okay, but given that the money arrived quite late into trusts' coffers and there is still some money not yet spent with four weeks to go, is there not a risk that it will get spent on short-term expensive options such as highly paid locums, if you can find them? The evidence we have had from many finance directors is that it is hard to find staff even if you have the money. Is it not more sensible to look at doing this in a more long-term, sustainable way, Sir Chris?

Sir Chris Wormald: Ideally, you allocate money very early, for the reasons that you say. In this case, as I may have said to the Committee before, we were investing in the NHS's existing plan for winter. A lot of what David has described were plans that were already there in the system. We were back-funding the money that people had already spent.

- Q7 **Chair:** To be clear, there were plans, but without the funding attached, so they were still having to find staff. David Williams talked about adding capacity, including beds. It sounds so easy to open up a bed, but it is the staff you are paying for. You have to find the nurses and other ancillary professionals to support that at short notice. Even with the plans in place, if they have not opened them before, it is because they did not have the staff.

Sir Chris Wormald: Yes, that's true—

- Q8 **Chair:** So have you monitored whether they overpaid for the staff they then had to get in?

Sir Chris Wormald: I do not think that we have seen any evidence of overpaying.

Simon Stevens: Trusts had been planning, ahead of the Budget money becoming available, for having additional services online over the holiday period. What the Budget money has done is provide a funding source for that. Over and above that, a range of non-hospital-related services were put in place for this winter that were not available last winter, such as the fact that every major A&E had clinical GP streaming available this winter and we had a much higher proportion of calls to 111 being dealt with by a nurse, a paramedic or a GP: 40% compared with 22% last winter. All of those were additional services put in place for this winter, and the Budget money has helped fund some of those cost pressures.

- Q9 **Chair:** If they were put in place before the money was available, was the trust saying, "We hope we will be able to pay the staff; we hope the Department will pay more money," or was it the case that the plans were there but the people were not there, and they had to go and find the people to fill those slots on the phone or wherever?

Simon Stevens: Ian may want to come in. Trusts had been asked to and were planning for expanded services over the holiday period ahead of the Budget money becoming available.

- Q10 **Chair:** Ian Dalton, had they recruited the staff already or did they have to do that?



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Sir Ian Dalton: Perhaps I could give a concrete example. Before I came here, I was privileged to be the chief executive of one of our largest trusts, Imperial College Healthcare, and we had planned to increase our capacity, at risk, by a significant amount going into winter. It is a completely legitimate call on the resource to meet in part costs that trusts knew they were going to incur.

Q11 **Chair:** How would Imperial have funded that if you had not had the money at short notice?

Sir Ian Dalton: If we had not had the money we would have had to make additional savings or see our budget go out as a result.

Q12 **Chair:** So you had people in position—salaried staff, doctors and nurses—to fill the capacity.

Sir Ian Dalton: Inevitably, when you plan this, you work on an assumption that you can fill your shifts. We know there is a significant issue with vacancies across the service, but in general times that is the basis on which you plan; you plan in advance to build the capacity.

The other point that may be worth mentioning is that management information tells us that if one compares the bed state on 2 January with 30 November, we had moved up from 96,298 opened beds to 99,116 open beds, so there is no question but that the NHS steps its capacity up. Some of the really impressive work that clinicians across the NHS have done to see patients within four hours, despite the pressure, relied on that. It is an important contribution, notwithstanding all of the other debate that we have just had.

Q13 **Chair:** I am going to bring in Bridget Phillipson in a moment, but Mr Dalton, you were chief exec of a large trust. With that hat on, would you not think it more sustainable to have that money built into your budget, given that you are planning for this? And now, as chief exec of NHS Improvement and sitting next to the Department, what would you say to them about how sustainable this approach to funding is and what they should do in future years?

Sir Ian Dalton: I would say two things, Chair. The first is that the money was really welcome, for the reasons we talked about. The second is—this is something that NHS England and ourselves have signalled in the 2018-19 planning guidance—that it is absolutely right that people should be planning for this on the basis of the cash that they are projecting for the year, rather than receiving the money late in the year, welcome though it was. That is a signal we have sent to the NHS for next year, partly to address this issue.

Q14 **Bridget Phillipson:** In terms of how the winter money is spent, Sir Chris, you said you are not quite sure whether that in effect means that we have been overpaying, because the money—

Sir Chris Wormald: No, I said we have not seen any evidence that we have been overpaying. This comes out in the Report: we monitor agency spend extremely closely indeed and have a whole series of controls around



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agency spend that NHS Improvement manages. Indeed, we were looking at the numbers earlier today and we have not seen any evidence in those numbers that there was a loss of control on agency spend over that period at all.

- Q15 **Bridget Phillipson:** So where is the extra capacity coming from? Who is doing the additional hours that can be created through the funding?

Sir Chris Wormald: Ian will comment further, but it will normally be existing members of staff doing extra shifts, either as part of overtime or as part of bank arrangements. What we have seen as agency spend has declined is a big expansion in trust-run bank arrangements, that being the way in which temporary cover is funded. That is, of course, more efficient, but it also fits better with the staffing model of the hospitals. Do you want to add to that, Ian?

Sir Ian Dalton: Later in the discussion, we may talk about the reduction in agency spend, which has been really quite extraordinary. There is a 20% projected reduction this year. That is a dramatic reduction. But to answer the question specifically, normally the best way of staffing a surge in capacity—bear it in mind that hospitals have to maximise their capacity to cope with the emergency patients who come through the door on a daily basis, as well as just across winter—is absolutely to offer your own staff, who know the hospital, the patients, the protocols and the wards, work through the bank. You will have seen, therefore, a very successful move from agency to bank as part of the overall staffing plan for the NHS, and that was the case again this winter.

- Q16 **Bridget Phillipson:** I appreciate that many NHS staff may welcome that opportunity to earn extra money by doing additional hours, but is that sustainable in the long run, given that it must be a highly pressurised environment for those staff over the winter period? Although they clearly do this of their own free will, would we not do better to look at longer-term solutions that involve creating those positions earlier in the year? Even if that comes at a cost, it would be a more sustainable way of managing some of those winter pressures.

Sir Ian Dalton: The key message that we give the NHS and that we have given very clearly in the planning guidance for next year is that absolutely the NHS needs to plan for the capacity that it expects to see and particularly the emergency demand, which we have seen—I think the Committee has commented on this recently—moving ahead significantly over the last few years. To give one particular number that is on my mind, during December the NHS admitted 400,000 people through A&E as medical emergencies into hospitals, which was a 5.9% increase on the same period in the previous year. There is a significant rise in demand and it is absolutely right that hospitals plan for that. We have had a particularly demanding winter and NHS staff have done a phenomenal job. Nonetheless, we should be planning for it.

- Q17 **Bridget Phillipson:** Hospitals and trusts may plan for this, but if they do not have the funding available they cannot get on and recruit the people,



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surely.

Simon Stevens: The bottom line is: would it be desirable, if there was going to be extra winter money, to have it earlier in the year? Sure, but we are nothing other than grateful for the fact that we got the extra winter money. Our message to the NHS for 2018-19 is that we have to plan on the assumption that we will not have it again and therefore build in plans for the full year with the emergency capacity build-up for December and January. That is the straightforward answer to the question.

Sir Amyas Morse: I just want to make sure that I understood that last bit clearly. Are we saying that last year you planned at risk? You used the phrase "at risk", Mr Dalton. So you did not have the budget capacity, and you decided you would take the risk that either you would get the funding or you would be allowed to have a deficit and would get assistance with that.

Sir Chris Wormald: Not quite—

Sir Amyas Morse: Okay. Let me carry on for a second longer, please, Sir Chris. This year, if I understand rightly, the plan is that you will plan earlier for the peak that you are going to have during the winter and you will have more staff on board. Does that mean that you will have the money already allocated to you? What does it mean exactly about funding? I am not quite clear.

Sir Chris Wormald: When you get a winter pressure, the bit of the NHS that suffers is the discretionary bit—the elective bit—not the emergency bit. So you would always expect a trust to meet, and resource itself to meet, its emergency demand. In the absence of extra money to pay for that, what it would need to do would be to cut its elective activity and its other discretionary activity. Every trust will plan for the emergency bit. What, essentially, we did was to fund what would otherwise have been reductions in service elsewhere in the hospital. That is the effect. That is why it is perfectly possible to have a plan—

Q18 **Chair:** I think that as the Comptroller and Auditor General has highlighted, the NHS is being forced to rob Peter to pay Paul, because if you do not do elective you are creating problems for the future, whichever way you cut it.

Sir Chris Wormald: Exactly, which is why we wanted to invest the extra money. As Simon says, would it be even better to have that money right at the beginning? Yes, of course it would, but we didn't. Clearly, it is better to remove from trusts the need to make those reductions in other services by funding their existing winter plans than it is not to. We are not denying the Committee's bottom line. Is it better to have all the money at the beginning of the financial year so you can spend it properly? Yes, that is clearly the optimum state. The second optimum is to get it during the year and the third optimum is not to get it at all.

Simon Stevens: In support of what Chris just said, I have one additional data point. There was a lot of speculation about the amount of non-urgent



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surgery in January that would have to be deferred. We will have the definitive figures later this week, but the early indications are that, partly because of the extra funding that was available, the number of operations deferred was substantially—substantially—lower than that which was being speculated about in the press at the time. We will have those figures definitively on Thursday. So, that is some good news, Chair.

Chair: So a lower than very bad figure is a good result. Mr Stevens, you see optimism in every bad figure.

Sir Chris Wormald: There was one other question I wanted to come back to, which was about bank staff and flexibility. This is a question that is all about balance. For something the size of the NHS, or indeed a trust, it is perfectly sensible to have a bank of flexible staff to allow you to manage the peaks and the troughs. You do not want to staff for the maximum for the entire year. It is also true that we have more vacancies in the NHS than we would like. Even if your vacancy position was perfect, you would still want a bank of flexible staff. We are definitely not saying that we want that out of the system. We want much less agency and much more bank to meet those flexible needs.

Q19 **Bridget Phillipson:** Does an overreliance on those bank staff therefore create broader workforce pressures, which mean that NHS staff find it more difficult? Part of the reason they are struggling to fill vacancies, so we hear, is that staff find the pressure of working in under-staffed and over-stretched environments too much. Are we not just continuing this cycle?

Sir Chris Wormald: Well-run banks help you with that problem, rather than hinder. There are of course members of staff who rather like bank work: you chose when you work and it is very flexible, and you can do it at points in the year when you want to earn more, so there are some positive advantages in the flexibility of bank work. But, as you say, you also need a properly staffed core, which is one of the reasons we are consulting on our future workforce strategy at the moment.

Q20 **Chair:** In our limited straw poll of finance directors—some of them were asked their views—one of the key points that came across, as I said at the beginning, was the vacancies rate, and the inability to recruit to some of those vacancies. There is a danger that we are talking about the bank as though it is a solution.

Sir Chris Wormald: No, that was why I made the point that I did. This is all about balance. A well-run bank has a part to play, but it does not take you away from some of those underlying issues, which we have acknowledged.

Chair: It does not fill gaps in the workforce on its own.

Q21 **Gareth Snell:** David, you said you had £50 million of the winter money still held centrally. How many trusts asked for more money than they were allocated as part of the winter pressure funding? As an example, my hospital trust was given around £2 million, but it has calculated that the



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actual additional cost to it was around £10 million, so there is an £8 million bill for them to pick up and you are sitting on £50 million. How many trusts would have liked that money earlier in the year, rather than you thinking about how you might be able to spend it now?

David Williams: I don't have that information. The money was allocated through a series of engagements by the national lead on emergency care, Pauline Philip, with regional directors and trusts, in order to come up with the allocations which we have been talking about. In practice, I think this £50 million will help off-set some of those additional pressures that trusts have faced in managing winter; it is just that at the moment those pressures are being off-set with the money on the commissioner side of the equation, rather than being allocated out to individual providers. That is one of the things that we need to work through over the next few weeks.

Q22 **Gareth Snell:** Will you be able to send through that information and those specifics, on whether anyone did come back to you and ask for more at the particular time? I think it would be interesting to know what trusts were seeing as the resources that they needed at the time, as opposed to what the Department was offering.

Has anyone done any work to actually see what the total cost of the winter pressures was to the NHS, and how much money was allocated and what that was as a percentage? To pick up the point my colleagues have raised, we will have a winter next year and it is likely that we will have a winter pressure point again. If we know what the cost of winter will be, surely we should be looking now to create the circumstances, while the trusts are thinking about how they make small surpluses throughout the rest of the year to meet those costs or, in the case of those trusts that are never going to get into surplus, they can start talking to their commissioners about how they can meet that demand without having to rely on one-off payments from central Government.

Sir Chris Wormald: Yes. With our colleagues we do a review of how winter has gone at the end of winter every year and we build that into the planning for the next winter. Do we look specifically at that?

Simon Stevens: We do. As I think Ian said earlier, the going assumption for 2018-2019 has to be that the funding which is made available, with realistic planning assumptions around emergency growth and with the right seasonal phasing, has to be built into the capacity plans at the start of the year. I think that is a statement of the obvious. There was a significant positive this year and a significant negative, when it came to pressure on in-patient beds. The significant positive was that we have genuinely turned the corner on the delayed transfers of care problem, which has been brewing now for many years. We were able to free-up nearly 2,000 delayed transfer of care beds come this January, which means it is the best DTOC position we have had in two and a half years. That was in the zone of the 2,000 to 3,000 beds that we had planned to free up. That is the good news. The bad news is that we have obviously had the worst flu season in seven years. We have had a hospitalisation



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rate for flu three times higher than last year. As a result, even today we have got around 5,000 hospital beds occupied by people with flu or with norovirus. Now, 5,000 hospital beds is the equivalent of having 10 acute hospitals solely looking after those patients, which would not normally be the case. If you think on a 100,000-bed base, roughly speaking, 5,000 beds tied up with that is obviously a very unusual incremental pressure compared with the last six or seven years.

So, yes, great progress on whole-system working, as evidenced by the DTOC reduction, set against this real pressure from flu and respiratory and norovirus, which we have experienced this year at a far higher rate than in recent memory.

- Q23 Sir Geoffrey Clifton-Brown:** Mr Stevens, surely the ideal situation is that no elective surgery is cancelled, and that trusts and commissions are planning for winter pressure but at the same time are planning to carry on their normal elective work. Wouldn't that be the ideal?

Simon Stevens: Yes, and to some extent that is what the national emergency pressures panel were reminding people of when they said, prospectively at the beginning of January, "Don't engage in last-minute cancellations the night before, or the morning of, when people are coming in for surgery. The assumption should be, given the extra flu and norovirus pressures"—which I've talked about—"that you'll have to free up capacity for those patients during the month of January."

Of course, hospitals and surgeons rightly want to try and use every last available bed that can be deployed for patients on waiting lists who have non-urgent needs for surgery. There is always that kind of balancing act. But, as I say, the good news is that the number of elective deferrals for routine operations in January will come in substantially lower than was feared at the beginning of January.

- Q24 Sir Geoffrey Clifton-Brown:** While it is the Government's ambition to recruit more nurses and more doctors, it is having great difficulty doing so. Doesn't it therefore make it even more urgent, with these constant winter pressures, that the Government puts greater attention on recruiting and training more nurses and doctors?

Simon Stevens: Yes, I think on both fronts that is right. On doctors in the hospital and community health services, it is worth remembering that the number of whole-time equivalent consultants is up by nearly 1,500 over the course of last year. Obviously, that compares with GPs, where the number is down. And in the case of doctors in training, again there has been an increase of more than 1,200 over the course of the last 12 months. So that is an important fact to bear in mind.

In the case of the nursing and health visitor workforce, however, I think there are genuine pressures there. A combination of nurse training place expansion, new routes into nursing, better retention and, indeed, the action that the Government is poised to take on dealing with nurses' pay through the new Agenda for Change reforms—all of those have got to come together to deal with the obvious pressures that we are facing in



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nursing. I am not in any way decrying the pressures that exist in other parts of the workforce, but I think the nursing pressure is very front of mind.

- Q25 **Sir Geoffrey Clifton-Brown:** It is all very well increasing the number of consultants, but, as the NAO Report makes clear, unless you have the back-up staff—the nurses and the administrators and everyone else—they are not a waste of time, but they are not as effective in productivity terms as they might be. So, surely the whole picture has got to come together.

Simon Stevens: Yes.

Sir Chris Wormald: Yes, and that is why, led by Health Education England but drawing on the whole of the NHS, we are doing the consultation we are doing about future workforce strategy. We have a number of pressures that Simon has mentioned and we will need some new approaches.

- Q26 **Chair:** So are you going to be looking at the nursing bursary again, then?

Sir Chris Wormald: We are not looking at changing the funding model, but we will certainly be looking at the routes into nursing, including nurse apprenticeships and other mechanisms, so that we maximise over different routes—

- Q27 **Chair:** Can I just be clear? So, a nurse apprentice will be paid to learn on the job, rather than having the nursing bursary, which paid people to train through the traditional route?

Sir Chris Wormald: Yes. If you are a nurse apprentice, it works like any other sort of apprenticeship.

- Q28 **Chair:** So you are looking at expanding nurse apprenticeships, where you pay someone to train, having got rid of the bursary, where you paid someone to train.

Sir Chris Wormald: No, it is a completely different model.

- Q29 **Chair:** It may be a different model, but whichever route you go through, at the beginning you have somebody who is not a nurse, and at the end you have someone who is trained to be a nurse.

Sir Chris Wormald: Yes, but we are looking to get to a variety of different routes into nursing that suit different types of people. We will have people who continue to want to go through classic undergraduate routes, people who wish to go through nurse apprenticeships, and people who will want to convert—

- Q30 **Chair:** Just to be absolutely clear, for fear of misunderstanding, if I wanted to train to be a nurse today, I could train under a nurse apprenticeship, which the NHS would fund, and I would come out as a fully qualified staff nurse, yes?

Sir Chris Wormald: Yes.



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Q31 **Chair:** And if I wanted to train to be a nurse, but go through university, I would have to get a loan and pay £9,000-a-year fees and come out as a fully qualified staff nurse, yes?

Sir Chris Wormald: Yes.

Q32 **Chair:** So the NHS is still funding nursing. Even though it has got rid of the bursary through one route, it is funding it through apprenticeships.

Sir Chris Wormald: Well, the apprenticeship is funded through the apprenticeship levy, as I am sure you know.

Q33 **Chair:** So it is a way of the NHS saving money.

Sir Chris Wormald: Would you like us to set out the various routes into nursing?

Q34 **Chair:** I would be very keen for you to set them out to see how many people you are getting through each route and what the variation has been. It would be very interesting to see that.

Sir Chris Wormald: These are exactly the things we are consulting on—what is the future of all these things—for the reason that Simon set out.

Chair: The apprenticeship levy is still taxpayers' money when it comes from the NHS. Bridget Phillipson will now ask about recruitment and GPs.

Q35 **Bridget Phillipson:** On numbers of GPs, I am particularly concerned about the decline that we have seen in Sunderland and across the north-east. There has been a 9% fall in the number of GPs in the last two years. That continues a declining trend in an area that has real health problems—often chronic problems associated with industry. Mr Stevens, what can we do to address some of the regional imbalances that exist in the workforce?

Simon Stevens: I think you are right, and you are obviously right about Sunderland—it is not just the north-east, but other parts of the country too. We have to decompose the problem, if I can put it that way. First, we have to ensure that for newly qualifying doctors, general practice is seen as an attractive career option, which for several years prior, frankly, it has not been. We have had unfilled places and significant shortages of people going on to the GP training scheme.

We have increased recruitment on to the GP training scheme. We had 3,157 places filled last year, which was the highest intake of GP trainees ever. In addition, we have been offering salary supplements to GP trainees who agree to train in parts of the country where, as you describe, we have had problems filling training spots. We filled 133 such places last year, and because of the success of the scheme last year, we are expanding that to 250 places this year.

In addition, we know that we have to make it easier to come back to GP work if you have taken time out for a family break. We have a GP return to practice scheme that aims to support at least 500 GPs in induction refresher programmes through 2020. We have had 600 GPs apply to join



that programme. We are also trying to develop a more flexible model of being a GP, so if you do not want to sign on as a partner or to work the majority of your week as a salaried employee of a practice, we have something called GP Career Plus, where you agree to work with multiple practices in the area where you live, with a more sustained commitment. In exchange, you get a series of supports from the NHS.

We also have a problem that we do not, I would say, have an answer to as yet, which is the premature retirement rate for people in their late 50s and 60s. The Department's evidence to the review body pointed out that one of the contributory factors was broader change to the pensions system. I am not going to sit here and pretend that that is not a problem. We have more work to do on that.

- Q36 Bridget Phillipson:** When you look at the numbers of people coming into training places in 2017, you see that the problem is that there is a regional imbalance again. In London, the fill rate was 106%, whereas in the north-east, it was just under 77%. Even at the point at which we are recruiting people into general practice, there are significant regional variations in our ability to fill those places. It is welcome that we see more people coming in, but it is not enough to just have a raw number—we want to make sure that those people are in the right places.

Simon Stevens: Exactly. That is why we have the salary supplement scheme and why, frankly, we are not just creating lots of extra training places in London, which we could probably fill, because the worry is that that might draw people from other parts of the country in those training schemes.

I also didn't mention the work that we are now doing on GP international recruitment, with a particular intention of placing those internationally recruited GPs in parts of the country where it is hard to recruit and retain. The north-east obviously falls into that category, as do places like Lincolnshire, where our first cohort of international GP recruits have been recruited to and are installed. We are aiming to see if we can resource perhaps 2,000-plus international GPs over the next three or four years.

- Q37 Bridget Phillipson:** I agree on the issue of medical school training places. Sunderland University, for example, has bid to open a new school to provide additional places. Do we not need to look at making sure we are opening up access to medicine more broadly—not just supplementing existing provision but looking at creating new and different ways of getting people into medicine?

Simon Stevens: We certainly do. It has to be said that there is probably not a town or city in the land that hasn't bid for a new medical school. Nevertheless, your advocacy for Sunderland is warmly welcomed and noted.

Sir Chris Wormald: There is quite clear evidence that people tend to stay where they train or where they are first placed, which is why we need to take all the measures that Simon is setting out.



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Q38 **Chair:** We have spent a lot of time on the preamble. We really need to move on to the main issue, which is long-term sustainability. Sir Chris, have you have been at the Department for a year now?

Sir Chris Wormald: Nearly two years.

Q39 **Chair:** Nearly two years? Forgive me. Time flies when you are enjoying yourself. How would you rank the financial year 2016-17, in terms of success in balancing the NHS budget?

Sir Chris Wormald: I think the National Audit Office set it out very clearly. We clearly made a lot of progress from 2015-16, both in terms of the overall deficit and in the level of financial rigour we saw in the system, following the financial reset that we did in July 2016. However, we did not achieve everything that we were trying to achieve, as the National Audit Office sets out. We still have a lot of challenges going forward.

Q40 **Chair:** I think “challenges” is the word. You are still papering over the cracks, with money being taken from capital budgets to fund revenue, are you not? There are also still these one-off savings. We know from the finance directors who sent us information that a number of them are very concerned. The individual at East Lancashire Hospitals NHS Trust, for example, said: “Over the last three years, the trust has become increasingly dependent on non-recurrent measures to balance our books, and while there remains an opportunity to reduce waste”—I guess they will say that in their letters to people, especially if they think we might tell you what they are saying—“it is increasingly difficult to release this opportunity.” I think that is a mild way of saying that they cannot keep doing it, but you are still doing it.

Sir Chris Wormald: Yes. I think figure 10, on page 27 of the National Audit Office Report, sets this out extremely clearly. The level of recurrent savings that trusts have achieved remains by a long way the biggest proportion of the savings made. We still have one-off measures, and there are of course one-off measures in every set of accounts in every sector. We wish to see our reliance on that fall over time, and as we have discussed with the Committee, before—

Q41 **Chair:** Over time? How long will it take before you are no longer reliant on one-off measures? There might always be an outlier hospital, but in general?

Sir Chris Wormald: As we have said before, we want to eliminate capital revenue switches by the end of this Parliament. David, what have we said on the one-off measures?

David Williams: We haven’t set a timescale.

Q42 **Chair:** Very clever of you, Mr Williams. Can you set a timescale for us now then? For how long do you think it is acceptable to oversee a budget, as you do as finance director at the Department for Health, that allows hospitals to limp on, year by year, only because they are raiding capital budgets?



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David Williams: I would prefer not to set a precise timetable now, not least because of what you see within the Report and as comes out in data that NHSI publishes. There is a general set of issues that NHS providers need to deal with, but also a set of specific challenges for a relatively small number of trusts with particularly difficult financial situations and particularly large deficits. When thinking about a reduction in reliance on one-off measures, you need to look at the balance between those two things.

- Q43 **Chair:** You highlighted that those hospitals are one of the biggest challenges in the NHS budget. There are some trusts with large deficits that, if they do not get support to get over that hump, will continually be a drain on the overall budget. Perhaps I should turn to Ian Dalton on that. Is it possible for the trusts with those big problems to overcome them over a year or even two years? Do they not need help to get to a place where they no longer have this large and growing deficit?

Sir Chris Wormald: Yes, they do. It is why in the July reset that I mentioned we introduced the financial special measures regime, which has been one of the things in the reset that has worked. For those going into the financial measures regime, we have seen either stabilisation or improvement in basically everyone's finances. That is partly about the pressure put on, but it is also about the support that NHSI puts in for their financial management.

Sir Ian Dalton: Can I just respond to both points, first on the non-recurrent and then on the challenged trusts, because I think both are important? On the recurrent/non-recurrent thing, it is important to have a sense of context that says that the NHS provider sector—the 232 organisations—is continuing to deliver, year on year, more cost improvements than it has in the past. Overall, we have seen that rise from £2.9 billion in 2015-16 to £3.1 billion in 2016-17, with a forecast based on Q3 numbers of £3.3 billion for 2017-18. That is the good news.

It is true to say—it concerns me as much as my colleagues—that while it is legitimate to have a degree of non-recurrent in that, the amount of non-recurrent is rising, although it is still relatively small compared with the overall savings. That is an issue for us. There is no question but that the sector is continuing to deliver cost improvements, and it needs to continue to do that, but we cannot rely on the same amount of non-recurrent on an ongoing basis.

- Q44 **Chair:** They are producing cost reductions, but as Simon Stevens said earlier, we know that demand is rising, so costs are going up at a rate faster than even the most optimistic efficiency savings, if you are talking about true efficiencies. Would you not agree with that?

Simon Stevens: On that particular point, I disagree. The Institute for Fiscal Studies has shown that our funding and our costs have been growing far slower than the rate at which the NHS has been doing extra patient care. To put some numbers around that, if you look at the period from 2009-10 to 2016-17, the IFS data show that English Department of



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Health per capita funding has gone up by 3.2%. The services that we provide for emergency patients have gone up by 6.7%, and the planned surgery that we provide has gone up by 15.7%. The NHS has got a superb record on productivity growth. That is why evidence prepared for this Committee by the Health Foundation points out that NHS productivity growth has been faster than that of the UK economy overall. These are genuine savings that have enabled us to do far more with the modestly growing funding that has been made available.

- Q45 **Chair:** That was interesting evidence, because it showed what the NHS can do at its best, but demand is nevertheless increasing. You have said it often enough, Simon Stevens. I am giving you an open goal here. You are next to the permanent secretary. There is a challenge with the sustainability of a funding mechanism. As we have just heard, the winter crisis was planned for without the full money available. There is a gap because trusts know that they just do not have the staff, yet they have accepted a funding model that does not allow them to effectively recruit those staff, even if they were available. You have got that consistent gap. Last year, £4.9 billion was given in financial support just to keep NHS trusts afloat.

Simon Stevens: There is a gap. We have obviously talked about that in this Committee on many occasions.

- Q46 **Chair:** I was puzzled there, because you suddenly seemed to be—

Simon Stevens: No, I think both things can be true at once. It can be the case that the NHS has become even more efficient over the course of the past several years—all the independent data show that that is the case—while at the same time a wedge is opening up between what is being asked of the NHS and the funding that is available. Those things are true at the same time.

Let me give another number that I think illustrates the point very graphically. The NAO Report references the fact that since 1948 NHS funding has grown on average by 3.7% a year in real terms. The difference between 3.7% and what the NHS has successfully managed with over the last five years is an £8.8 billion funding difference in 2018-19. Cumulatively, that is £27 billion of funding that we, the NHS, have contributed to economic turnaround for the UK economy over that period, compared with our trend rate of funding growth at 3.7%.

- Q47 **Chair:** As ever with these things, it depends which period of time you are looking at. If you take it over a long period of time, the suggestion is that—

Simon Stevens: Well, this is since '48—since the start.

- Q48 **Chair:** But if you look at what has happened since 2010, Ian Dalton's predecessor acknowledged that the 4% efficiency savings target was increasingly challenging to deliver. Ian Dalton, you were at a trust before, and now you are at NHS Improvement. What is your view on the 4% efficiency savings?



Sir Ian Dalton: Could I answer the point about the more challenged trusts first? I think that is also relevant, although I absolutely agree that the productivity point is not insignificant; we anticipate a 1.8% like-for-like efficiency forecast for this year, which considerably outstrips the rest of the economy.

On the most challenged trusts, it is fair to say that a small minority of our trusts have particular financial issues that they need to resolve. It is also true, of course, that returning some of those trusts to financial surplus is not going to be a one or two-year job. It is a process of improvement against an underlying deficit problem, so it needs to be improved over a period of years.

One of the reasons my predecessor introduced the financial special measures regime back in 2016 was to allow more support from NHS Improvement to go into the most financially challenged trusts. The record in the initial year, according to the NAO Report, is that the first eight trusts improved their year-end position by just £96 million as a result of being in that programme. In the next category of trusts—those that were in what we call the financial improvement programme—22 trusts improved their position by £107 million.

There is a general need to create continued efficiency across the sector as a whole, and doubtless we will talk about some of the elements of that as this Committee hearing goes on, but there are also some individual organisations that are further away from where they need to be financially. I think we have to be realistic about the pace of improvement that they can make, which will not be a single year's improvement.

- Q49 **Chair:** Does it not cause challenges that effectively there is a reward system? If you accept a control total, there is the potential for more funding to come from the centre. If you are one of these challenged trusts—maybe this applies to some others as well—and you do not accept the control total because you know you will not manage to deliver on it, you get less of the additional money. The additional funding is supporting trusts that are already doing reasonably well, according to the Report. Where there are serious problems with a trust, the additional funding is not so readily available. Is that not a topsy-turvy way of dealing with it?

In reality, what tools do you have with these very challenged trusts, which have deficits that will take several years to resolve, to make sure that they do so without being further penalised because of decisions that were often outside the control of the current management and were certainly outside the control of the patients? I am thinking of some of the very large trusts that have been brought together in interesting ways.

Sir Ian Dalton: There are several different elements to that question, so maybe I should pick some of them apart. It is quite a complex question, so I hope I will not forget any elements of it; doubtless you will come back to me if I do.

It is fair to say that the most challenged trusts need support across a period of time, which is why on occasion we have had to move trusts into

the financial special measures regime. I have had to do that in my tenure, and I started this role on 4 December.

With regard to the point about the sustainability and transformation fund—the provider sustainability fund, as it is now named—and the underlying position of trusts, I think they can be different things. The control totals have proven their worth as part of the financial reset that my predecessor was part of overseeing. I am convinced that they were a contributor to the NHS provider sector improving its financial position during 2016-17 to the extent commented on by the Committee.

It is fair to say that because the sustainability and transformation funds need to be continually acquired, they are different from the underlying position of our most challenged trusts and the imbalance between their income and their expenditure. Those two things are different, and therefore the remedies necessarily need to be different as well. It is fair to say that the more challenged trusts are going to need support over a longer period of time than the quarter-by-quarter approach of the sustainability and transformation fund, and the associated control totals go with that.

On the point about control totals, these were set on a consistent basis across the NHS in 2016-17. They were meant to create an incentive for incremental improvement. Many trusts have control totals that are deficits, which reflects the fact, which you rightly highlighted a minute ago, that the trusts with the biggest problems will take a number of years to bring their finances back. It would be unrealistic to set a success criterion of moving into surplus in any less period of time. So they reflect incremental improvement.

That takes me to the third part of your question, which was whether the existing financial regime for the most financially challenged trusts remains optimal in all its parts. Although I am genuinely convinced that in 2016-17 and 2017-18, and looking forward into 2018-19, the regime of control totals, the sustainability support funds and the package of measures we help trusts with are right, I think that there are some areas, and I would perhaps highlight the rate of interest paid on loans for cash support to our most challenged organisations—currently running at 6%, as opposed to the 1.5% levied on other organisations that are capable of accepting their control totals—that we should look at as part of a financial review. Looking ahead, and speaking on behalf of my colleagues, I think there is general support for reviewing that.

Q50 Chair: I have to say that on this Committee we would not agree that you should reward financial mismanagement, but a 6% rate seems a high penalty and it hits patients, ultimately.

Sir Chris Wormald: We will come on to that point. I agree with everything Ian has said. Just to be clear, getting into financial special measures is not simply a question of, “How big is your deficit?”

Q51 Chair: No, it is about management.



Sir Chris Wormald: It is about management, and the trusts we are most concerned about are the ones where we see rapidly rising projected deficits, because that cannot be about underlying structural questions—if you have an underlying structural question you should know what it is and be able to cost it. It is those where you see the deficit projection changing from month to month that we have concerns about. We agree with Ian that the regime that was put in has achieved a lot and we also agree that going forward there are some elements, including the interest rate question, that we will want to review, to see whether this is the right mechanism. As the NAO Report sets out, we are committed to the STF as a funding mechanism only for the next financial year and we will have a choice about whether we continue with that regime or wish to use that money in a different way. Now is the right time to be reviewing it.

Q52 **Chair:** I have to say that it seems to be a pot of money that is a bit like the current trend among kids for slime—it moves wherever it is needed in a rather gloopy way. It is about sustainability and transformation one minute; it is about bailing out trusts another.

Simon Stevens: It doesn't stick, as I know from my own nine-year-old daughter's preponderance of interest in slime.

Chair: It doesn't stick. Very good. We could carry that metaphor on for too long, I think, if we were not careful. Seriously, this is supposed to transform services but it is being used to fill the gaps, isn't it?

Sir Chris Wormald: Very explicitly, we used the resources to tackle the big challenge we had in 2015-16 around where the provider deficits had got to, and it was a mechanism that was designed to incentivise exactly what happened, which was for those deficits to come down. The question, as I say, of whether that regime, which has achieved an enormous amount across the last financial year and in this financial year, is exactly the right regime going forward, is one we will be asking.

Simon Stevens: I am offering textual support for that proposition. The NAO Report itself states that "the sharp decline in the financial position was halted", and that the sustainability and transformation fund "incentivised most trusts to improve their financial discipline." We agree with that.

Q53 **Chair:** But whether it transformed anything is another matter.

Simon Stevens: As the NAO also say, "Effective transformation takes time and resources."

Chair: Exactly. That is our point.

Q54 **Bridget Phillipson:** On that point, in terms of how the funding is being used, the NAO also talks about the fact that 40% of that funding is being used to create or increase surpluses in trusts. Is that an effective use of money, Sir Chris?

Sir Chris Wormald: At system level it all comes to the same thing, because at the end of the year we net off deficits against surpluses. In

terms of system level stability, it makes no difference at all whether you invest in one or the other.

Q55 **Bridget Phillipson:** That's not what patients would be concerned about.

Sir Chris Wormald: The question, which is one of the things we will want to look at, is what behaviours you create at trust level. Exactly in line with the NAO Report and the quote that Simon read out, we think that the way we used STF incentivised greater financial rigour both across people who were in deficit and across people who were in surplus but could have been in greater surplus. We think the evidence supports that. Whether that—I think this is the question Ian raised—remains the mechanism to incentivise the right behaviours at trust level is something that we would look at.

Simon Stevens: I think the NAO, as is so often the case, but not always the case, got its recommendations absolutely right on this point where it talks about the need for more—

Chair: I don't think the Comptroller and Auditor General is swayed at all by any flattery—unless he's getting soft.

Sir Amyas Morse: I'm feeling ill!

Simon Stevens: It talks about the need for more system incentives and working. The opportunity to think about the deployment of the STF funding in 2019-20 represents such an opportunity, which we will take. But, for 2018-19, NHS Improvement and NHS England have got a very clear set of rules and allocations set out for the sector as a whole. It is that which we are putting our emphasis on for the year ahead.

Chair: On which cue: Sir Amyas Morse.

Sir Amyas Morse: I have just a couple of questions. You will not make your savings target in this year, will you? I think that is right.

Sir Ian Dalton: The forecast outturn is for £3.3 billion against £3.8 billion.

Sir Amyas Morse: So you will not make the target.

Sir Ian Dalton: There is an underachievement this year against what was a very aggressive target.

Chair: So you're calling a spade a spade.

Sir Amyas Morse: So you will not meet the target this year. I don't say that is necessarily bad, but you need to be realistic about it and about what balance of recurring and non-recurring will actually turn out to be the case, which, I think I am right in saying, you do not know at the moment.

Sir Ian Dalton: We don't know and we haven't got to the end of the financial year yet.



Sir Amyas Morse: If I might finish, I also think it is worth asking yourselves a question, as you come to the end of this programme, about how much damage it may have done. In other words, the diversion of capital funding. Admittedly, those capital fundings may have been slightly more than were strictly required in the first place, but still in all there must have been quite long periods of deferment of capital spend. Are you going to take stock of that? It may have been necessary to do it, but are you going to take stock of that and understand where that leaves you and what you may need to do as a result?

David Williams: On that last point about capital, the Report refers to the review of capital funding requirements that Sir Robert Naylor led, which set out an ambition for around £10 billion of capital investment in the NHS over a period of time. That £10 billion split roughly into 50/50 for transformation of services and picking up on backlog maintenance in the system. The Chancellor set out in the autumn Budget the third share, as it were, to come from direct investment by Government.

We are working with STP areas and individual organisations on how we can increase that, in particular through estates disposals. We are undertaking a review of capital flows—again, the Chancellor set that out briefly in his Budget announcement—in particular to understand how, at a local level, the decisions around whether to maintain an estate or to use money elsewhere to support day-to-day operations are taken, how backlog maintenance has built up and how we can look at the way in which funding flows around the system and the incentives we have to try to guard against that in future. That work is just starting.

Chair: It is interesting that it is just starting now, when you have had a few years of raiding capital fund revenues. We will be following that, as you will not be surprised to hear.

- Q56 **Bridget Phillipson:** To return to the sustainability and transformation funding as was, would it be better for trusts to have a greater degree of security and certainty in the system, rather than coming to a late stage of the year and getting some decisions as to whether they will have a boon to sort things out in the short term?

Simon Stevens: The way the control total regime works is that those are set out prospectively at the start of the year and it depends on how well the trust does as to what it earns. I do not think it is quite as you describe it.

- Q57 **Bridget Phillipson:** They could plan better for the longer term, if they had a greater degree of certainty about the money they were to receive. In some trusts, you would agree a control total, then you meet it, then you get money for meeting it and potentially a bonus on top of that. Is that really an effective means of funding services in the medium to long term?

Simon Stevens: In the medium to long term, we are obviously looking to move more of the funding of the health service on to a population basis, where different organisations within an area are able to plan together for



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the kind of wider, more profound changes that they think are needed to join up parts of their primary, community and hospital services. That is what is happening in the first of the so-called integrated care systems across the country, covering about 10 million people across England. They are taking shared responsibility for their STFs under a system control total—that is the plan. That is incrementally the direction we want to move in.

- Q58 Bridget Phillipson:** Will that include a review of tariffs, in terms of looking at procedures and how they are funded, where trusts are receiving less than the cost of a procedure?

Simon Stevens: We have a two-year tariff in place. We—NHS England and NHS Improvement—have decisions to make about the tariff for 2019-20. At the same time, we are being pushed by many across the NHS to make it easier to move money around between different services, rather than the click-of-the-turnstile payment system, which was more oriented towards the problems that we were dealing with in the early-2000s—needing to expand a lot of elective surgery to cut long waits for care.

There are a set of things going on in terms of the urgent and emergency care pathway that will have to be looked at. There is a case for saying that some of the funding that is implied in the sustainability and transformation fund—the trust's STF—probably reflects the underlying costs of emergency care. That is the basis on which it is allocated, so we need to factor that in.

Equally, there have been some big shifts in the clinical pathways for emergency care. At the moment, the tariff system does not adequately reflect those. Specifically, as Ian said, the headline increases that we see in the number of emergency—non-elective—admissions that require a stay in hospital have been going up by just over 1%, if you look at this year to date. The number of so-called emergency admissions that are dealt with on the same day—in less than 4 hours, in the case of half of them—have been going up by between 6% and 7%. Should we call that an emergency admission? They are a new type of care—ambulatory or day case emergency care—and we have to make sure that the system properly funds efficient care delivery for those kinds of pathways as well.

- Q59 Chair:** So you are planning to change the tariff system. When will trusts know what the new tariff system will be?

Simon Stevens: During the course of this year—2018-19—we will set out our proposals together. We will then consult on them with the usual section 118 consultation process.

- Q60 Chair:** During the course of this year—do you have anything more specific than that? If you are a finance director of a trust—

Simon Stevens: The autumn.

Sir Ian Dalton: We need to give the NHS certainty going into 2019-20—

- Q61 Chair:** Absolutely. That's why I was asking the question. So it's autumn



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this year?

Sir Ian Dalton: Yes. And in particular, I think we absolutely need to have a look at the way—

Q62 **Chair:** I'm just going to remind Members and witnesses about the time, because if you're quick in answering our quick questions, we might be out of here by 6 o'clock.

Simon Stevens: The future of £109 billion of NHS funding is not a quick question.

Chair: No—absolutely. But I'm just saying that if you can answer our questions quickly and we can ask our questions quickly, we have a chance of at least scratching the surface, Simon Stevens.

Sir Chris Wormald: At the risk of delaying matters, the only thing I would add is that this is, of course, a hugely complex area. The law requires quite a lot of the commissioner-provider system, and we of course comply with that, and that builds a level of uncertainty into trust finance; it's just by the nature—

Chair: Absolutely. We do understand that.

Sir Chris Wormald: So there are things we can do, which Simon and Ian have described, that create more certainty, but it doesn't answer the whole of the original question. We will, for the foreseeable future, be running a commissioner-provider system that has some of those uncertainties in it, which, as Simon has set out, has some advantages and disadvantages.

Chair: We will move on to the commissioning side of it, because there are certainly some changes going on there as well, rather under the radar.

Q63 **Bridget Phillipson:** But isn't the current funding system opaque and often unfathomable, even for people who have worked in the NHS for a long time and are currently working in the NHS? There's a lack of certainty and a lack of transparency; it's very unclear what's being asked and what they can achieve. If you have a bad winter, you miss your control total, what then happens?

Simon Stevens: In terms of the refresh on the planning guidance that we've set out, Ian and I—together for next year, 2018-19—have been very clear and transparent about what the ask is of the NHS.

Q64 **Bridget Phillipson:** I don't think trusts would accept that there's transparency around funding arrangements.

Simon Stevens: What is it that you've picked up that is uncertain about the 2018-19 arrangements?

Q65 **Bridget Phillipson:** I am talking about what's gone previously, in terms of the sustainability and transformation funding: you agree a control total, you're uncertain as to what you're then going to receive, whether or not you do or don't meet it, if you then get a bonus on top of that.



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That just seems a rather perverse way of—

Simon Stevens: We had a choice here. We could have just run that STF through the normal commissioning system. The judgment that we took was to give NHS Improvement levers over that £1.8 billion so as to give them the ability to have those trust-specific conversations. As the NAO says, that has incentivised improved financial discipline, but as Ian and I have also said, we don't think that that is a mechanism that we would want to see continued in perpetuity.

David Williams: Perhaps I can just put it into context. As the Report sets out, combined income for trusts in 2016-17 was just over £80 billion. Of the £1.8 billion of STF, £1.3 billion was paid out essentially as planned. And the uncertainty element around the incentive and bonus arrangements was around £500 million. So, £500 million on an £80 billion baseline is a degree of risk which should not be too difficult to manage.

Q66 **Bridget Phillipson:** Why has the fund failed to improve performance in acute services?

Simon Stevens: Do you mean, why did everybody not earn the 30% of it that was linked to their A&E performance?

Q67 **Bridget Phillipson:** Well, it's sustaining but it's not really transforming.

Simon Stevens: Yeah, I agree with that. I think the "T" was probably a misnomer and that's why we dropped it. *[Interruption.]* Well, it's truth in advertising!

Sir Chris Wormald: As I said before, we took a very explicit decision in July 2016 that the level of deficits and the level of financial control that we had seen in 2015-16 was a big problem, and that we would focus our efforts on that. And we did it very explicitly. Did we emphasise reintroducing financial rigour and stabilising trusts' finances? Yes, we did. Does that have a consequence for some of the transformation things? Well, quite clearly whenever we do a cap-rev switch—whenever we do these things—we have that consequence. As I say, we did that as an explicit piece of policy.

Q68 **Chair:** Do you think you over-promised on the transformation?

Sir Chris Wormald: I might leave it to others to comment, but as the Report notes, quite a lot of progress has been made through STPs. It's variable across the country.

Q69 **Chair:** Sorry, but progress with STPs doesn't mean transformation, does it?

Sir Chris Wormald: That is what they were there to do. What we have seen—I am sure Simon will add to this—in some of our leading areas of STPs is some genuinely original approaches. As the Report sets out, we do not see that across the country as a whole, and that is where we need to get to. While we took some very explicit decisions to prioritise stabilisation, there was also quite a lot going on with the transformational side, in line with the five year forward view.

Chair: We will move on to some of that later.

- Q70 **Bridget Phillipson:** Mr Stevens, you talked earlier about the contribution that the NHS had made towards the UK targets by way of spending reduction. That rather speaks to the point that all of this comes at a cost, and that is not simply a financial cost. There are the impacts on patient care, on A&E wait, on the length of time people are on waiting lists, on the ambulance backlogs and on the time it will take to see your GP. The NHS has had to make a pretty big contribution, but that has not just been at a financial cost to the service; it has been at a direct cost to patients and those who need the NHS.

Simon Stevens: We discussed this last January, and we aired precisely that issue, and I have been very upfront about that point since then. I think Sir Amyas made a wise statement in his comment on the press release for this Report when he said that “the public purse may be better served by a long-term funding settlement that provides a stable platform for sustained improvements”. I think that is why the Health Secretary also has been arguing for a 10-year funding settlement.

Sir Chris Wormald: The only thing I would add on that—I have said this to the Committee before—is that on the quality side, the CQC has not found a drop in the quality of service provided by the NHS. Indeed, CQC ratings have been going in the other direction. The impression that none of us would want to leave with anyone is that the basic quality of care has in any way been sacrificed. We have put a huge quantity of effort into that, and the NHS has responded extremely well, although I would of course not deny that there have been consequences around some of the targets. However, in terms of what is the base quality of care—

Chair: We are going to come to some of that.

Simon Stevens: I also agree completely with what Chris said on that. The access targets are clearly under pressure and they are important, but when it comes to the quality of cancer care, 7,000 more people are surviving cancer now than would have been the case three years ago. When it comes to mental health services, we have got a lot of work ahead of us, but access and the range of services are clearly improving in many very important areas. When it comes to major trauma, the fact is that you are 25% more likely to survive if you are knocked off your motorbike by a bus and taken to an A&E department now than would have been the case five years ago. We see many other examples of that nature. We have underlined that clinical quality of care has been and is improving.

- Q71 **Chair:** And as we have repeatedly seen in different service areas when we have looked at this in the Committee, there is growing demand in all those areas. That is one of the challenges.

Simon Stevens: Indeed.

- Q72 **Chair:** Before we move on—Gareth Snell and Gillian Keegan have got quick questions—I wanted to ask about the issue of the loans, David Williams. There is a high-interest rate for the struggling trusts. Do you



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think there is any real prospect of those struggling trusts actually paying back the loan? Have you got any secret plans to convert it to a grant or funding?

David Williams: The 6% rate that we have touched on already was introduced as part of the finance reset moment in 2016. The way in which it works is that trusts that are in financial special measures—

Q73 **Chair:** The question was—you do not need to describe it—whether the trusts will realistically be able to pay it back, given that they are the struggling ones with the higher interest rate.

David Williams: We have refinanced at a lower rate the two trusts that have exited financial special measures, as part of the incentive to encourage people to sign up to a recovery plan and then deliver it. Of the 12 trusts currently in financial special measures, eight that have shown at least three months' worth of improvement against plan are now being financed at a lower rate. Only four are still attracting the 6% rate for new borrowing.

Q74 **Chair:** You have still got the loans, but you have dropped the interest rate.

David Williams: It is intended to be an incentive, but as we have said, it is something that we will review as one part of the overall package of support.

Q75 **Chair:** Ian Dalton, is that working?

Sir Ian Dalton: I think we do need to review it. The distressed loans that have been given to some of our largest trusts are in the hundreds of millions of pounds. As part of the look at this that we have committed to, it would be absolutely right to consider the rate of interest and the nature of the financing. Effectively, trusts need that financing so that they can pay their staff and pay their bills, so I think there is a legitimate question about their ability to pay the principal as well as the interest rate on it. I do not think that people enter into those loans without cause, and I think we need to have that conversation that we have all committed to.

Chair: That is heartening to hear.

Sir Chris Wormald: The only other point that I would add is that this only affects the trust level, not the system level, because the amount we raise in interest goes straight back into the system.

Chair: Absolutely. It is rather like robbing Peter to pay Paul.

Sir Chris Wormald: It was introduced as part of the package to try to create the right incentive pressure on individual trusts, not to have a system effect.

Chair: And we gather that, except for the eight, it seems to be working—if that is what you call “working”—but we will see.

Q76 **Gareth Snell:** On the point about robbing Peter to pay Paul, trusts that



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are not meeting their various A&E transfer targets or ambulatory transfer targets are fined by their clinical commissioning groups. In the case of my trust, which is in financial special measures, that will add almost £10 million to its £60 million deficit. Given that, how do you see fining those hospitals as being either transformative or sustainable?

Simon Stevens: That is why we are not doing that.

Gareth Snell: You are.

Simon Stevens: The bulk of fines were waived this year for trusts that have accepted a control total and are in receipt of an STF. For next year, from 1 April essentially all fines except for a very small number—five small items, which do not include the ones you have mentioned—will be waived for trusts that sign up to their control totals. That is the fact of the matter.

Q77 **Gareth Snell:** How is that being communicated to the clinical commissioning groups? The North Staffordshire and Stoke-on-Trent CCG has budgeted, in its budgets for next year, to receive those fines as part of—

Simon Stevens: For missed A&E, four-hour performance and for RTT? Then they need to study the 2018-19 refreshed planning guidance and the consultation on the amendments to the NHS standard contract, both of which make clear the point that I have just set out.

Gareth Snell: Excellent. Thank you, Simon.

Q78 **Gillian Keegan:** It seems to me that key to both the sustainability and transformation of the NHS is the success of the integrated care model. This involves a whole load of people working together—GPs, pharmacies, community beds, acute services, social care services and so on. When we tried it in the Western Sussex Hospitals Trust, only one of those parties signed up to move to an integrated care model. The change management of these organisations working together is massive. These are organisations that perhaps are not known for dealing with change management challenges in the best way. What mechanisms do you have to make sure that that key to success is one that you can actually use?

Sir Ian Dalton: It is absolutely right that we need to integrate services; that is something that is increasingly recognised right across the NHS. We have our role to play in helping that to happen, so it is absolutely right that, working with our colleagues in NHS England, we have agreed system control totals with the 10 integrated care systems that are looking to go live on 1 April. That will give them an opportunity to respond to new models of patient care with new financial incentives—incentives to collaborate and work together, rather than to compete and protect different budgets. I think that will be incredibly helpful.

It is interesting that, in addition to those 10, there is enthusiasm across the country about joining in with and participating in integrated care systems going forward. Again, with colleagues in NHS England, we have invited patches, hospitals, community services, mental health providers and commissioners that want to go on this important integration journey



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to apply to us, and we will do what we can to support them in that. It is also fair to say that we are looking at the support that NHS England and NHS Improvement give, because it is really important that, as the regulators of our respective sectors, we work together to support integrated care.

Chair: We will come on to this later. One of the things we want to talk about is the role of the regulators and how you integrate nationally, because that is certainly an issue.

- Q79 **Bridget Phillipson:** More broadly, how do we shift the NHS from the short-term survival that we are talking about—just getting through financially—to some of the longer-term transformation that we need to see? Simon Stevens, how do we move away from short-termism to some of the long-term challenges that we face?

Simon Stevens: I don't want to give a glib answer, because the reality is that we have to do both at once. The short term needs attending to as much as the future proofing. Just to be very here and now about it, the effort has been brilliant across the NHS, even over the course of the last week with the appalling weather in different parts of the country. I publicly praised staff at your hospital in Sunderland on Friday for having come in and stayed overnight in the hospital to be there for the next day's shifts. We have had issues with getting staff into work. We have had volunteers and the Army helping. The health service has performed really very well indeed under these trying circumstances over the last week. That does not happen by accident. That is a consequence of a lot of focus by ward nurse managers, clinical directors, hospital chief execs, CCGs and so on.

Chair: We acknowledge that.

Simon Stevens: I do not want to decry the short-term operational realities, because that is when the service does well.

Chair: No one here would. Perhaps you could answer Ms Phillipson's point about the long term.

- Q80 **Bridget Phillipson:** How can those longer-term challenges be used to address some of the short-term problems? For example, we often talk about moving care out of hospital and into the community. Achieving it is far more difficult. What are the savings that can be delivered from that and are they sufficient?

Simon Stevens: There are some tensions and some trade-offs—of course there are. But in those parts of the country that have gone furthest on the service redesign and integration agenda, we are seeing early signs that that is helping moderate pressure on hospitals. I think we are going to have a discussion, facilitated by the NAO, with yourselves on this topic and on emergency admission pressures in the not too distant future. The Report that the NAO published last week showed some of the data for the early vanguard programme, but in no sense is this mission accomplished. Parts of the country are showing what it looks like, but there are some bigger changes that have to happen everywhere. While supporting



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individual GP practices, we have got to have much more networking between practices on a 30,000 to 50,000 population basis. We have to put more support into care homes. Obviously, Sunderland and the north-east have done a good job in showing what that looks like.

We will be expanding the funding for clinical pharmacists in care homes to help reduce the emergency hospitalisation rate for people there. We have a big programme under way to join up what is happening in community mental health services and community physical health services. So, at a national level, we know what the shape of this looks like, but in practice it will be different in West Suffolk than it is in Sunderland. That is what the integrated care systems are all about: driving that change with the hearts and minds of local people and clinicians in each part of the country.

Q81 Bridget Phillipson: Where demand is growing more quickly than funding will allow, what action can be taken to manage some of that demand?

Simon Stevens: We have said that for next year certain things cannot be used as the balancing item. In November and then again in February the NHS England board publicly said that, looking out to next year, we ranked a series of priorities that the NHS had to get right for next year. The first was that we had to acknowledge the fact that there were services currently being delivered that are, in a sense, unfunded. That is why, of the extra money for next year, we have allocated just over £1 billion to both the trust provider sustainability fund and the equivalent for deficit CCGs.

Secondly, we said that funding realistic levels of emergency activity growth next year is going to be important. We will kick the tyres more vigorously between NHS England and NHS Improvement on what those activity growth and capacity plans look like in every part of the country.

Thirdly, however, we said that we didn't think that financial pressures should be balanced on the back of mental health services, primary care services or cancer care. We went further and said that we are making it a requirement that every CCG next year increases its mental health spending faster than its overall funding growth. That will be subject to independent external audit.

Fourthly, we are looking to expand the amount of routine surgery that is being funded in the NHS next year. Lastly, we said that the much-deserved pay rises for NHS staff will have to be funded separately—the Government accepted that—rather than being the first call on the growth that is going in next year. All of that is the context within which people are going to be making those kinds of judgments next year.

Q82 Chair: Can I ask about funding the routine surgery? A lot of private hospitals currently provide some of what you might call clean operations, like hip replacements, because they are an easy thing to provide and they are funded by the NHS. Are you saying that those will go back in to provide bulk income for some of our NHS hospitals?



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Simon Stevens: What we are saying is that, as a result of where we ended up in our discussions with the Department of Health and other branches of Government, we are able to have a funding expectation that we will have a bigger increase in operations next year than we had this year. As it happens, we expect it is likely that the majority of them will be delivered by NHS hospitals. We are not changing the policy. The point is that the amount of the funding increase for elective care should be greater next year than it was this year.

Q83 **Chair:** So basically more operations are taking place.

Simon Stevens: At a faster rate of growth.

Q84 **Bridget Phillipson:** You mentioned the lifting of the restriction on the pay cap. What impact do you think the changes may have on NHS finances? Have you got any up-to-date assessments of that?

Simon Stevens: The fifth principle that I set out, which the Chancellor accepted in his Budget on 22 November, was that in exchange for reforms around the Agenda for Change group, the Government, rather than the NHS, would pick up the tab for the costs. I don't know whether David wants to add to that. That is what the Government said.

Q85 **Bridget Phillipson:** Finally, in terms of the greater role you anticipate for primary and community care, and so on, how likely is it that the savings you want to make can be achieved without additional resourcing? The NAO talk a lot in the Report about the fact that change and transformation to deliver some of those savings can cost money in the short term. We all want these savings to happen, because we want more effective care and we don't want money wasted. How do we get that right so we deliver the savings we all want to see?

Simon Stevens: There is a genuine pressure here. The NAO were right to say that, and we have talked about it before. The fact is that, given the aggregate funding available to us, the pragmatic response is that we have to support the services that are needed in the here and now. That means that there has been less available than might have been desired for pump-priming and extending some of these wider changes. To give you a figure for that, the amount that has been spent on the vanguards—the places doing the care redesign—in each year of their existence will have been less than one tenth of 1% of the NHS budget, so it has not been a big investment.

Q86 **Bridget Phillipson:** In terms of what local bodies need to be looking at, should they be planning for reduced admissions to hospital or growing admissions to hospital? On the one hand, we want to reduce admissions in some cases, but we are seeing increasing levels of admission. Where will that take us?

Simon Stevens: Our central planning assumption for England for next year is that the default, or at least the conversation starter in the local plans that were entered into, is growth of non-elective admissions of 2.3%. However, that comes with the important caveat that we have got this bifurcation opening up between the day case emergencies, which are



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growing at about 5%, 6% or 7%, and the overnight emergency admissions, which are growing at 1.3%. We have got to understand the dynamics of that in each part of the country. Realistically, with a growing and ageing population, with the pressures we know about in social care, and with GP numbers down, not up, we should be planning on the basis that there are going to continue to be pressures in the hospital part of the system, which need to be resourced.

- Q87 **Bridget Phillipson:** Which then continues the cycle of A&E problems and needing to put in money at the front end, doesn't it? All of these problems just seem to continue in a cycle.

Simon Stevens: Except that, remember, compared with France or Germany we do a superb job of looking after people at home. Our emergency hospitalisation rate for many common conditions is lower than those of other comparable countries. Your chance of being admitted to hospital as an emergency patient, against being looked after at home or by your GP, has gone down by 12% over the past five years. There is an awful lot that is working well, notwithstanding the underlying, long-term pressures that you rightly point to.

- Q88 **Anne Marie Morris:** Mr Stevens, we are on a journey, and I am not quite sure now where we are going. We started out with the concept of STPs and we set a timeline—

Chair: Perhaps we should spell STP out.

- Q89 **Anne Marie Morris:** Sustainability and transformation plans, which set out what exactly had to be done by when. They morphed, if you like, into something different again: they weren't fixed, hard plans, but a staging post. Now we have these very different accountable care systems, and the totally devolved systems. You say that a number of these—10—are going to go live in April this year. I am totally confused. What is the difference? As I understood it, we had STPs, which then moved. We seem to have a number of different bodies going in different directions. What is the end game? What are they going to look like—or, at least, what will they look like in April 2018?

Simon Stevens: If you wind the clock back three or four years, the landscape locally across the NHS was one of individual hospital trusts, individual community trusts, individual mental health trusts, individual GP practices, and individual CCGs all ploughing their own furrow. The expectation was that the combined effect of all that ploughing would be a beautiful field. What we have now done is say, "Actually, can we gather round and discuss the crops that we need to grow for the people in this area?" I am going to stop this—

Chair: You are flogging a dead horse.

- Q90 **Anne Marie Morris:** Mr Stevens, we all know that this is about integration, but what will it look like if I am a patient?

Simon Stevens: What has changed is we have won a big argument about the clinical logic, the patient logic and the economic logic of taking a



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holistic population view of health in a given geography. That is counter-cultural to how the health service has worked for more than two decades. STPs were just the mark 1 version of getting people round the table to have that conversation, and as the NAO Report rightly says, "New partnership arrangements across health and local government are laying the foundations for more strategic system-wide planning and delivery." That is what has happened everywhere with the 44. For 10 parts of the country, covering 10 million people, they are more intensively saying, "We're going to share these system financial incentives, and we're going to get on with the process of care integration." The Health Committee has an inquiry into this right now.

Q91 Anne Marie Morris: Mr Stevens, what are they actually doing? Are they actually creating one budget, and putting all the money in it?

Simon Stevens: I invite the Committee to do what the Health Committee did within the last fortnight, which was to spend a day in South Yorkshire talking to patients, local authorities, GPs and hospital doctors, finding out what it means in Doncaster and Sheffield. I think that will make it very practical for you.

Q92 Anne Marie Morris: That is absolutely right, but just like you, Mr Stevens, we find it very difficult to find the time to invest in all of that. I am asking you, as you clearly have the time, because it is your job, to look at this. My concern is that the concept of the sustainability and transformation partnerships has become a bureaucracy. Instead of trying to simplify it, you effectively have a number of bits. You are trying to force them together, but you are saying, "You're not going to have one budget, and you're not going to have one set of accountabilities." They still have their accountabilities to your different organisations, and accountability to local authorities.

Simon Stevens: No, it doesn't change the law. They still have individual accountabilities, as you describe, but over and above that they also have a shared and common interest in charting a course for health improvement in their area. There does not need to be a contradiction between those two things.

Q93 Anne Marie Morris: But what we are talking about is goodwill, isn't it?

Simon Stevens: Relationships.

Q94 Anne Marie Morris: Okay. And relationships take time, don't they?

Simon Stevens: Yes.

Q95 Anne Marie Morris: So what is it about the 10 that have got through that is different from the remaining 44 minus eight?

Simon Stevens: Some of them have been on that journey together for longer. That relates to your point about time. Some of them have got fewer organisations in their area. The NAO Report has got a good chart showing that some of the STPs have got a very large number of entities within them. At one end of the spectrum, you have got east, north and



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west Cumbria, which has something like five statutory bodies. That is the bar chart at the end, which shows the fewest. At the other—

Q96 **Chair:** I think it is figure 15 you are referring to.

Simon Stevens: Yes, quite possibly. The other end has got Cheshire and Merseyside, where there are 42 statutory bodies. In Cheshire and Merseyside, that is obviously a much more complex task.

Q97 **Anne Marie Morris:** The two that are most ahead and are going to be devolved systems are Greater Manchester and Surrey heartlands. Is that right?

Simon Stevens: And a number of others as well, including South Yorkshire. There are 10 systems.

Q98 **Anne Marie Morris:** Okay. So you are now saying that all 10—not eight and two—are heading in the same direction.

Simon Stevens: Inasmuch as they are beginning to act together, taking system shared responsibility, yes.

Q99 **Anne Marie Morris:** What I am trying to discover is this: what is going to be the difference from the patient's perspective, and what learning from those 10 ought to be shared with the remainder?

Simon Stevens: The difference is not going to affect every patient. It is going to affect a group of patients—principally the people who have got the greatest need for NHS use. They are going to find more teamwork, less being passed from pillar to post, less having to repeat your information when you are sitting down in front of a nurse or doctor, and a lower likelihood of ending up in hospital for a preventable condition. The data from the places that have done this first show that those are the results they are getting.

Q100 **Anne Marie Morris:** What data are you going to be collecting from April 2018 to demonstrate from a patient perspective—not just a finance perspective—that you are delivering what you set out to deliver?

Simon Stevens: For all 44 areas of the country, we will be publishing for the second year running the overview of how well they are doing on their early cancer diagnosis, how well they are doing on access to new mental health services, how easy it is to get a GP appointment, how easy it is to be looked after at evenings and weekends, how quickly you get a routine operation, and what the access experience is if you need to go to A&E. All those measures, which I think the public will readily see as being very important for the NHS, will be published for all 44 STPs, as well as for the integrated care systems.

Q101 **Anne Marie Morris:** That's great Mr Stevens, but in one of your answers to, I think, Ms Phillipson, you said, "We talked about transformation, but it's now about suitability."



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Simon Stevens: That was just about the £1.8 billion of funding that was going to the trust sector specifically. It was not about the NHS budget in total; it was about that £1.8 billion.

Q102 **Anne Marie Morris:** But these are also about transformation, are they not? Is the plan not transformation, rather than just keeping the ship afloat?

Simon Stevens: For the £2.45 billion, which is going into the provider sustainability fund in 2018-19, that is what it says on the tin: provider sustainability.

Q103 **Anne Marie Morris:** Right, but the whole point, when we set out the sustainable transformation partnerships, was that we were going to transform care, not just sustain care. The measures of success you just set out are very much about how much people are getting of what we already offer, and how fast they are getting it. The bit that's missing, it seems to me, is the vanguard work. There has been a lot of vanguard work, but it doesn't seem to be being shared. I asked you this question last time we met on this topic, Mr Stevens. Your approach was very much, "Well, it's there if they care to go and find it," to which, as I recall, I said, "Haven't you got to push? These are busy people, and unless you push they are never going to make the changes."

Simon Stevens: Given the level of pressure in the system, people are very eager to find out what other parts of the country have done on, for example, moderating the emergency pressures on hospitals, to improve the care of people with diabetes and improve your chance of having your colorectal cancer picked up at an early stage, when it will be possible to give you treatment such that you will do well.

All those things that are part of these programmes are now being layered across the country. Some of the programmes that are referred to in the Report, such as the RightCare programme, are specifically about holding up a mirror to each part of the country and saying, "How do you compare? Where can you learn from? Here's where you will find good practice."

Q104 **Anne Marie Morris:** With respect, Mr Stevens, I am still unconvinced that some of the learning from the vanguards has been dissected and used by some of these new organisations. I fear that you are very much still talking about how you improve care for challenges we already have and illnesses we are already aware of. It seems to me that you are not talking at all, for example, about the challenges in a rural community. You have many more people with complex comorbidities living past 85. They generally come into the health population at 65, when they move to rural areas to retire. You need a very different form of care. You need more geriatricians. You have challenges with footfall in the different types of care entities to ensure that professionals keep up their training. I am not hearing anything about how you might adjust and develop the fundamental model so it is fit for purpose whether you are urban or rural.

Simon Stevens: Let me ensure that you do hear something about that, then. Let us talk about both Dorset and Somerset. In Dorset, they are



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doing a fine job for the population in a county that, outside Bournemouth, has very rural elements to it. I can have the folks from Dorset come and meet you, because I think hearing from them at first hand about what they are doing, how they are doing it and the results they are getting would definitively answer your questions.

Q105 **Anne Marie Morris:** That would be really helpful, but that is just one. We have 44 of them. What is your plan to help all 44?

Simon Stevens: Not all 44 are highly rural. You were talking specifically about rural areas.

Q106 **Anne Marie Morris:** Indeed, but more than one or two of them are rural. There must be other learning from other STPs or these new system organisations that could and should be shared because of the particular similarities between different clusters across the 44. Is that happening?

Simon Stevens: Yes, to some extent, but I am not going to say—look, going back to Bridget's question, a lot of people are also dealing with the here and now. Like you, they are busy people and they are not out touring the country on fact-finding missions. People are having to do both at the same time.

Q107 **Chair:** Can I press you on that? Anyone who has ever experienced any part of the NHS can see that there are issues and challenges in the system for a lot of the good staff working there—it does not always hang together as well as it could—but a lot of people just have their heads down and think, "Here comes another initiative from the centre." You have regulators, you have NHS Improvement, you have you—Simon Stevens—and you have the Department issuing edicts about money and other things. You have all that, and it sometimes does not interact very well on the ground. At the senior level, you have hospital managers and other health managers trying to balance the different demands of different regulators and funders. At the more junior level, that comes down to many more initiatives that people have to learn about and take on board. That cuts into what Ms Morris is saying. You have the grand plan, but in reality, on the ground, how are you going to deliver it? Can you each say how you co-ordinate your work to make sure that you do not make competing demands on people lower down the system?

Simon Stevens: Sure, and I am sure Ian and Chris will come in on this as well. If I might suggest so, there is a danger of a slight contradiction between your respective lines of questioning. On one hand you are saying, "You need to be more directive nationally about banging people's heads together to make sure they learn," and on the other hand you are saying, "People are very frustrated at the level of national intervention to try to bring about results."

Q108 **Chair:** No. Let me be really specific. My question was about guidance that comes down that requires one set of activities by one part of the system and another by another part of the system.

Simon Stevens: That is a separate point.



Chair: Take billing arrangements—whether you bill CCGs and how you do that—for example. You have one bit of the system asking for one thing and another saying, “Do it differently.” You have a complete clash, because you have an individual in a trust who has to balance different advice or guidance from different parts of the system. How do you make sure that you actually work together? What Ms Morris has described will not happen unless you have that—

Simon Stevens: In the case of Dorset, the answer is that they are evolving towards a situation where they take shared responsibility for the NHS funding available in Dorset and then are able to redesign care themselves. That is going to take out a lot of the transactional hassle between different parts of the system, but in order to be able to take on that responsibility you need to be working in a coherent fashion between the various organisations involved, which is why this is an evolutionary journey that cannot proceed at the same pace in every part of the country. It is a developmental journey.

To support that, NHS Improvement and NHS England have got to work together in a different way. We are, I think, on a course to do that. The discussions that Ian and I, with our teams, are having—at the end of March our public board meetings will be setting them out—will show that, within the confines of the statute and the distinctive responsibilities that Parliament has assigned to Monitor on the one hand and NHS England on the other, nevertheless you will see much more join-up between our work both regionally and nationally.

Sir Chris Wormald: We have seen that this winter around the A&E operation, which was almost entirely joint—NHSE and I worked with the same person, in Pauline Philip. It is, however, incredibly complicated. We are talking about nearly 10% of the economy. It is very, very difficult to have a completely clear and single message. Of course, in the case of some of the regulators, we set them up specifically not to do that, so CQC is there to give an independent assessment of quality, including giving the Government and the NHS tough messages when needed. We specifically set that out and we guard their independence extremely jealously. We work very closely with the regulators about seeking to ensure that the improvement work led by NHSI fits with and learns from the inspection system of CQC, but we keep them separate for a very good reason—because we value independent inspection. There are some tensions that come with that, inevitably, but here, as we have for schools, prisons and lots of other public services, having an independent regulator that can say what it likes, regardless what the three of us think, is a good thing and not a bad thing.

Q109 **Anne Marie Morris:** With respect, Sir Chris, we are slightly getting off the point here. If I was to be really cynical, I would say that this move towards integration without actually changing job titles, job descriptions or budgets could be seen as a way of getting a change in the health system by the back door. Has anyone had a go at any of you, or individual organisations, particularly the STPs—by way of a judicial review



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or anything like that—to say, “Hold on a minute: is what you’re doing really within the law?”?

Simon Stevens: Yes. I will not comment in detail, given that these matters are before the courts, but two judicial reviews are pending. That will bring complete clarity, based on what the courts decide, as to the contours of the current law.

Q110 **Chair:** Clarity, or it could derail the whole thing—if the complainant wins.

Simon Stevens: The claim that is being made is that the 2012 Act prevents joined-up working and integration as expressed through a particular approach to varying the NHS standard contract for something called ACOs. That is for the courts to be clear with us all. If the courts say, “The approach that has been taken is consistent with the legislation,” I hope everyone will accept that; if they say it isn’t, the ball will be in Parliament’s court, if that is indeed the direction in which you think the NHS should be headed.

Q111 **Anne Marie Morris:** If that happened, would you be recommending to Sir Chris Wormald that he should be recommending to the Minister that, instead of trying reformation by the back door, we should be doing it publicly. The great British public out there want it and need it.

Simon Stevens: I think we are doing it publicly. We have been very explicit about the benefits of joining up services and, by the way, we are not the only country for whom that is true. When the NHS was formed in 1948, it was formed on the basis of brief encounters between patients and their doctors. Now, we need steady relationships, based on the fact that we have people with long-term conditions—

Anne Marie Morris: Mr Stevens, that is a lovely story, and you are absolutely right about where we want to go. From the sound of it, I think we are all in violent agreement that there are many barriers, and that at some point we will have to remove them.

Chair: Less Tinder, more stable relationships.

Simon Stevens: I don’t know what the first concept you are referring to is, Chair.

Sir Chris Wormald: I will try to give an answer without metaphors. I add to what Simon said that the history of the NHS has not been short of reorganisations. One of the key things about the STP process, and the integrated care systems that Simon described, is that we are not trying to change the statutory basis of organisations or their accountabilities. Those will remain exactly as they are. The focus is on how all those people work together, as opposed to whether we can redraw the map of the NHS so that it in some way works better.

Q112 **Anne Marie Morris:** I totally understand that. It is entirely the answer I would expect from you—I am not in the least bit surprised—but it doesn’t really help us move forward.

Simon Stevens: It is true.

Q113 **Anne Marie Morris:** But it doesn't help us in terms of the overall agenda, which is about transformation, not just simply staying within the law, important and crucial as that is.

Sir Chris Wormald: Just to be clear, we obviously have to stay within the law. We are saying that, rather than spending another several years redrawing the map of the NHS, can we get on with the very important clinically led discussions about how professionals relate to each other, as opposed to redrawing the map of the NHS? Most of the things we are describing as transformation come down to how clinicians and others relate to each other, not the organisations that they sit within.

You mentioned the vanguards. That is exactly what they found. Referring back to your own questions, it is all about whether we can get the right types of behaviour and good practice in the system, as opposed to worrying about who sits in which organisation and what law might come up.

Q114 **Anne Marie Morris:** I agree. That is about culture change, which is always one of the slowest things to actually change. Mr Stevens, can I take you away from the 10 that somehow seem to have managed to achieve much of this and focus on the remainder? As I understand it, they are effectively penalised for not having achieved a best plan that meets the necessary financial criteria. It seems to me that, for many of them, the challenge is that they are trying to do the impossible with insufficient funds. Telling them that they have to save even more will not really help to deliver the vision.

Simon Stevens: As Ian said earlier, we are inviting the next group of geographies around the country to come and join the liberated zone.

Q115 **Anne Marie Morris:** How are you going to help them do that? Is it clear whether there are any commonalities between those that have succeeded in being in the top 10 and those that haven't? From what you said, maybe it is just about the time they have been working together, in which case there is not a lot you can do about it. However, it may be something like historical underfunding.

If I can just for one minute allude to the standard funding formula—this is true not only for health, but for education and many other sectors—there is generally agreed to be an underfunding if you compare urban areas with rural areas. Certainly, in the examples I have seen, more of the rural STPs—if I can call them that temporarily—seem to be at the bottom of the list and not succeeding, as compared with the urban ones towards the top.

What can you tell me about some of those issues and fundamental differences, and the extent to which, when you set their objectives and targets, you took into account that historical mismatch and underfunding? If we are looking to the future, we should surely take this opportunity to level the playing field and then give people reasonable targets?



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Simon Stevens: We must not conflate a question about the aggregate funding available for the health service with the question about its zero-sum distribution between parts of the health service. On that second question, the way in which money is allocated to different parts of the country is now the fairest it has ever been in the history of the national health service. It is certainly fairer than at any year since 1976, when our predecessors first went down this route through something called RAWP—the resource allocation working party.

The reason I feel confident in saying that is that we have an independent committee called ACRA—the advisory committee on resource allocation—that looks at need allocation and has specifically looked at the incremental cost of sparsity and rurality versus the incremental cost of being in an inner-urban area with a high population churn and the costs that go with that.

Over and above that we have now not just applied that fair funding formula to hospital and community health services; we have done so to primary care services and also to specialised hospital services. As a result, no CCG is more than 5% below its fair funding formula, and not just for hospital and community health services, but for its primary care and its spending in the round.

So I do not think that, to use one of the Committee's favourite labels, this is a question of robbing Peter—in this case you, Chair—in order to benefit you, Ms Morris, which is kind of the argument you are making. I think this will be a question of the aggregate funding available for the health service in the round.

Q116 Chair: I think this may be a subject for a wider discussion. I think Ms Morris may be angling to do more on it, but perhaps we can move along.

Simon Stevens: It will boil down to your area versus Hackney, and as far as we can tell we are being as objective as we can be about that allocation. There is a related question that we are going to start lifting the stones and having a look at, which is for those parts of the country that are getting extra funding because of unmet need—health inequalities; the extra health inequalities adjustments we make—how are those resources being used in those geographies? Some disturbing data are emerging around life expectancy trends, so we really want to understand whether those extra funds in parts of the country such as the north-east are being used for things that would be likely to improve health and reduce inequalities; or are they just being used for more vanilla utilisation of services rather than getting upstream? That is a conversation that we are going to be having, and kicking off at our public board meeting in March, jointly with Public Health England.

Q117 Anne Marie Morris: Mr Stevens, as the Chair rightly identifies, this is a much bigger topic, and it will come as no surprise to you that I do not necessarily agree that some of the criteria that are currently being used are fit for purpose in today's world, but that is a separate agenda. Let us now go back to the integration, which is what we are also keen between



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us to achieve. One of the concerns that I hear is that the voluntary sector feels excluded, that the local authorities engage and do not engage with a great degree of variety across the country. Given Nirvana and where we want to get to, and the challenge of breaking down cultures, what are you and your colleagues, and Sir Chris Wormald and the Department, actually doing to ensure that they are not just talking the talk, but walking the walk—and not just across health and social care and community care, but the other key players? The voluntary sector play a huge role in all this and without them we would fall over. How are you getting that co-ordination?

Simon Stevens: I agree completely. There are things we can do nationally and there are things we have got to try and stimulate local action on. The things we can do nationally include ensuring that the national level voluntary and community organisations are involved with us in the big improvement programmes that we have got across the National Health Service. That is why I have invited the chief executive of Diabetes UK to oversee the assessment process for how well CCGs in different parts of the country are doing on the diabetes element of the annual assessment framework. It is why Cancer Research UK—I had Harpal Kumar chair the cancer taskforce improvement programme. It is why I invited Paul Farmer, the chief executive of Mind, to lead the work on mental health improvement.

At a national level we are setting that example, but I think we also recognise that locally there are different levels of community asset, engagement, funding pressures. Some of this is about the different expectations that the statutory sector and the voluntary sector have. Within the last several years, for example, we have taken a lot of the bureaucracy out of being able to get funding from the NHS. Instead of having to do the telephone directory-worth of NHS standard contract, there is now a shorter version that can be used for funding with the voluntary sector.

But look, this has been a time of pull-back of grants for many voluntary organisations. There is a whole local ecosystem, with some of the larger national organisations having local representatives and some of the smaller local organisations sometimes feeling that their nose has been put out of joint about the role of some of those national organisations as well. So this takes considerable sensitivity and local sophistication to get right.

Q118 **Anne Marie Morris:** You are absolutely right, but do you not think that you ought to have as a target that you then measure—further down at the level of the 44, not where you guys are, sitting in London—to say, “Demonstrate to me that you have engaged with at least 10 of your local charities that provide X, Y and Z: community transport, befriending, and so on”? It is not just the paid bit of the voluntary sector, but the unpaid bit.

Simon Stevens: You make an important point; we have been discussing, as recently as this morning, the extent to which we should try to build



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some of that into the processes we use to assess and check how well the STPs are working.

Sir Chris Wormald: On the local government side, we have generally seen local government playing a bigger and bigger role in STPs. It is, of course, voluntary for them; we do not have any powers to compel and they are democratic institutions in their own right, so it will always be variable. The big lever we have—the Committee has discussed it before—is that the better care fund, which there were clearly upsides and downsides to, has undoubtedly created a conversation between local government and the NHS that was not there before.

We mentioned earlier in this hearing that when we were doing the delayed transfers of care programme, which spans local government and the NHS, I think most sides would say that there was a quality of conversation around that that we have not seen before. There is clearly further to go—we were discussing it last week—on how the health service, social care and the wider local government system work together, but we have seen signs of progress.

Q119 **Anne Marie Morris:** That is very encouraging, but can I put this question to you? That common working is extremely good, but I am looking at this and beginning to think there almost seems to be a blurring between commissioning and providers with the overall Government move toward decentralising and putting power in the hands of the local parts of local provision, if I can put it like that. For example, there is a proposal in my area of the west country for two counties, two STPs, three LEPs, 10 local authorities and some unitary authorities to come together to provide both health and social care. If that ever happens, it seems to me that we will have totally blurred the distinction between commissioning and provision, which, to be honest, had its benefits; we introduced it to ensure that there were some checks and balances. From what you are saying, I am a little bit confused as to what ultimately will happen with all this integration. Is there going to be a breakdown between commissioning and provision? What will this integration look like in the end? How far will it spread?

Sir Chris Wormald: Obviously we are not changing the law; as you know, the health system and the social care system operate under very different types of statute. That limits things in the way you describe. Where we see really good examples of health and care working together, it is often—almost exclusively—at the nuts and bolts level rather than the grand conceptual level. The areas that do this well share data well, they have a common decision-making process, they have a single trusted assessor and they do all the mechanics things. They tend not to worry about how big the statutory divide is between services. Certainly, we are encouraging them to tackle those bread-and-butter issues that get in the way of good joint working. That is built into how we do the better care fund and other programmes. It does not help with the bigger question you raise, but I think that is for another day.

Q120 **Chair:** In all of this, the simple question for us is: who is accountable? In



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these integrated care arrangements, if I have a complaint or concern, where do I go?

Simon Stevens: As Chris said, nothing about the statutory accountabilities has changed. The law is the law. You have gifted us a legal framework and we work within it.

Q121 **Chair:** But in all honesty, if you are a patient caught in the middle of all this, getting support from different bits of the organisation, and you have a problem, you are not thinking along the bureaucratic lines that we probably think about. You are trying to make a point. You might go and raise the concern somewhere, but will that really have any impact? Does that bit of the joining up work?

Simon Stevens: You will have the same ability to raise complaints and concerns as you have now, because the formal accountabilities have not changed—

Q122 **Chair:** But you might have to do it in several places.

Simon Stevens: But hopefully you will have less reason for doing so, because the quality of patient experience will have improved.

Q123 **Chair:** You are ever the optimist, but who is accountable, ultimately? As you say, the law has not changed. Everyone has their own accountability—

Simon Stevens: The accountabilities are the accountabilities with which you are familiar already.

Q124 **Chair:** So everyone will still pass the buck and blame each other.

Simon Stevens: No. We can dance on pinheads, but I really think that if you actually spent a bit of time with some parts of the country that are getting on and doing things, you would just hear it from patients, GPs and nurses, and it would be a much more practical conversation than the one we sometimes have.

Q125 **Chair:** Mr Stevens, can I just be clear that as a Committee we are just asking the questions. It is yet unproven; we are just asking if you, at the centre, have the plans in place to make sure that, for instance, where accountability lies and how you raise a complaint is sorted out. You paint a perfect picture—

Simon Stevens: There are no new questions in terms of social care/NHS budget pooling, which has been lawful since 2006 under section 75 of the 2006 Act, as everybody recalls. We are absolutely clear that there can be no change to the principle that NHS care has to remain free on the basis of need, not ability to pay. Having said all of that, the fact is that this year local authorities and CCGs have voluntarily chosen to budget-pool £2 billion more than they were required to as part of the better care fund. People are, in practice, working this out well.

Q126 **Chair:** I don't doubt that at local level, where people want to do it they can find a way, but we have talked about some of the barriers. Let me



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raise another example. If you have an issue to raise in the NHS, you go to the patient advice and liaison service and talk to them, but with integrated care you could have several PALS—patient advice and liaison services. You could have a local authority bit, and another area. With the integrated care systems, if you raised a concern in one place, would you envisage that that would then be dealt with across all the organisations involved in that patient's care?

Simon Stevens: I would hope so, but your statutory rights to complaint—

Caroline Flint: A one-stop shop.

Chair: Yes, one-stop shopping, as Ms Flint has pointed out.

Simon Stevens: But that is obviously the status quo, as you know, dealing with many complaints all the time at the moment.

Q127 **Chair:** But is that your vision?

Simon Stevens: At the moment we have separate arrangements for complaining to GPs and to hospitals. We have separate appeal rights, to the ombudsman and so forth.

Q128 **Chair:** That is exactly my point, but is it your vision that you will have a one-stop shop?

Simon Stevens: That is clearly where we would like to get to, but that will not affect your ability to complain individually about the different services that you received.

Chair: I am saying complaint, but it could be a comment—I do not want to be overly negative. It might not always be a complaint. There might be comments.

Q129 **Caroline Flint:** Why are NHS trusts setting up subsidiary companies?

Simon Stevens: That is really a question for Mr Dalton.

Sir Ian Dalton: That is very kind of you. Since 2006, I believe, NHS Foundation Trusts have been able to establish subsidiary companies where they further the purpose of the NHS. It is not a new thing. Subsidiary companies have been set up across the country, most notably to generate additional income to support the clinical work of hospitals. I guess it is quite long standing.

Q130 **Caroline Flint:** I understand that Barnsley Trust, for example, has set up a wholly owned subsidiary company. I think Gloucester is looking into that as well. From what I understand, and having had a catch-up with my chief executive at the Doncaster and Bassetlaw Trust on Friday, the idea of these wholly owned subsidiary companies is, first, to look at how they can reduce tax liabilities and, secondly, to transfer non-clinical staff into these organisations. While they will be TUPE-ed across, any new-starters coming in can be outside the Agenda for Change programme, and therefore there is a potential saving in lower salaries and pensions for those new starters. Is that the purpose of these subsidiary companies?



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Sir Ian Dalton: I have not seen the individual companies to which you refer, but the general point, which I am happy to respond to, is that where there are genuine commercial reasons for creating a subsidiary company, a foundation trust in law has the power to do that. That is an existing legal power that has been on the statute book for many years.

Q131 **Caroline Flint:** I am trying to understand this, before it gets a head of steam. There are only a few of them at the moment, but I understand that there is discussion going on within trusts. I think that within my own trust there has been some discussion about it, and it has not landed on the view that it wants to go down this path, but before this becomes widespread, do you not think it is important for us and the public to understand why now and why this model, and to understand what it is trying to do? This whole discussion this afternoon has been about saving money. Is this the vehicle we are going to use in the future, where anybody who cleans in a hospital, provides admin in a hospital or provides finance services in a hospital—everything that is non-clinical—will end up in a different organisation to the NHS?

Sir Chris Wormald: I have not heard the specific suggestions that you make, and I am not sure if anyone else on the panel has. We probably ought to go away, look at that and write to you. Of course, a number of the staff that you refer to are already in different organisations. A lot of those services are contracted out. I have not come across the model you are describing for these purposes.

Q132 **Caroline Flint:** I find this rather surprising, to be honest. Mr Dalton, you are in charge of NHS Improvement, which presumably helps to advise trusts on what they can do and has discussions with them around money. I am a little bit surprised that I am getting less than I hoped for, in terms of understanding why this model is being developed and actively discussed by trusts. I understand, Sir Chris, that in September last year the Department of Health sent to NHS finance directors an article on tax avoidance issues in the NHS. I wonder what prompted that, given the story about these new forms of companies. Albeit, as you say, Mr Dalton, that the power has been there before, given the fact that it is being activated now and being actively discussed, for the two reasons I have outlined, do you not think we should know more? Do you not think you should be more open and curious about why this is happening?

Sir Ian Dalton: One of the things that we will be doing is looking again at our regulatory oversight in this area. We absolutely are prepared to do that. At the same time, we need to go back to the fact that this is not a novel or new power. Our line remains that where there are genuine positive commercial reasons for doing this, and that is the law, trusts should not be precluded from doing that. But our role as regulator is to ask questions, looking ahead, about whether our regulatory regime, which previously has not tracked these, should do so.

Q133 **Caroline Flint:** You seem, Mr Dalton, to be rather less concerned than I hoped you would be, given that this power has been around for a substantial amount of time, about what may be driving people to utilise it



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now. I would suggest that maybe it is because trusts are having to find savings and manage budgets, for all the difficult, complicated reasons we understand—something that has been addressed in this session. But the question is, if they are doing it in terms of, for example, tax flexibilities, why is that not something they can look at and have an open discussion about within their current trust arrangements, with yourselves and HMRC? More worryingly, if it is to separate out more members of NHS staff into another organisation that further splits up the NHS family, surely that will be worrying for recruitment and retention down the road as well. I will leave it there, because I feel that I am getting blank faces on this. But I urge you to consider what is going on here, because there are concerns outside of this room today, first, that this could be a backdoor route to privatisation and, secondly, that it may not be the model that delivers the financial savings that some people involved in this think it will achieve.

Sir Chris Wormald: Yes; as I said, we had better take away these questions and write to you.

Q134 **Sir Geoffrey Clifton-Brown:** Sir Chris, as you know, there is a proposal to set up one of these social enterprise companies in Gloucestershire—Gloucestershire NHS Trust—and I am slightly surprised that you do not know a little more about it, because in a submission to the trust, the Royal College of Nursing, Unison and Unite said: “The Department of Health wrote to all NHS trust finance directors on 28th September 2017, in a letter entitled ‘Tax Avoidance issues in the NHS,’ discouraging all trusts from pursuing tax avoidance schemes; reminding them that ‘the fees chargeable to the tax advisors represent a direct leakage out of the health system’ and that tax avoidance ‘involves operating in the letter but not the spirit of the law.’” That is a serious letter and I am surprised that you do not know a bit more about it.

Sir Chris Wormald: Yes, and exactly as you say, we discourage those things for exactly those reasons. The bit that I have to say that I have not looked at and have not come briefed on is the specific arrangements that Ms Flint raised. We look at tax in a variety of areas, and we do exactly what you just said. People should pay taxes fairly, as set out by HMRC. From memory, the things we were concerned about when we wrote that letter were individual taxation questions around agency staff.

David Williams: It was a combination of that and a set of pension procurement arrangements that potentially had an impact on VAT treatment for suppliers. It was not a letter that had been prompted by either of the arrangements that Committee members have raised. As Sir Chris says, we should take that away, look at it and come back to you.

Sir Chris Wormald: But, as you say, the principles would be exactly the same in any situation. We think people should pay tax fairly.

Q135 **Sir Geoffrey Clifton-Brown:** The unions go on to say: “We believe that VAT savings remain one of the major incentives for the proposal, but that this aspect is being deliberately downplayed in order to reduce the risk of



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SubCo being denied VAT-exempt status under the Contracting Out Directive by HMRC.” Surely there is either a VAT saving or there is not? If there is a VAT saving, surely the Department should resolve it with HMRC, rather than trusts having to go through this elaborate and expensive procedure in order to get around VAT problems.

Sir Chris Wormald: I am not an expert on VAT, but I do not think that a wholly owned company has a different VAT status from its owners.

Sir Geoffrey Clifton-Brown: That is what the unions are suggesting.

Sir Chris Wormald: As I say, this is not something that I have personally looked at.

Caroline Flint: Can I just interject here? When I asked about why this was happening, the chief executive of my local trust said it was about VAT flexibilities.

Q136 **Sir Geoffrey Clifton-Brown:** Sir Chris, I do not think we will get much further with this. We would appreciate it if we could have a letter.

Sir Chris Wormald: As the reference you read out says, all these types of questions are things that we take a serious view on. If the issues raised are correct, we will definitely look into them.

Chair: Could I ask Ian Dalton and NHS Improvement to write to us as well? The really key point, among many, is Ms Flint’s point about whether anyone is watching the ecosystem of the NHS. We now have many different types of provider, and the sustainability issues of that for staffing, as people move in and out of pension schemes and so on, is potentially a very big issue. If it is not identified and acted on now, it could be a long-term problem.

We will leave it there for now; it is an important issue but we are towards the end of the hearing. I will bring in Sir Geoffrey Clifton-Brown, who has a couple of very quick points.

Q137 **Sir Geoffrey Clifton-Brown:** I have two other issues I want to raise with you, Sir Chris. One, which is mentioned in the NAO Report, is the business of recouping fees from foreign visitors to the NHS. How do you intend to meet your £500 million target, when I gather there is significant backlash from doctors, accident and emergency departments and GPs in trying to recover those fees?

Sir Chris Wormald: We had a whole hearing on this subject and we set out our plans for improving in that area. We have been running a number of pilots at trust level on how we can improve recoupment, and we are just evaluating the results of that. Of course, we have also been looking at the surcharge we place on visas, which is our other area of income.

Actually, the biggest area we need to improve on is not the individual charging but getting people to claim under the EHIC—European health insurance card—scheme, where other Governments pay. That is the bit where we are furthest away from hitting our target. However, the plan is



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exactly as we set out at the previous hearing, when we considered the NAO's Report on this subject.

Q138 **Chair:** On the European health insurance card scheme, when Brexit happens, depending on what the arrangements are, there will be a lot of tourists who may not end up having visas to enter the country but will not have EHIC cards either. Have you given any thought to the impact of that on the NHS budget, and are you making any representations to the Home Office?

Sir Chris Wormald: What the future of our mutual health insurance arrangements are with the European Union is one of the areas that is part of the discussion. With the proviso that nothing is agreed until everything is agreed, as you know, we already have an agreement on people who are already in receipt of EHIC payments, whether they live abroad or here, but the issue you raise is one of the ones that we will have to cover in the negotiation.

Q139 **Chair:** Is that one of your eight work streams in the Department?

Sir Chris Wormald: Yes. It is an extremely important one—

Q140 **Chair:** We would be grateful if you could tell us what the other Brexit work streams are.

Sir Chris Wormald: Our biggest one, which I think I have described to the Committee before, is obviously workforce. There is also mutual health insurance; medicine regulation, our other very big one; a range of public health questions around public health monitoring, which are with Europe, but there is of course a world dimension too; and the NHS supply chain, which we are looking at in detail, because a lot of that is bound up. Those are our biggest five.

As I think I have said to the Committee before, we are not as affected as some Departments that come before you. Most health issues are common to everyone in the OECD, whether in the EU or not, but we have a quite small number of quite significant issues—I suppose research would be the other one that we are looking at—which are very important in their own right. It does not dominate our thinking, as I say, in the way that it does that of some people who come before your Committee. Nevertheless, they are important things—

Q141 **Chair:** But it is helpful to have that list. We are collecting the list of these things but the Government seem reluctant to deliver to us—

Sir Chris Wormald: Yes, and on your original question, if someone is here, does not have a visa exemption and is not entitled to NHS care, then we have to charge them individually.

Chair: It is going to be more complicated. We will park that—

Sir Chris Wormald: We of course already do that.

Chair: We are interested and glad that it is on your radar. We look forward to learning more.



Q142 Sir Geoffrey Clifton-Brown: Sir Chris, it is getting late, but may I ask you one question on efficiency savings within the NHS? Paragraph 2.15 and the table, figure 13, make it clear that you have got a £22 billion gap in obtaining efficiency savings. Figure 13, over three pages, details a number of ways in which you intend to try to fill that gap, but even those very detailed efficiency savings only come to about £12.5 billion. There is still a big gap that you need to fill in terms of the efficiency savings. I wondered what your aspirations were in filling that gap.

David Williams: I will go first, though it is possible my NHS colleagues may want to join in. The £22 billion reflects the original view from the five year forward view of the level of efficiency that would be needed to help manage a £30 billion counterfactual, with at least £8 billion of additional investment in the NHS by 2021. As we have set out previously, I think, this is a combination of central measures taken forward by the Department, nationally facilitated and run programmes led from within the NHS, and a series of bottom-up measures in individual NHS commissioning groups and providers. A lot of the £22 billion is around constraining cost growth rather than taking cost out, whether that is on the demand side through programmes like RightCare, which NHS England leads, or on the productivity side within providers, like the Lord Carter operational efficiency programme.

As we have progressed through Parliament with additional investment in the NHS, the precise composition of the £22 billion is necessarily something that is quite fluid. For example, the single largest component of the £22 billion to be delivered centrally was based on an assumption around the continuation of Agenda for Change pay restraint. We will see where we come out in the discussions and negotiations with trade unions on that point, as we have touched on in the hearing already.

That is a slightly long-winded way of saying that the £22 billion is a moving target. What the Report sets out is progress against a range of those savings. What NHS colleagues set out earlier in the year is a more focused approach to delivery of the level of efficiency and productivity needed through the 10-point efficiency plan, which is also set out in the NAO Report at figure 9. That is really now primarily the way in which we are monitoring and tracking performance. As I think we have heard from witnesses today, the NHS actually has a very good track record of delivering such efficiency and productivity improvements. The question, short term at least, is whether you are hitting the level of plan that we assumed.

Q143 Sir Geoffrey Clifton-Brown: Given that these are pretty detailed proposals in a jointly agreed Report—in figure 13—it does seem somewhat alarming that there is £22 billion gap and yet the detailed proposals only amount to some £12.5 billion. That is a very significant mismatch of figures, it seems to me.

David Williams: We have set out previously—I would be happy to circulate it to the Committee—precisely how the £22 billion was made up.



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I think all I am really saying is that that specific breakdown is getting slightly long in the tooth now—

Sir Geoffrey Clifton-Brown: I think we are much more concerned about how you are going to meet it, rather than how it was set up. I think we know that it was from a report that you commissioned, but what we really need to know—perhaps through you, Chair, we could have a note on this—is how you intend to meet that quite large figure in efficiency savings.

Q144 **Chair:** It rather underlines some of the questioning earlier—our concern about sustainability. David Williams, will you outline that, send us a letter?

David Williams: Yes. With colleagues from NHSE and NHSI, I think we can send you a joint letter.

Simon Stevens: This is not comprehensive list, for the reasons that David set out. There are various national efficiency programmes that are not on this list; this is really the NHS-facing list. There are matters around pay and matters around the way in which drug prices are negotiated nationally through the PPRS, and various other programmes that do not fall to local health service to sort out, that are not on this list.

Q145 **Chair:** Does that fill the gap that Sir Geoffrey pointed out?

Simon Stevens: As David said, the £22 billion was a counterfactual construct in October 2014. Obviously, as we advance, we can see what are dealing with in reality, and we have been able to adjust as we go. Delivering on these items, together with the national programmes that are not here, is what we think we need to do. But none of that detracts from the fact that we still have very significant funding pressures in the system, in the way that the NAO Reports. We can take more action on efficiency, but that is not going to avoid the need for a conversation about what a properly resourced health service needs to look like.

Chair: Thank you very much for your time. The transcript, as ever, will be up on the website in the next couple of days. We are hoping, with a fair wind, to get this Report out before Easter, but obviously we will keep you posted about that.