

Health and Social Care Committee

Oral evidence: NHS funding, HC 1352

Monday 2 July 2018

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Andrew Selous; Martin Vickers.

Questions 1 - 104

Witnesses

[I:](#) Professor Chris Ham, Chief Executive, King's Fund; Anita Charlesworth, Director of Research and Economics, Health Foundation; and Sally Gainsbury, Senior Policy Analyst, Nuffield Trust.

[II:](#) Julie Wood, Chief Executive, NHS Clinical Commissioners; Chris Hopson, Chief Executive, NHS Providers; and Niall Dickson, Chief Executive, NHS Confederation.

[III:](#) Ian Dalton, Chief Executive, NHS Improvement; and Simon Stevens, Chief Executive, NHS England.

Examination of witnesses

Witnesses: Professor Chris Ham, Anita Charlesworth and Sally Gainsbury.

Q1 Chair: Good afternoon and welcome to this special session following the Prime Minister's announcements on funding. We are delighted to see all of you here. For those following from outside the room, will you introduce yourselves and say who you are representing, starting with Chris Ham?

Professor Ham: I am Chris Ham, chief executive of the King's Fund.

Sally Gainsbury: I am Sally Gainsbury, a senior policy analyst at the Nuffield Trust.

Anita Charlesworth: I am Anita Charlesworth, director of research and economics at the Health Foundation.

Q2 Chair: May I start with the question about whether this is enough? You have all previously commented that you were hoping for a 4% annual uplift. It has been commented that 3.3% represents standstill and that the announcement covers just NHS England, not all the other areas such as public health, social care, capital and workforce training.

Will each of you set out what you feel about the funding settlement? Is it enough, and what hard choices will have to be made?

Professor Ham: We have given a qualified welcome to the Prime Minister's announcement. More money is desperately needed, as the Committee has said in its own inquiries, and this is substantially more than we have seen in the last eight years. From that point of view, this is a big step forward, but it is a qualified welcome and there are four principal qualifiers.

First, 3.4% on average over five years falls short of the 4% that our foundations came together to argue was the minimum necessary to invest in the NHS and to improve services as well as deal with operational pressures.

Secondly, we have yet to see what the funding settlement will be for public health—the public health grant to local government—and indeed what the funding settlement will be for social care. We know from spending review 2015 that both of those were cut and to some degree raided to pay for a bigger headline increase in the NHS budget. My understanding is that that was discussed before the agreement was reached a couple of weeks ago, but until there is a clear, firm commitment about protecting and increasing public health spending and social care spending, judgment must be suspended.

The next qualifier is workforce. We desperately need to see what the final 10-year workforce plan will be for the NHS. If we have the money but we cannot recruit the doctors, nurses and medical staff that are needed, we will not see the improvements in care that we would like to see.



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Finally, all this means that hard choices have to be made within the NHS about where this money will be spent and, to be honest, about what improvements, over what timescale, can be delivered.

Sally Gainsbury: We agree with much of what Chris has said. We also have welcomed the new money as recognition that additional funding was needed, but of course we agree it is not enough.

To give a slightly different take from Chris, we have done some early projections to try to work out how much of this money will touch the sides. The NHS is starting from a position of being behind. We think that by the end of 2017-18 the NHS was in a net position of around £1.5 billion behind—overspending—taking into account various factors that we can talk about later. Yes, £6 billion extra cash will go in, but a chunk of that will be swallowed up by recovering that position.

The “Agenda for Change” commitment will start to be funded from this year. When that is taken into account, we calculate that in 2019-20 the new funding will boil down to just under £500 million—but that is before medics have had any form of pay rise.

Yes, it is new cash but we need to be very careful about the extra commitments, the level of expectation and the time period for being able to do stuff with that new cash. It will be several years before the NHS has any significant headroom—the £3.5 billion that the NHS was supposed to have as transformation funding headroom way back since 2015-16.

Anita Charlesworth: There are a couple of things in the announcement that it is really important to welcome. The first is the principle of a five-year funding settlement and some funding certainty. We and others have argued for a long time that the culture of short-termism and feast and famine has been a real problem for the NHS, so a five-year funding settlement coupled with a 10-year plan is very welcome. Once again, that is a one-off initiative as opposed to something embedded in the system, and there are some real questions about that.

The worry about capital, workforce, public health and social care cannot be overstated because the real risk with them not yet having clear plans and not funding them is that we are forced to spend the money badly and undermine the drive to make sure that the NHS is sustainable. We lock in current models of care because there is not enough funding for transformation, unless some very tough choices are made, particularly about how quickly we try to get back to waiting-time targets and the extent to which we prioritise immediate performance over the investment that is needed to change the way we deliver care, which in the end is critical to unlocking productivity.

Chair: Thank you. We are going to explore many of those areas in more detail, starting with Luciana.

Q3 **Luciana Berger:** I have a technical question on the sums. Forgive me if



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you cannot answer this, but I thought it was worth asking. In your report, Anita, you had worked out that the age-adjusted per capita growth within the NHS had been just 0.1% since 2009-10. Have you had an opportunity to look at those sums in the context of this funding settlement until 2023?

Anita Charlesworth: I have not, but I can do them and send them to you.

Luciana Berger: That would be fantastic, so that we can get a picture of what the funding will be over that entire period.

Anita Charlesworth: I will update that.

Q4 **Mr Bradshaw:** What about the Brexit dividend, Chris? Is that not going to deliver a whole load of extra money?

Professor Ham: We share the scepticism that your Chair has expressed about whether there will be a Brexit dividend. The reality is that the Government are going to have to fund this through a combination of tax rises—the Prime Minister talked about doing that in a fair and balanced way and asked the Chancellor to bring those rises forward—and maybe through increased borrowing. We know that the public finances are improving and there may be more latitude to do that as well.

Q5 **Mr Bradshaw:** You referred to the Chair's comments. I believe she called the claims of a Brexit dividend absolute "tosh". Have you and your organisations done any impact studies about the impact on the NHS overall of the different types of Brexit or of no deal?

Professor Ham: We have done some work; I know sister foundations have, too. We have not looked at the Brexit dividend issues. That is what the IFS and others have commented on with some authority and have concluded that there does not seem to be a Brexit dividend at all.

We have expressed concerns, particularly around the workforce given our dependence in social care, as well as in the NHS, on people who come here from the EU. We are already seeing pressures growing, people returning to their countries and not coming in the numbers that they were before.

We have also expressed concerns around the uncertainty associated with the future trading arrangements and what it will mean around pharmaceuticals and the ability of the NHS—I think Simon Stevens has spoken about this recently—to source the equipment, drugs and other things we need within the NHS. They are real concerns.

Anita Charlesworth: I think there is a bigger point about the nature of the task for the NHS. It is not that the NHS needs a one-off injection of funding and then there is no problem. The nature of healthcare is such that, as we have seen over the last 70 years, it increases by more than GDP and more than prices year in, year out. That is a completely natural



phenomenon. It is not because of the way we organise the NHS; it is true of every developed nation. We need a sustainable way of funding the NHS, and that means that we have a tax base that is commensurate with our ambitions for the health service.

In the short term, there are things that you can do to get around that. Fundamentally, we owe it to the public in the 70th anniversary of the NHS to have an honest debate. If you want a high-class NHS not just for today but for the next 10, 20 or 30 years, there is a consequence to that in how we pay for it. A tax-funded NHS free at the point of use makes economic sense, but it does have implications. Pretending that you can fudge your way through it as if it is a short-term problem is not helpful.

We need some leadership to say to the public that the health service is a treasured institution, an efficient institution and a great way of delivering healthcare but that, if we care about it, we have to decide as a nation whether we are prepared to pay for it, and that does come through tax.

- Q6 Mr Bradshaw:** May I bring you back, briefly, to the Brexit issue? Simon Stevens was asked by Andrew Marr at the weekend about contingency planning in the event of a no deal and whether he could guarantee the continued flow of vital medical equipment and vital medicines. He did not quite answer the question, but said that was our priority. Have any of your organisations had a look at contingency planning in the NHS for a no-deal scenario? If so, what have you found?

Professor Ham: We have not, no.

Anita Charlesworth: I have not done any work on it, no.

Sally Gainsbury: We have some ongoing work on Brexit and various different options, so we can share that with you, but it is not my particular area.¹

Mr Bradshaw: Great, thanks.

- Q7 Andrew Selous:** Some of you have already referred to the fact that the funding settlement starts in April 2019. We have come through a very challenging winter for the NHS. What are your thoughts about this coming winter in relation to the financial position of the NHS and the announcement on the funding settlement?

Sally Gainsbury: The provider side of the NHS—hospitals and other service providers—started this financial year about £4 billion behind in

¹ *Note by witness:* Dayan, M How will our future relationship with the EU shape the NHS? Nuffield Trust, 2017. Accessed at <https://www.nuffieldtrust.org.uk/research/brexit-relationship-eu-shape-nhs>. While some developments in Brexit negotiations and policy have taken place since the publication of this report, nothing has changed which would materially alter the Nuffield Trust's findings regarding the effects of leaving the EU without withdrawal and future relationship agreements in place.



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underlying terms. Their reliable income—their predictable recurrent income—is £4 billion less than their predictable recurrent costs.

For the last couple of years, that gap has been closed in part by about a £2 billion bailout fund that has been paid by NHS England on a non-recurrent basis—it is year to year and it is not guaranteed at the level of individual providers.

Before this funding settlement, for the year 2019-20 NHS England's budget was not large enough to make an additional payment to cover that £4 billion gap between provider recurrent income and recurrent costs. This funding settlement does now mean that that is affordable. That is obviously a policy decision that NHS England have to make. Our feeling is that providers need a permanent correction in this £4 billion gap between their predictable recurrent costs and their predictable recurrent income; it needs to be fixed. That would still leave providers with a £2 billion problem, so they are going to have to work very hard on efficiencies to close their gap.

Q8 Andrew Selous: I am sorry to interrupt, but this coming winter is obviously in the 2018-19 financial year, is it not? That is really what I wanted to focus on. We have been through a very tough winter for the NHS. How do you think, financially, it is going to work out this year looking at what happened in previous years, and do you have any comments on what you have seen the NHS doing around that?

Anita Charlesworth: I will make two points. One thing that would be very helpful is if it was clear to NHS Providers that they could seek to recruit permanent staff. It will be hard to find them: one challenge that we have, even if we have money late, is finding staff. A lot of hospitals have had headcount plans very driven by budgetary constraints and have tried to staff using temporary staff.

Providing some comfort around staffing would be really important. It reinforces the point that it is not going to be realistic to expect a miracle, rapid turnaround in performance on the back of the Prime Minister's announcement, because getting the people to be able to spend the money well will be incredibly challenging.

Secondly, an important thing for winter is thinking about social care and at what point we are going to get some announcement and commitment to the future of social care.

Andrew Selous: We know that the Green Paper is coming in the autumn.

Anita Charlesworth: It is now delayed until the autumn. If decisions on capital, workforce, the public health grant and social care are all for spending review 2019, none of that money would flow until 2020 at least. I do not see how that is sustainable.



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Professor Ham: We are in July and it is a lovely summer spell out there, but it feels like it is winter all year round in many parts of the NHS. It may seem strange to say this, but there is limited scope for doing things now that will impact in the forthcoming winter.

The big issues are going to be around bed availability because of the high levels of occupancy of hospitals during the winter—95% plus—and the availability of funding for social care to do something about that in partnership with the NHS. I see very little room for manoeuvre on either of those.

The message we have heard from Simon Stevens and Ian Dalton in the last two or three weeks is that the target must be to cut the lengths of stay of people who are in hospital for long periods, to free up thousands of beds to create that slack and to enable next winter to be easier than this winter. It is the right aspiration, but whether it can be done remains to be seen.

Q9 **Chair:** Thank you. Chris, may I press you further on the hard choices you referred to in your briefing? Will you set out the areas where you think those hard choices are going to need to fall?

Professor Ham: Yes. The direction set by the five year forward view and the current priorities—getting back on track in delivering the waiting-time standards in the NHS constitution, parity of esteem for mental health, which is the right idea but not the reality, shoring up and strengthening investment in general practice and beginning to develop a more integrated urgent and emergency care system—feel to be the right priorities for the NHS.

There is something here for me about using the resources now to demonstrate more constancy of purpose behind the direction in which the NHS is going, but it is not just about shoring up and sustaining the current system; we would like to see some of the extra money earmarked for investment in some of the new care models on which the NAO reported last week and to further develop the integrated care systems that the Committee has reviewed and reported on recently.

We know that Greater Manchester has made real progress because it got its share of extra funding—£450 million over five years. The rest of the country did not get that. The rest of the country needs to have its fair share to be able to catch up with the good work going on there.

Beyond that, we would want to be very cautious about either Ministers or NHS England making further commitments that have cost consequences when even delivering the commitments I have rehearsed may not be possible within the increased funding envelope. That is where the hard choices are.

Q10 **Chair:** Right, so it is not making extra new, shiny pledges but focusing on the priorities you have referred to.



Professor Ham: Yes.

- Q11 **Chair:** What is the best way to ring-fence transformation funding? A recurring recommendation of all the think-tanks and, indeed, of this Committee has been making sure that the transformation money is there, because it always seems to get sucked into other priorities.

Professor Ham: Putting it very simply, it is to make sure that the ring fence is solid and not permeable.

- Q12 **Chair:** Thank you. Sally or Anita, would you like to comment further on those points?

Sally Gainsbury: To protect the ring fence you need to make sure that the baseline funding is adequate. That is clearly why the transformation fund got swallowed up most recently—there was a shortfall on the day job, essentially.

On our projections, assuming the non-consultant medical workforce receives a pay rise similar to the “Agenda for Change” pay rise, because that has also has been subject to a cap for as long as the nursing workforce, we do not think there will be anything like a transformation fund level of additional cash in the system until about 2022-23. Around 2021-22 there could be some headroom of around £2 billion or £3 billion, but that really represents the estimated cost of clearing the backlog on elective waiting times, which we suspect is going to have to be a quite high priority in plans and the mood music coming out of No. 10 and how your colleagues and Parliament feel.

- Q13 **Chair:** You are seeing that it is all going to be sucked into addressing the backlog in waiting times.

Sally Gainsbury: In the early period, yes. By 2022-23 there might be something that would be a similar proportion to the original transformation fund.

Anita Charlesworth: But that is a choice. The really hard choice is just how far we put current performance, particularly around waiting times, against investment in areas of service that are much less high profile but may be fundamental to some of the changes that Chris was talking about—investing in things like community health services, where we have seen very big reductions in the workforce. It is very difficult to see how the model of care and the vision set out in the “Five Year Forward View” can happen without a community-based service that has much more capacity than it does at the moment.

Lord Carter’s recent review of community and mental health talked about the fact that more than one in four community providers are still on an entirely paper-based system. We constantly raid capital investment that would be needed for that sort of thing to shore up the day-to-day expenditure. Living with the day to day of waiting times is not easy and it has an impact on people, but the question is that the Government are not



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providing enough resource at 3.4% to do all of it. It is a question of “or”—not “and”—and it is a very important issue.

If it all gets swallowed up again in getting the system stabilised and getting back to target performance, we will be back here again with exactly the same problems in five years’ time.

Professor Ham: May I add one minor but important point? We have not talked about productivity expectations. We know, looking back, that the NHS has outpaced the economy generally; the number cited is usually 1.4%. I do not think there has been much clarity around the funding settlement—about what the expectation will be going forward. We know that when funding increases more rapidly, productivity tends to increase more slowly. There are various reasons, good and bad, why that might be the case, but unless we factor that in we might be missing a very important element here as to what this will and will not buy.

Q14 **Chair:** Would you recommend that they focus on things that will improve productivity early on?

Professor Ham: Yes, absolutely. The work that Anita has referred to from Lord Carter and the work that Tim Briggs and Tim Evans are leading on looking at clinical variations and waste across the NHS—and we know there is a lot of that—is a great starting point.

Chair: Thank you. Andrew, did you want to come in at that point and then I will come to Lisa next?

Q15 **Andrew Selous:** Yes. Are you able to give us an update from your perspective on the GIRFT programme and the savings and improvement to patient care? It is quite important that we focus on patient care. We often just look at “X” billions, but if you think of a patient who has had the right operation rather than the wrong one and is saved a lifetime of pain, it is very important.

Professor Ham: We are really supportive and excited by the GIRFT work. Ian Dalton will be more on top of the current numbers on the financial savings or productivity opportunities than I can be, but you are right that the benefits are around safer care, higher quality care and not just more cost-effective care.

The analysis that Tim Briggs did in orthopaedic surgery demonstrates that, with some hard data supplied by hospitals themselves. The variations in infection rates after orthopaedic surgery are significant. The litigation costs of hospitals vary widely, and he would be the first to say if he were health Minister that he would put no more money into the NHS until those variations had been addressed and waste reduced.

I think he is overstating his case, but, if you say that for orthopaedic surgery, we know there is data coming forward for other surgical specialties and medical specialties demonstrating exactly the same picture. Focusing on clinical variations and having that credible



experience, clinical leadership, nationally and locally, feels like a very important part of the plan that is now being put in place.

Anita Charlesworth: We are talking about the five-year settlement for funding, but it is to be accompanied by a 10-year plan for the service. I think the Getting It Right First Time and RightCare programmes have been fantastic at identifying the opportunity to go for and highlighting that quality and productivity improvements are not alternatives; they often go hand in hand. But once you have identified that variation in practice, what we have seen over and over again across healthcare systems—we are not alone in this—is that it is the devil's own job to reduce that variation and spread the best practice.

By and large, everyone in the NHS goes to work every day to do a good job. They are not delivering those poorer outcomes or that inefficiency intentionally. The work on the skills and support for quality improvement in clinical teams, the sustained effort, the ability for people to access data on how they are performing, have people who are supporting them to understand that data and to see how they can deliver services in a different way needs to go in once the GIRFT analysis has been done. You cannot do that work without stable teams of enough people who have some time and headspace as well as practical support.

This transformation agenda and transformation funding is not just for new care models where we are shifting services from one setting to another. The task that Getting It Right First Time identifies is a transformation task within our hospitals to reduce variation and standardise good practice. That also needs to be supported in the same way.

Sally Gainsbury: None of these numbers makes any sense without assuming that the NHS will continue to make huge efficiency savings every year. The cash increase for the new settlement is 5% extra a year in cash terms. NHS inflation is running at around 3% once you factor in the new pay rise. Demand has increased by 3% as well. That is 6% pressure against a 5% cash increase each year. Obviously it cannot be done. There would be a £10 billion deficit by the end of the funding period. All our assumptions and the figures I have given you assume that the NHS will continue to make around a 2% efficiency saving each year. The NHS will fall over if it does not at least absorb the first 2% of any inflation.

Chair: Thank you.

Sally Gainsbury: That is what is assumed.

Chair: That is a very helpful point, thank you.

Sally Gainsbury: That is around about the Carter figure as well, by the way.



Chair: Thank you, Sally. Andrew has a quick follow-up point.

- Q16 **Andrew Selous:** We always seem to look at one side of the equation and never seem to think about lifestyle and whether serious change in people eating more healthily, exercising more and doing lots of things would reduce demand on the NHS. Have the three of you given up on that ever changing, or do you think we could make serious progress on diet, exercise and health as opposed to treating illness?

Professor Ham: There is huge scope, Andrew. We have done some work recently in trying to understand what the deal is between the public and the NHS, and what it should be going forward around what we should be expected to do on living healthy lives, and what we should expect of the NHS when we need care and support.

Perhaps we do not have that balance right at the moment. Of course, we need to understand that not everybody is equally capable of changing their dietary habits and taking exercise, and we need to support them. It is not about blaming the people who are victims of the system but about enabling them to make those healthy choices. That might mean being much more explicit about what the deal is going forward, how we can support people to do what we hope we would all do, and what other things the NHS needs to do and commit to in order to make that happen.

Anita Charlesworth: This is another point where the public health agenda is really important. Spending on smoking cessation services since 2014-15 has been cut by a third. That is a highly cost-effective intervention. We know that if we can reduce the rate of smoking we will have a very rapid impact on people's health.

- Q17 **Andrew Selous:** Are more people smoking now?

Anita Charlesworth: No. Smoking rates are going down. Nevertheless, we still have the seventh or eighth highest rate of smoking across the EU15. We have got better compared to ourselves but we are far from best in class in the world.

If you look at the work our organisations did for "NHS at 70" for the BBC, where we were looking across countries, one area we do poorly at is respiratory. If we could support the number of people with COPD who are still smoking to stop, that would make a really big difference to them and outcomes.

Chair: Thank you. I am conscious that we are running rather behind, so I am going to move on to our final group of questions from Lisa.

- Q18 **Dr Cameron:** Given what has been said, do social care and public health need the same degree of funding uplift as the core NHS budget? What are the implications if social care and public health are underfunded?

Anita Charlesworth: The analysis for social care, the estimates, is that just to keep pace with the demographic changes—and these results come



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from the LSE's analysis—we would need increases of around 4% a year. It is important to note that that is based on the current quality and access to care and the current means-tested system, so it is 4% to stand still.

Almost everybody agrees that quality and access to care are inadequate. As Sally has described, there is real financial fragility in the acute hospital sector, so the Competition and Markets Authority has identified very clearly that at the moment the rates that local authorities are paying to care homes are not enough to cover the costs of decent care. Any attempt to improve quality, access or any reform of the means test, such as a cap or a cap and floor or whatever, would cost considerably more than that.

We have seen public health cut since 2014-15. To get back to where we were, you need further increases, again around the 4% level.

Q19 **Dr Cameron:** Does anyone else wish to answer?

Professor Ham: The follow-on from that is that the Chancellor said a day or two after the Prime Minister's announcement that the cupboard is now bare; whatever extra funding there was is going into the NHS, and other spending Departments should not have high expectations, which creates a worry that we will see the same impact as we saw in 2015 on those two budgets.

Q20 **Dr Cameron:** Would it be better to have a combined budget for the NHS, social care and public health?

Professor Ham: Yes, in theory it would be, but there is a bigger issue that the Green Paper is, I hope, going to address, which is: can we put social care funding in particular on a much more sustainable basis, because the reliance on the combination of national and local taxes is not delivering and it is very inequitable around the country?

We have been arguing for some time for perhaps a new settlement with a single ring-fenced health and social care budget where, over time, we could progressively align the entitlements to social care with the entitlements to healthcare. That has big implications around where the money would be found. We have argued that most of it would have to come through the tax system rather than relying on people to make their own contributions.

Q21 **Dr Cameron:** What assessments have been undertaken on the cost savings that public health interventions bring to NHS services?

Anita Charlesworth: Public Health England does an analysis of the key public health interventions, but I would argue that it is the wrong test. We set a much higher bar for public health than we do for other healthcare interventions. When we offer someone cancer treatment, we do not say, "Will this reduce cost?" The overall analysis of the rate of return on public health interventions is that they are slightly better value



for money, as it were, than healthcare interventions, which is common sense, I guess. The bias away from public health interventions makes no sense in the overall efficiency and sustainability of the system. It will not make the service cheaper in the end, but it will make the service better value.

Professor Ham: Of course, some of the most important public health interventions require Governments to regulate and to legislate, as we saw around smoking control. There is no financial cost, but there might be political cost in doing that.

Sally Gainsbury: While you are thinking about other elements of the Department of Health and Social Care's budgets that are not captured by the NHS England bit, obviously there is capital, which I have already spoken about, but Health Education England's budget is not covered by this funding settlement. I think I am right in thinking that is about £4 billion, of which £3 billion goes directly to hospitals, generally—half of that to cover junior doctors' salaries, or elements of junior doctors' salaries, and the other half to cover the costs of training and hosting those doctors while they are learning.

In the one year between 2015-16 and 2016-17, hospitals were down about £150 million on that income. I am sorry, that is also including R and D income from the Department of Health and Social Care. When those budgets are frozen in real terms, which is what has happened since 2015-16, it does come back round to bite the frontline quite directly, so we need to think about all these budgets and what they contribute to the health system.

Chair: Thank you. I wish we could have had longer, but we really appreciate your thoughts this afternoon. Thank you.

Examination of witnesses

Witnesses: Julie Wood, Chris Hopson and Niall Dickson.

Q22 **Chair:** Welcome to our second panel. I think you were all here listening to the first panel's answers. Will you introduce yourselves to those who are following from outside the room, starting with Niall Dickson?

Niall Dickson: I am Niall Dickson, chief executive of the NHS Confederation.

Chris Hopson: I am Chris Hopson, chief executive of NHS Providers. We represent all the 229 community, mental health, ambulance and acute hospital trusts.

Julie Wood: I am Julie Wood, chief executive of NHS Clinical Commissioners. We represent all the clinical commissioning groups across England.

Q23 **Chair:** Thank you. May I go straight to the point of asking you all where



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you would like to see this money directed? We have heard from the previous panel about whether it is enough, but we would like to focus on where you would see we can get best value from it.

Niall Dickson: The first point to make is around the overall settlement. You have heard a lot of these arguments already, so I will try not to repeat things that have already been said.

While this is a large sum of money, it does not represent the kind of increase that will automatically transform the service. There is a real danger that we repeat, arguably, the mistake or the situation in which we have found ourselves in which we simply prop up the existing system and find ourselves back exactly where we were.

Accepting the fact that 3.4% is on a narrow base—it does not cover those areas you have just been hearing about, which includes training and capital, and obviously it does not cover social care and public health but is simply confined to that area—there will be relatively little money after the pay uplift is included over the next few years. That means that the opportunity to spend on new and different things may be much less than people realise.

I suppose one of the first things to do is to lower expectations and be absolutely realistic about what the service can and should do over this period.

One key area that we have to do that we have not successfully done before is, if I can put it this way, to industrialise the process of developing new ways of delivering services in the community. The fundamental question that underlies all the problems that this healthcare system faces—as do all healthcare systems in developed countries—is how you manage the increased demand that Anita and her colleagues identified in the report they did for the Confederation. How do you manage that process?

It seems to us that this is an opportunity—accepting the fact that, especially in the early years, there is not an awful lot to go on—to identify and ring-fence a transformation fund, which absolutely has to start looking at how you introduce new ways of working that will eventually reduce demand on the hospital sector. If we do not do that, we will end up in the position that we are in now, which is that you will throw money at the existing system, you will attempt to prop it up and you will fail to do so.

Chris Hopson: For us, that is exactly what the NHS 10-year plan is designed to answer. The way we are thinking about it is that there are four different buckets where you could spend the money: one, you could recover performance and finances; two, you could just keep up with the cost and demand that Sally was talking about; three, you could transform, and Niall has talked about a transformation fund; four, you



could make an investment in some of the enhanced performance that people have been talking about—for example, cancer and mental health.

I was listening with real interest to your question about where are the hard choices. Let me give a real and good example of the hard choice. If we wanted to meet the cost of the pay rise that we are already committed to, to recover the 18-week elective surgery target, which as we know is 92% within 18 weeks, or to recover the 95% four-hour A&E target, if we wanted to deal with the very significant maintenance backlog that has built up—and I am not talking about the whole backlog, just the high and significant risk backlog—and if we wanted to deliver the Prime Minister's stipulation that we should eliminate the provider sector deficit, we think that probably means that the entire £6 billion increase in 2019-20 would be used up to effectively just fill in the gap that has opened up, before you even started thinking about transformation and enhanced performance offers.

I thought Amyas Morse, with his customary perspicacity, had it absolutely right this morning: very welcome though this money is, nobody is pretending that this increase is doing more than sustaining current services. I thought that was a very salutary and helpful contribution to the debate.

Q24 Chair: If you wanted to shift money into ring-fencing transformation, which of those would you want to give in order to do that?

Chris Hopson: We have already committed to the pay rise. There is an £800 million cost this year and it is £4.2 billion across the entire three years, so that is another £1.7 billion that needs to come if you do flat profiling in 2019-20 and 2020-21. So there is £1.7 billion of the £6 billion.

Clearly, we need to debate what timescale we would want to see the performance standards to be recovered and indeed whether we want them recovered at all. For example, the Prime Minister did say in her speech that she would be interested to see whether we should maintain those targets.

The bit that particularly worries us at the moment is if you were to literally tot up all the indicative commitments that were made in the speech, in the parliamentary statement and in the two media articles that were written over the weekend when the funding settlement announcement was made, and put a price list against all of them—recovering, transforming, IT, genomics, pay rise, and so on—there is absolutely no way it is anywhere near 3.4%, which is why we have said clearly, and I think Niall said exactly the same, that some really hard and difficult choices are needed here.

Julie Wood: In effect, I am going to say exactly the same. Chris mentioned recovering the provider deficit position. We are also seeing an



increasing commissioner deficit position, so that needs to be on our list of things that need sorting.

For us and our members, transformation has to be the key because—and I repeat what my colleagues have said—if we do not absolutely radically transform the out-of-hospital offer in terms of primary and community services as well as really being serious about prevention and public health, we will just be back where we have found ourselves. We have to take a very deep breath and somehow ring-fence that transformation fund; but, as colleagues have said, that will mean choices about how fast you recover, where you recover and where your priorities lie in delivering on the expectations of the service, as well as very difficult choices.

You saw at the weekend publication of the NHS England work on which we have been working with them about evidence-based interventions. That is the first tranche, looking at how we focus our ideas, our thinking, about interventions that maybe do not work or only work in certain circumstances but on which we are currently spending a significant amount of money. We need to get serious about getting them out of the system to liberate some resource to help pay for some of the other things that colleagues have talked about.

Q25 Martin Vickers: Mr Dickson, you specifically mentioned—I wrote down the phrase you used somewhere—that we need to lower expectations. Will you elaborate on that a little, please?

Niall Dickson: Chris touched on it. First, there are the political aspirations and to acknowledge the fact that when we were trying to campaign with others to get an increase we probably hoped for more but feared we would get less. This is a considerable increase. It takes the NHS back to the kind of figure that it was used to certainly prior to 2000. It was around 3% and 3.5% over the whole period from 1948 to 2000. It left the service, I have to say, at that point pretty underfunded, but it had met most of its objectives. So we are reverting to that.

The danger in a reversion is that people think that it is all fixed. First, there is a slight tendency in the Treasury to believe that if you put more money in you have solved the reset problem, and you have not solved the reset problem. Chris described the reset problem a moment ago. For example, you would have to do 600,000 additional operations—over 4% more—just to try to get back in terms of the backlog. You can see that in almost every single area.

I know the politicians want something shiny, something about which they can say, “Look, we have done this,” and so forth, and that simply saying, “Things are not as bad as they would have been” does not sound great when you have taken a political risk and possibly asked the British people to pay more.

That is why I think that going down the transformation route, although it will mean hard choices about, for example, slowing down the pace at



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which you can pay off the deficits or slowing down the pace at which you can reduce waiting lists and times, may free up funds to be able to do that transformation.

Quite rightly, alongside that—and I think the Government are right to have expectations of the service in this—there is a reasonable question to ask of the service: how do you reduce unwarranted variations, how do you reconfigure services, and how do you get back office into a better place than it is currently?

There are things that the service absolutely wants to do and embrace, but again the centre has to put the enablers in place for them to be able to do that.

Q26 Martin Vickers: The expectation of the public, whether it be five, 10 or however many years, is for better outcomes. What can they expect? Will there be better outcomes in survival rates and the like?

Niall Dickson: There will be better outcomes because that is certainly the history of the service throughout all its period, and I think that will go on happening, but you can have better outcomes on the one hand and on the other you can have increasing numbers of people whose needs are not being met. That is the danger. We will continue to have, not least because of increased technology and some changes of lifestyle and so forth, better outcomes as medicine improves and as the way we organise healthcare improves.

If we can get better integrated services, the experience, which is equally important in terms of outcome for many people, will also become better. Services are too fragmented at the moment. If we can get a better way in which we deal with our supply chain, which is being tried out successfully in some parts of country—again, if we can industrialise that—then we will meet that as well as producing longer lives, with a better quality, which is the key point: even though people may be suffering from a range of long-term conditions, the quality of their life during that period is better.

Q27 Martin Vickers: Does anyone else want to come in on that?

Chris Hopson: No. I think Niall has answered the question.

Julie Wood: Yes, I think so.

Q28 Chair: When you use the term “industrialise”, that makes the public nervous because they want to hear the term “personalised”, not “industrialised”. I know what you mean is having a service that is based around patients, but I presume what you mean by that is that you plan it at scale rather than—

Niall Dickson: I do not mean industrialised in that sense. Maybe it is the wrong term, but what I am trying to describe is a frustration that I think many in the service feel. We had, for example, the vanguard projects,



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which produced some interesting results, and it is this frustration that actually we need to do this everywhere and it is no use having—

Q29 **Chair:** So it is at scale.

Niall Dickson: It is everything at pace and scale.

Julie Wood: Turbo charge is a way of describing it.

Chair: I wanted to clarify that because people hearing it might feel something different. Rosie has a supplementary.

Q30 **Rosie Cooper:** I hear lots of comments about hard choices. The future depends on really good management, competency and efficiency, yet NHS England now announces and tells the British people that in these austere times we have been wasting shedloads of money on operations that everybody is gaily now signing up to saying were not necessary, were useless, or whatever it is. How has that been allowed to happen? Who is responsible for that? How come British taxpayers' money has been wasted if what is being said today is correct? How has British taxpayers' money been allowed to be wasted on things that are of no use?

Why are we wasting millions on useless audit? Everything I have looked at recently suggests that when there is a problem auditors just pass it by. You are now saying this system depends on every penny. What confidence can we have, if this is an example, that it can be delivered, because I do not have a lot?

Chris Hopson: I will let Julie answer the specific on the clinical issues because she has been working on them, but on the point about how efficient the NHS is, the latest OECD report, which effectively looks at all of the industrialised advanced health economies and measures what percentage of health spend is spent on administration, if you go to America—

Q31 **Rosie Cooper:** I get all that. I want to know why you have wasted taxpayers' money.

Chris Hopson: My view is that I do not think we have wasted it. The view would be that you need to ensure every penny, as you are suggesting, is spent wisely. We are now, therefore, looking at the places where there is unwarranted variation but also where there are operations that are of less effective use as treatments have developed—that is, alternative treatments have developed that effectively mean that you do not need to carry on, for example—

Q32 **Rosie Cooper:** Why didn't these happen incrementally as those increases in ability and efficiency, or changes of practice, took place? Why are we waiting for the big bang?

Chris Hopson: Julie, this is your area.



Julie Wood: They have been happening incrementally and that is part of the frustration. Clinical commissioning groups have been working on these areas. For the first time we have brought together the national arm's length bodies, so NHS England, NHS Improvement, the Academy of Medical Royal Colleges—so you have professional input—with NHS Clinical Commissioners, to look at how we have a systematic focus on these across the whole of the country, not just in some parts of the country, to focus energy on liberating those resources.

For the first time, we have pooled it together and got it on an integrated basis. It is part of the frustration that the service has felt at not being able to do that until now. It has been happening—and some have absolutely done this—but we need to make sure that we ramp up the scale and the pace. We need to make sure that my colleagues sitting to my right, who represent provider interest and the system interest, are also very much on board—and they are—with making sure that we look at all the levers and focus on getting those operations that should only be performed in certain circumstances delivered in that way.

Q33 **Rosie Cooper:** So you can expect jolts every now and again. Niall?

Niall Dickson: There is a sort of wider underlying point about the relationship between the service and the medical profession. If you have absolute clinical autonomy, people will go off and do their own things. I think we have seen an erosion of clinical autonomy, and the profession, to be fair, has embraced that, although it has taken quite a bit of time. So, at one time it was, "I do the operation, I have decided I am going to do this, and you will pay for it because I have decided that is the right thing." That has gradually been eroded over time, and there is now recognition within the profession itself—and indeed a duty on individual doctors—that they use resources wisely. It is a coming together of those things that should allow us to do this.

Again, you can look at other systems around the world where a lot more medical interventions are allowed to be got away with.

Chair: Thank you. I think Andrew has a group of questions on efficiency, so shall we—

Q34 **Rosie Cooper:** Apologies, but could I just ask one quick question about audit, if I may? We are wasting millions on audit.

Julie Wood: We certainly need to look at a whole host of activities where there are frustrations perhaps across the commissioner and provider part of the service, where we are spending too much time on limited-value-adding activities. Both Chris and I have talked about CQUIN as an area where we are spending time.

Q35 **Chair:** Those who are following from outside might not know what CQUIN is.



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Julie Wood: I am sorry. It is commissioning for quality and innovation—a scheme set up with the reforms to incentivise change. Unfortunately, it has not had that effect, so we are spending time on a number of activities where we need to have a very hard look at whether they are worth the time we are spending. Audit may be one of them to some extent.

Chris Hopson: But, as ever, there needs to be an appropriate balance. Certainly the trust leaders we talk to say they feel they are spending too much of their time and resource needing to assure the level that sits above them—NHS England and NHS Improvement—but, on the other hand, Rosie, we are talking about £110 billion of taxpayers' money.

Q36 **Rosie Cooper:** Absolutely, but I have not spotted anything that you have managed to get yet.

Chris Hopson: I think it is appropriate that accounting officers, some of whom are managing £1.5 billion-worth of public money every year, should properly account for their spending, and that would include, for me, a proper financial audit each year.

Q37 **Rosie Cooper:** I absolutely agree. I just need it to be efficient, to actually deliver. As far as I can see, not one of those auditors has managed to spot anything in any of the big stories of the last five years, so don't give me that. Yes, it does need to be there, but it needs to deliver for the money the taxpayer is paying. These auditors are not doing it. They are walking by, and I will ask the same question to Simon Stevens in a minute, but it is a point to be made: we are wasting millions.

Chair: Andrew has more points on efficiency.

Q38 **Andrew Selous:** I do. I guess this is at the other end of the scale, but it is one that the public raise repeatedly with all of us as constituency MPs—the one about medical aids and devices. You get given a set of crutches, a commode and even quite an expensive bed to take home. It is perfectly serviceable and it can be disinfected and re-used. It is virtually impossible to return this sort of thing. Are we wasting a lot of money in this area?

Chris Hopson: We know there are some hospitals that are now starting schemes that enable you to bring back appropriate medical aids that can be recycled. Again, we need to be careful about working out cost of collection and disinfecting and all that kind of thing, and also that they are appropriate; some medical devices are clearly personal to the individuals.

Can I just make the general point, though, that, in terms of efficiency in the system, the NHS over the last five years has realised annual productivity gains of about 1.6% a year? That compares to the whole economy average of 0.2% a year.



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One problem we have at the moment is that NHS trusts have been set an impossible target over the last four years because we made some over-optimistic assumptions about efficiency. We all know there are things that can be done. I know, Andrew, you have been working hard with Tim Briggs on GIRFT. We think there are some really good opportunities there and we have talked about them with the previous panel. We need to be realistic, though, about how quickly we can get to those, and not make the mistake that we did under the five year forward view of coming up with an over-ambitious set of assumptions and then setting providers a task, the vast majority of whom have missed that task, however hard they worked. We need to ensure that, allied to funding, we will be setting the NHS an efficiency and productivity ask over the next four or five years that is realistic and sensible.

Niall Dickson: I think it also needs to be linked to what is expected to change. I am not in favour of a Stalinist approach but of identifying very clearly the areas that are expected, not just in one area of the country but everywhere, as it were, and there are savings. There are savings on estates, and again people are not starting in the same position; they are all in very different positions. There are issues of back office where again some areas have done spectacular things in reducing their back-office cost. There are issues of reconfiguring services, and in particular duplication or inappropriate clinical appointments in some places that could be rationalised with others to make a more effective service, never mind a more efficient one. There is a whole series of such areas, not least around clinical pathways: the GIRFT stuff, all the work that Carter or Naylor and all these people have done has identified areas.

Probably the challenge to the centre, instead of just coming up with an unrealistic figure that people cannot deliver, is to say, "These are the things that we would expect to happen at local level," and then hold people to account for delivering them.

Q39 **Andrew Selous:** One key difference with GIRFT and some other efficiency programmes is that the datasets that have been used and agreed are all clinically led, and that perhaps has not always been the case, so hopefully there is buy-in from clinicians.

In the earlier panel we heard the good point about having the capacity within the system to learn from the top performers. Can you say a little bit on how that is going in realising the benefits?

Chris Hopson: We did a very interesting round-table with our members last year about GIRFT. What absolutely came across was real recognition, exactly as you are saying, about the potential benefits that that data can bring, but they then were describing to us the process that you need to go through.

First, you need to gather all the clinicians together, which at a point when effectively you are talking about very specific operational pressures is no mean feat in itself. Quite often, most of the trusts were saying they



needed to go round that data two or three times to be absolutely sufficiently confident, and tweaking it here and there to get something that they agreed was an appropriate representation. They then had to spend the time to work out the difference between the warranted variation and the unwarranted variation, because we know that there are some good reasons. If you are in Cornwall and you are absolutely isolated from other trusts, you will find that your case mix and, for example, the costs of employment and a number of different things may change.

Once they have identified unwarranted variation, they were saying to us that there then needs to be discussion about exactly what physical changes need to be made to clinical practice. You then need to embed them. They were saying to us that the data started a really good and helpful conversation, but, "Please do not underestimate the time that is then taken to reach the end point of properly embedding a bunch of changes." They were specifically saying to us, "If you look at the data analytic resource that is required, the change management resource that is required and the project management resource that is required, those are things that we do not necessarily immediately have around. We are all fans of GIRFT and we all think it offers the potential, but we just need to be realistic about how quickly we can change clinical practice on a consistent basis and what resource and support is needed to deliver that."

Niall Dickson: It is the resource and support plus clinical engagement, because again there is varied clinical engagement around the process, so getting high levels of clinical engagement is the first step towards it.

Chris Hopson: Exactly.

Julie Wood: That is why we have started with the 17 interventions, with the evidence-based interventions programme, because that is clinically led. Get the clinical buy-in from people who are providing the care but also CCG leaders, and then you can start to make some changes and hopefully make them quite quickly over the country.

Q40 **Andrew Selous:** Looking at geographic variation, the IFS report, I believe, pointed to the fact that hospital activity had increased to a much greater extent in England than it had in Scotland, Wales or Northern Ireland. Do you have any comments on what that reveals and whether there are lessons to be learned from it?

Chris Hopson: Our view would be—and we are not a cross-UK organisation; we are an English organisation—that demographics explains part of it, but it is also the nature of the system. Scotland, Wales and Northern Ireland tend to be more integrated; there tends to be a better balance between health and social care. We know, don't we, that one key driver of increased hospital activity in England over the last two or three years has been the somewhat parlous state of social care in a number of



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local health and care economies? We think those two reasons are interesting possible explanations.

Andrew Selous: So roll on the social care Green Paper and the joint plan this autumn.

Julie Wood: Yes, absolutely, and the focus on transformation. We have to move to integrated out-of-hospital offerings fast so that we can do something about the rise that will otherwise happen if we do nothing.

Niall Dickson: If you look at the incentive system in England, which has driven acute sector activity—basically, a turnstile on the top of every hospital, as it were—with nothing equivalent within community services, you can see how that might arise. Again, you have to be very careful and caveat all this with the comparison between the different parts of the UK—and certainly some more work is required. But, as Chris says, integration, the way in which we have incentivised our system in England, may be a part and it also may be that some aspects of social care in Scotland may be more generous and therefore may be dampening demand on the acute sector.

I do not think we have hard evidence around that, so we need to be very careful. We are certainly encouraging the idea—although we do not cover Scotland, we cover Wales and Northern Ireland—of better information sharing across the four systems, which, dare I say, is not about trying to show that one political system is better than another, or indeed that one system is better than another, but that we start to try to understand the things that are going well within one jurisdiction and encourage cross-fertilisation across the UK. It has been one of the partial victims of a devolved system.

Q41 **Mr Bradshaw:** May I ask you about another issue that might affect all of your finances quite dramatically in the next few months—Brexit—and exactly what contingency planning your organisations are doing for a no-deal Brexit in less than nine months' time?

Niall Dickson: Shall I start? I co-chair the Brexit Health Alliance that brings together industry and research, the NHS and other bodies, including NHS Providers and Clinical Commissioners. We have been pressing for some time for Government to face up to the possibility that there may be a cliff edge in March 2019. We were aware before the announcement over the weekend that the Government were starting to do that.

There is a natural wish—and I understand this—not to cause people to panic about a situation that may very well not happen, but the reality is that it could happen and therefore planning needs to take place.

There are different layers of the planning that need to take place. First, there is the question of what, at a national level, can be done to make



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sure that there are not shortages of supply and, if necessary, warehouses, or whatever else, are built to ensure that.

People are not as aware that the NHS to a large degree works on the “just in time” basis: for an operation that is being done across the road, some of the materials will actually arrive the day before to make that operation happen.

It is important to understand the levels of dependency—the fact that 45 million packs of drugs leave the UK every week and 37 million packs come in every week. If that were all suddenly to judder to a halt, we would find ourselves in a very difficult situation. We need to plan at national level about how we avoid this happening at all, and, if some of it is going to happen, what mitigating steps are going to be taken.

At local level, it is important that boards within NHS organisations—and they are already starting to do this—look at their own procurement, their own supplies and work out what their vulnerabilities might be.

There is then the staffing side, which I think is quite a significant issue.

It has to be said, though, that the migration policy post-Brexit is a matter for the UK Government. In a way, if the UK Government are willing to be open-minded and to see the advantages that EU staff bring, that, in theory, should not be a problem. The bigger problem we currently face is, frankly, the uncertainty, which is what affects so much of this debate and is leaving staff feeling uncertain, whatever assurances have recently been given and the encouragement to register and so forth.

Q42 Mr Bradshaw: Are you being given the level of detail that you need? You mentioned, Niall, the “just in time” nature of a lot of these tens of millions of movements of vital medicine and equipment, but some of it cannot be stockpiled because it has a very short lifespan. What are you being told will happen if the ports and airports seize up and the certification and licensing of batches becomes obsolete after a cliff-edge, no-deal Brexit?

Niall Dickson: We are being told that there are plans. We have yet to see those plans.

Q43 Mr Bradshaw: You have been given no detail at all.

Niall Dickson: We have not been given the plans and, of course, the plans will be, we are told, shared, so we will see—

Q44 Mr Bradshaw: Have you been given any idea when they will be shared? This is not very far away.

Niall Dickson: That is the point. There is a need to make clear what is going to happen at what point, and it needs to be enough time for decisions to be made ahead of March 2019.

Q45 Mr Bradshaw: When will it be too late for you to do that?



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Niall Dickson: I am not sure that I am absolutely qualified to answer that question. It depends on some of the detail around it, but I certainly would hope that by the autumn we would be able to—

Q46 **Mr Bradshaw:** Lots of private sector companies are moving overseas and making contingency plans for worst-case scenarios, but are you not leaving it a bit late?

Niall Dickson: Industry is already having direct discussions with Government about what it needs to do. I think you would have to ask them whether they think those discussions are fruitful or not. Our perception at the moment is that they are working on this; it is ongoing. We have not been privy to the detail of it.

Chris Hopson: At trust level, as Niall has said, people have been immediately focused on some of the workforce implications of Brexit. Given that we are talking about the levels of staff shortage that we currently have—10% of the workforce in vacancies; in some places I have visited there is a 20% nurse vacancy rate; and I came across a 27% doctor vacancy rate in one trust the other day—people have been focusing on a number of workarounds to solve those problems as the number of staff coming from the EU have dropped.

There is an assumption from trusts that on the kind of issues that you have been talking about, exactly as Niall has said, there are national-level conversations going on and that at the appropriate point trusts will be informed of exactly how that is going to work.

Julie Wood: As clinical commissioners, we are involved in the work that Niall has talked about, but specifically with regard to medicines I am involved in the Medicines Value Programme board. One of its tasks is to look at the implications, as you describe, on medicines' supply and price, so I have seen earlier conversations going on about what those plans might look like. I do not have the plans, I do not know what they look like, but I know specifically from medicines in primary care as well as medicines in hospital that this last year we saw some unexpected price hikes and shortages of supply of certain drugs. Partly that may have been due to concerns about Brexit, so we need to make sure that we do not have those sorts of issues happening again.

Q47 **Mr Bradshaw:** Could you give us a bit more detail about that—price hikes and—

Julie Wood: That was about drugs for which no cheaper supply is obtainable—NCSO drugs—that basically have been prescribed by GPs and pharmacists have not been able to supply them, so there is an agreement for a short-term price increase to pay for supplies from somewhere else while the shortage of supply is being sorted out.

Q48 **Mr Bradshaw:** Can you give me an example of what some of those drugs were and what they are used to treat?



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Julie Wood: I cannot remember the detail. I can certainly provide you with it.

Mr Bradshaw: It would be helpful if you wrote to us about that.

Chair: A detailed note if that is all right.

Julie Wood: I can certainly do that for you, Sarah.

Q49 **Luciana Berger:** You mentioned a moment ago the issue of workforce, and we have covered it a bit on this panel. When the announcement of funding was made, Chris, you said that it needs to be accompanied by an NHS workforce strategy that copes with growing and changing demand. Can you elaborate on that a bit further and tell us what you believe is required and where the gaps are?

Chris Hopson: When you talk to a lot of trust chief executives, they say—almost as directly as well: “It would be great, but even if you did give me more money, actually I cannot find the staff to increase the capacity.” We know that we are now in a period where we have a significant deficit in the number of people coming into nursing, into being GPs and doctors. We know that there is a time lag to catch up because they take time to train, so we are in a period—the NHS Pay Review body was saying so last week—until 2023 where we have this shortage of workforce.

Therefore, we really need to focus on how we can mitigate that in the short term as well as ensuring that the long-term pipeline is sufficient so that we get enough people who are coming through as domestic nurses and doctors.

In the meantime, I am afraid we are going to continue to be reliant on doctors and nurses from overseas, which is why the tier 2 visa cap being lifted was so important and why we need to do everything we can to retain as many doctors and nurses. We know that a number of them are going into retirement early.

Part of the issue is—and again I am sure Simon Stevens will explain that there is a piece of work due to be announced, I think, later this week—the offer for staff. One concern would be, okay, it is great talking about more flexible working, but if in the end the job becomes so difficult to do because of this mismatch between the demand and pressure in the service and the number of the workforce available to deal with it, then, however much you do around the margins, you have to make the job a really worthwhile and effective job to do.

It is in a number of different areas where, bringing all those together, we need to have a more coherent strategy than we currently have. For me, okay, it is fine having the long-term pipeline sorted out by having more doctors and nurses coming through the UK education system, but what are we going to do for the next four or five years as we suffer from these gaps?



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Q50 Luciana Berger: On that, are you confident in both the current vacancy rate plus the projected figures of what the NHS will need going forward? The report from the Health Foundation, Institute for Fiscal Studies and the NHS Confederation says that we will need 74,000 extra hospital doctors and 171,000 extra nurses over the next 15 years. What is your prediction for that five-year period?

Chris Hopson: Recent history has been—and there is a clear danger that the forthcoming history will be—littered with examples of where people have said, “We need X many more” of whatever it is, and then we have found that we have been simply unable to generate sufficient supply to meet the demand. It is great having people come up there saying, “The demand means we are going to need to have X more of these,” but, unless you can find people who are sufficiently qualified and trained to fill those gaps, the statements of however much extra you need are basically for the birds.

GPs are a great example. People have said we need a lot more GPs, but we are now finding that the number of GPs is going down, not up. People are retiring early because the job is so pressured.

This is why we have been saying that we absolutely welcome the draft workforce strategy, but one thing we think it is light on is what we do in this three or four-year gap where we are going to suffer workforce shortages. Even if we were to make it much more attractive for people to come through the education system, we have a lag before those people arrive.

Niall Dickson: You do need to fund that education system, and we have not yet heard on that very point.

Chris Hopson: Precisely.

Niall Dickson: Historically, the NHS has over-relied on overseas staff, not because they are not brilliant, because actually we would not have a health service without them, but because we have not trained enough, and probably for two reasons. Maybe there was some professional self-interest in keeping numbers down, but if the state is funding them it is much cheaper to recruit people from overseas.

There is recognition now, I hope, that that is neither an ethical nor a sustainable policy going forward. It is right that professionals move around the world, and that is great and they get experience from coming here or experience from going there, but a country like ours should be able to produce enough of what we need ourselves, and we need to invest in that process. I hope that is beginning to go right, although we will have to see what the funding thing is.

There are, of course, things that can be done at a local level around retention, and NHS Employers, which is part of the Confederation, has done quite a lot of work on this in improving flexibility. The new



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generation of staff do expect different things, and simply treating them as if they were 20th century people will not work. So there is recognition of a change there.

Then there are probably things—first, the pay uplift has been helpful—that the centre can do. I am not sure that the Treasury has been terribly helpful on the pensions front as one reason the doctors are retiring is the way their pensions work.

It is really welcome that there is now going to be a workforce strategy, but it will need to be realistic and funded. As Chris says, there is both the short term, “What do you do on this?”—you cannot just invent these people—and the long term, where to train a consultant takes around 15 years, so you are looking well ahead. To be honest, if you look at the NHS 10-year plan, the vast majority of staff who will deliver the NHS plan are already in post. They are not new people; they are already there.

Chair: We have gone past our time, but I am going to take one quick supplementary from Andrew.

Q51 **Andrew Selous:** Can you give us three or four suggestions on what practical things the Government could do now to deal with the GP issue?

Niall Dickson: One, do not just talk about GPs. You have to look at alternative professionals you can train within primary care. Physicians’ assistants, care navigators, all sorts of people can make the GP’s life easier going forward. I would certainly do that.

I certainly wish the Treasury would look at the pension issue.

Andrew Selous: I have raised it with the Prime Minister before and I am doing battle with Treasury Ministers as we speak.

Chris Hopson: One thing I find really interesting is that trusts are recognising that they cannot function effectively without primary care in their local system. They are now—Wolverhampton being a great example—if a GP surgery is falling over, saying, “Okay, we are happy to step in.” What is really interesting is the number of people who wish to be salaried as opposed to partners.

One thing I would suggest would be making sure it is as easy as possible for trusts that wish to step in to help local primary care—to help a GP practice often at their own request—which is things such as registration and the complexity of the registration, or ensuring contracts can easily be vired across. There is a whole bunch of things. We are seeing more and more either wholly-owned or joint ventures being created between trusts and a federation of GP surgeries.

Julie Wood: Think broader than GPs—the list that Niall mentioned—but also pharmacists in general practice, community pharmacy and what they can offer, nurse practitioners and a whole host of skill-mix issues that we need to think about.



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Think about pension issues, but also HR issues. If we are looking to integrate health and care, there are some devilishly detailed HR barriers that can get in the way of staff, not just GPs but other staff working across health and care. They need sorting out.

The other thing is about truly enabling the general practice model of care to transform into primary care networks. We have various examples of that—federations and primary care home—but we are looking at reinventing almost what we lost about 15 years ago, which is a truly integrated primary healthcare team based on knowing your GP, your nurse and your allied health professional, with everybody providing personalised care for a population and working together. It is all those sorts of things that need to be enabled.

Niall Dickson: Can I say—not to overuse the word “industrialised”—that that NAPC model, or, alternatively, not necessarily it exactly, but that model where they bring together community services, GP services and community services in one and start working closely with the acute sector, should not be experimented with here and there; it should be happening everywhere? Again, there is something about the centre incentivising and helping to take that process forward.

Julie Wood: I do know that NHS England is working on that. I have just left a call to come here about that, so it is certainly on that, but we need to turbo charge it and get it happening everywhere.

Q52 **Chair:** Do you think we need to go further in making it easier for people to return from experience overseas and to move within the professions and to change their careers?

Julie Wood: Yes.

Niall Dickson: We should not be defensive—going back to my previous role—about doctors who go overseas. The vast majority of them do come back and bring fantastic things with them.

Q53 **Chair:** Indeed, but they sometimes say that we do not make it easy for them to return; sometimes the barriers can be quite high.

Niall Dickson: As employers, we should absolutely make it as easy as possible and regulators should do so also.

Chris Hopson: The bit that I find interesting as I go round is the contortions that trust leadership teams are having to go through to meet 20% nursing gaps and 27% junior doctor gaps. Clearly, improving retention is a key part of that, but, again, as Niall has mentioned, looking at those roles that are not just the traditional kind of doctors and nurses’ roles is pretty fundamental. In the last trust I visited, it was really interesting that they were using ward-based pharmacists to pick up an amount of work that traditionally had been done by nurses to allow registered nurses just to do the work that only registered nurses can do.



We need to recognise that the amount of senior leadership time that it is taking to fill those kinds of gaps and come up with all kinds of weird and wonderful things like overseas recruitment, retention, designing new job models, new rotas and so on, is a very good example of an operational pressure that we are facing in the service that means we do not have the time to do some of the other things that we would like to do—eliminate unwarranted variation, improve efficiency and transform. The service is under huge pressure because of those workforce shortages. Until we sort them out, it is a natural brake on how quickly we can do, for example, the transformation task.

Chair: Thank you very much. On that final note, we appreciate your time this afternoon.

Examination of witnesses

Witnesses: Ian Dalton and Simon Stevens.

Q54 **Chair:** For our final panel, we have Simon Stevens, chief executive of NHS England, and Ian Dalton, the chief executive of NHS Improvement. Welcome to both of you.

Simon, we have a lot to get through this afternoon. We are very interested, first, to know how you are going to go about putting together your 10-year plan and who you are going to involve in that.

Simon Stevens: It is a “we” rather than a “me”. As the Prime Minister said in her speech at the Royal Free Hospital, the Government are asking the NHS to shape this. That means, obviously, the national leadership bodies in the NHS, it means our partners in the medical, nursing and other national staff bodies, and it means many of the patient groups with whom we work, as well as direct frontline leaders. We are going to be kicking that process off by the end of July with a view to then being able to have a plan that could be published in November.

Q55 **Chair:** July to November. Will that go out to consultation to the public as well?

Simon Stevens: We are envisaging there will be several strands to this. One will be that Healthwatch, which has statutory responsibilities for public engagement, will be involved in working locally on this as well as nationally. When the plan is developed nationally, to the extent it is then put into the NHS England mandate, the Government will do a formal consultation on the mandate for subsequent years as well.

Q56 **Chair:** How much of this will be genuinely produced by the NHS under the Health and Social Care Act, giving them much more autonomy, and how much will be directed centrally from the Government?

Simon Stevens: They have been pretty clear that they are looking to us, now that we have the certainty of the five-year funding settlement linked to a set of requirements around workforce and capital over a 10-year period, to set out what can be delivered within those funding uplifts.



Q57 **Chair:** Do you agree with the priorities that the Prime Minister and Jeremy Hunt have set out so far?

Simon Stevens: They are very congruent with the priorities on which the NHS has been working over the last several years: if we want to start with a frank and honest assessment about where we need to improve outcomes, clearly we want to continue to focus on cancer improvement; if we want to think about some of the unmet need in the gaps in care, we clearly need to do more on mental health services; if we want to future-proof the health and care system for the million and a half more people aged over 75 whom we are going to be looking after over the next 10 years, then care integration is going to be hugely important, supported by resilient general practice; and if we want to tackle inequalities and give children the best start in life, we are going to have to look at prevention, obesity, unmet need in young people's mental health services and so on.

There is a very strong empirical reason why those should be the priorities for improvement for health for the nation, so that is a long way of saying yes.

Q58 **Chair:** Great. What we have heard this afternoon very clearly is that, with the funding that is on offer, 3.4%, there are still going to have to be some hard choices—that we cannot deliver everything within that list. We have heard suggestions that, for example, meeting deficits and getting performance targets back on track may have to be the areas that give if we are to focus on transformation funding so that we can make some of the changes to future-proof the NHS. Would you agree with that or where do you see that the hard choices lie?

Simon Stevens: We are clearly going to have to phase improvement. As you say—and it sounds like you have had a realistic conversation in the earlier panels—this is an improved financial settlement compared with what we have had for the last five years, but it still is going to require phased improvement; there is no doubt about it.

Q59 **Chair:** Right. Is there anything else that you would like to say about where you think the hard choices may lie at this stage, or is it too early days?

Simon Stevens: No. That is what we want to use the process for over the next four or five months to really practically flesh out.

Q60 **Luciana Berger:** You mentioned that one of the points is around mental health. In the Government press release that accompanied the announcement on the funding, one priority of the five outlined was better access to mental health services to help achieve the Government's commitment to parity of esteem between mental and physical health. On that, you will know that it is enshrined in law, and has been since 2012, that we should be achieving parity of esteem for mental health. In reality, how realistic is it with the funding settlement that we will see real equality for mental health in this country at the end of that funding



period?

Simon Stevens: That is clearly the journey we are on and we have to use this plan to not only talk about the priorities for the funding but the workforce constraint, because we know that in mental health services, but not just mental health services, the speed at which we can grow the number of therapists, mental health nurses, psychologists and psychiatrists is going to be probably one of the two principal rate-limiting factors in service expansion. Those are very practical constraints that, with our partners, the Royal College of Psychiatrists, Mind, Rethink, YoungMinds and others, we have to work through.

- Q61 **Martin Vickers:** May I press you a little more about what people can expect from this additional funding? I got on the train at Grimsby station to come down to London this morning. I opened my newspaper and read an article that said, "Our weak performance on cancer care compared to Belgium amounts to the equivalent of the population of Blackburn or Grimsby being wiped out within a decade." It then goes on to say that, if I was unfortunate enough to have a stroke, I would have a better survival rate in Germany, Israel and Switzerland. The question is: can the residents of Blackburn, Grimsby and elsewhere expect better survival rates from those illnesses across the board?

Simon Stevens: The answer has to be yes. If that is not being achieved, clearly we will all have failed. We know that actually there have been very significant gains in cancer prevention and cancer survival over the last five and 10 years. We want to lock in and accelerate the year-by-year improvements that we are seeing in the proportion of patients diagnosed early, when it makes a real difference. We also see quite big differences between different parts of the country. In fact, the differences between geographies across England are likely to be as great as the differences between Belgium, Germany or any of the other countries that you cite. That tells us that this is doable and we now have to accelerate that improvement.

- Q62 **Martin Vickers:** Not only will that depend on the increased funding that is going to be available; it presumably will also depend on continuing efficiencies. What efficiencies do you foresee that are still achievable in areas such as procurement, for example?

Simon Stevens: Do you want to take that, Ian?

Ian Dalton: Yes, thank you. I think it is important to start off by recognising the fact that the NHS is already in a reasonable place in terms of its productivity. Listening to York University—credible commentators looking at the period 2009-15—productivity in the NHS was about 1%, which was significantly in excess of the wider UK economy, as estimated by ONS. None the less, the fact that we have the new money will not and cannot be allowed to stop us pushing on procurement, on the unacceptable clinical variations that still exist, that



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allow us to improve patient care, on the management of our estates and on all the other areas on which we can make significant efficiencies.

Already we are targeting £6 billion of cash-releasing efficiencies in the current period to 2021 and we will be keeping the pressure up across all those domains. Actually, I believe there is very significant further opportunity to add to this settlement.

Q63 **Martin Vickers:** I mentioned Grimsby. My Cleethorpes constituency neighbours Grimsby, and Grimsby is my local hospital. Is one of the efficiencies a streamlining of the service? Can residents in provincial towns expect continuing services, or will they have to look to centres of excellence further afield?

Ian Dalton: I will kick off and Simon may want to add. As always, we would be guided by the clinical evidence. You will know about the Getting It Right First Time initiative, which looks across 30-plus specialties with combined revenue spend of £45 billion, a clinically led programme to look at what is going to give patients the best deal. For me, that is the way to have a look at that. There will be some services, if you look at their reports—on vascular surgery, cranial and neurosurgery, for instance—where some changes will be necessary, but they will be led by the clinical evidence in predominant terms. That is where we start this debate from.

Q64 **Martin Vickers:** The clinical evidence is obviously reliant on the specialist knowledge of the medical profession. It is important that the profession and the NHS more widely try to sell that.

Ian Dalton: I agree.

Martin Vickers: The reality is that when politicians do that, people think, “Oh, well, they are trying to save money.” We need the profession to back up the decisions that politicians are forced to make. Is it a reasonable assumption that we can expect that?

Ian Dalton: The benefit of having something that is clinically led means that it is likely that the voices will be more perhaps trusted than those of us who do not have a clinical background. In this process, where those changes are going to be necessary locally—and they will continue to be necessary in the UK as they are in every other developed western economy—it is really important that clinicians, doctors in particular and other clinicians with them, stand up and be part of that conversation with the public, because, at the end of the day, that will hopefully take people with us on this journey.

Q65 **Luciana Berger:** Can I bring you back to mental health for just one moment? You mentioned some of the challenges, particularly around staffing, in response to whether you felt it was achievable to secure parity of esteem for mental health. In your interview yesterday on the BBC’s Marr programme, you said that the 10-year plan has to spell out what improvements in mental health will look like. I wonder whether it is just a case of the increase in the professionals that you mentioned, or is



there anything else you would like to expand on, to share with the Committee, about what you think those improvements are rather than just what the challenges might be?

Simon Stevens: We started off, Luciana, by saying: what is the inclusive process we are going to use to answer the question? We need to ensure that that is what we are doing. But I think there is a big discussion being had, particularly around the extra pressures that young people are experiencing. What is not clear is whether by doing more work with schools—and, indeed, with the social pressures on young people in general—that will offset some of the increased demand we are seeing for specialist young people’s mental health services; if it turns out that it does, then for any given increase in the number of child and adolescent psychiatrists, of whom there are a few—a thousand—in the country, or other health professionals, we will be able to see a higher proportion of the people who need services much quicker.

Those are the judgments that have to be made in the round. We know that for crisis care services and for people with severe and enduring mental health problems beyond the early onset phase, which we are successfully beginning to tackle through the early intervention for psychosis QIPP target, we need more resilient mental health services across the country. We know that we want to better join up what is happening for people’s mental health with their physical health. You know that there are parts of the country, such as Cambridgeshire, that are now doing this, but that is quite a sea change in what the clinical delivery model needs to look like—people with diabetes, congestive heart failure or COPD, ensuring that their psychological support is embedded in their physical health support.

We know that for people with severe and enduring mental health problems, and I might say autism and learning disability, there are many unaddressed physical health problems that we need the mental health services to opportunistically get to grips with. The learning disability mortality review has clearly shown that one of the greatest inequalities that exist across the national health service is the missed opportunities to provide appropriate physical health support for people with learning disabilities.

All of these are on the agenda. We have to work through them and be clear practically about what that would mean.

Q66 **Mr Bradshaw:** Simon, on Marr yesterday you were asked about contingency planning for a no-deal Brexit. Andrew Marr asked whether you could guarantee the continued supply of vital drugs and medicines in that scenario. You did not quite say that you could—you did not quite answer the question—but you said that it was, and I think your words were, at the top of your list on your contingency planning. Will you say a little bit more about that just to reassure us and the public?



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Simon Stevens: Yes. Andrew Marr asked whether the Department of Health is now doing contingency planning for all the potential scenarios and I was able to confirm that “yes” is the answer to that. That has to take account of continuity of supply of medicines, vaccines, radioisotope products, devices and clinical consumables. We have to think about the regulatory, the tariff and particularly the supply chain issues under those different scenarios.

That work is ongoing, but, to be able to crystallise the right response, there is still a little while to go before it is clear what the UK’s position will be. That is the point at which you make the choice in terms of the appropriate planning arrangements.

Q67 **Mr Bradshaw:** Indeed, we still do not have any clarity on what the UK Government’s position is, but we all know what will happen in the event of a no-deal Brexit: ports and airports will seize up and the drugs and medicines on which millions of British people depend will not be able to come in because they will lack the valid accreditation and licensing. That is the contingency plan I am talking about. What are your plans for that kind of scenario? Are you stockpiling? Are you going to start producing here all this stuff that we do not make at the moment—all this equipment?

Simon Stevens: As you say, Ben, the scenario planning there is around having to think about the level of buffer stocks, partly linked to the shelf life of individual products, the possibility of domestic supply, substitute treatments and products, alternative sources of supply. These are the kinds of contingency plans that are required.

Q68 **Mr Bradshaw:** As we heard from the previous panel, a lot of this stuff is “just in time” supply and quite a lot of it has a very short shelf life, so it is no good stockpiling it. You either need to make it or get it in from somewhere else quick. I still lack a bit of detail about what exactly you propose to do in the event of a no-deal Brexit.

Simon Stevens: Nobody is suggesting that this is a desirable situation in which to find ourselves. Some of these discussions are going to be commercially sensitive, so you expect that some of the negotiating detail around that is not going to be promulgated before decisions are taken by Government as to the right approach to take. If your underlying question is, “Is planning under way for this range of alternative scenarios, some of which are undesirable?”, the answer is yes.

Q69 **Mr Bradshaw:** When are we going to have a bit more detail? Again, the previous panel, who are responsible for running the service on the ground, said they do not have any detail at the moment and time is running out. We have less than nine months.

Simon Stevens: That is a matter that the Government and the Department of Health and Social Care are paying very close attention to, and we are working with them on it.



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Q70 Mr Bradshaw: May I ask you finally more broadly about the impact of not just a no deal but non-regulatory alignment, or a hard Brexit, as it is more commonly known, on the NHS and health and social care in this country? A number of highly reputable health organisations have now spoken out. The Royal College of Nursing, the Nursing and Midwifery Council, and the BMA last week all said that they are now so worried about the implications of a hard Brexit that they have called for a people's vote. Are these people siren voices?

Simon Stevens: I do not think it is appropriate for me to address the question behind the question, as it were. The Government clearly are—

Q71 Mr Bradshaw: Are they raising legitimate concerns, do you think?

Simon Stevens: As I said yesterday and repeat this afternoon, the principal logistical question that we would need to get right under that scenario would be continuity of supply, and that is top of the list of things, or among the top of the list of things, that the Government scenario planning is focusing on.

Q72 Mr Bradshaw: I am not talking about scenario planning any more for a no deal; I am talking about the broader picture that applies to staffing, to the impact of potential trade deals on the NHS and the whole range of impacts that we have outlined very clearly in a series of reports from this Health Committee. A lot of professional organisations that deliver healthcare on a daily basis in this country are so worried now that they think there should be a people's vote on any final deal. Your boss has criticised people in the private sector for raising concerns about the impact of Brexit on the private sector in this country and he has called them siren voices.

Do you not think it is the responsibility of people who are responsible for keeping our health and social care system running in this country to raise legitimate concerns when they have them to Government and to Ministers?

Simon Stevens: Yes, I am sure legitimate concerns of course should be raised—absolutely—but I do not, equally, think we are at the point where we either know enough or have to call the play such that the decision point has crystallised for some of the contingency planning that we have in hand. That obviously is hovering into view.

Q73 Mr Bradshaw: I am not talking about contingency planning. I am talking about the different options of Brexit. There are different options for Brexit on the scenario. The Cabinet is about to go off on its away-weekend at Chequers to try to iron this out once and for all. It is not about the contingency planning for a no-deal scenario. It is about the type of Brexit that will do least damage to our health and social care policies. That is what these organisations are speaking out about. They want continued regulatory alignment, they do not want the economic damage that a hard Brexit will bring, including the impact on the NHS's finances, and they want the continued free flow of people and equipment that the NHS and



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social care needs. Are they right to speak out?

Simon Stevens: From the NHS's point of view, we have a stewardship responsibility for the health service, but, frankly, it is Parliament that makes the judgments you are talking about, Ben, not the NHS.

Q74 **Chair:** Thank you. It would be helpful for our Committee perhaps, Simon, if you wrote to us with a note about where you see the impacts and consequences would be of a no-deal scenario and what the NHS side of that is planning for. That would be helpful.

Simon Stevens: Okay.

Q75 **Andrew Selous:** May I ask you about capital investment, which was not included in the announcement of funding? Will you talk about that generally, but I also have a specific question about capital funding for growth areas? You will be aware that the Government are building a lot of extra housing in different parts of the country. The question I get regularly from constituents—I think it is probably the same for all of us where that is happening—is: will all local hospitals be able to gear up commensurate with the increased housing population?

I find it very difficult to get straight answers to that question in order to address people's concerns because people, I find, are not against housing growth—they know we need it—but it is: will health funding shift in a local area? That is a specific question, but perhaps you would address the general capital issue to start with.

Simon Stevens: Yes. Perhaps we can do this in two parts. I will do the forward-looking revenue for population growth and Ian might want to do capital in the round.

When we set funding allocations for the next five years based on the resource that now is going to be made available for the NHS, we will take account of the forward projections that ONS has for population growth in particular parts of the country. In other words, in setting a budget for several years out, that will take account of the expected number of people, and their demographic profile, who will be living in that area in those years, not at the time now when we make the allocation.

Q76 **Andrew Selous:** May I press you on a little more detail on that? We have a formal planning process in this country. In my area there is quite a lot that is already booked, if you like: we know it is going to be built, it is in the system and I dare say the NHS is well aware of it. There is other stuff that is being looked at and then in my area we have the Oxford and Cambridge arc, which is potentially a million extra people coming into this area in however many houses that we need. That is not formally part of the planning process. How does that get factored in? I am just identifying one area of the country, and other colleagues will probably have similar examples from their areas, but I worry that there is not the proper meshing of the Government's thinking on forward growth for housing and NHS planning.



Simon Stevens: We use the Government's or the official population projections. Looking out over the next five years, to the extent that those plans are sufficiently clear that they have been baked into the population growth numbers that ONS uses or would use for the local authority allocations and for schools funding and so forth, we will use those as well. Looking out over 10 or 15 years, that is not going to be covered by the five-year funding settlement that we will be allocating for the NHS.

Ian Dalton: Shall I address the capital point? Last year we spent around £3.1 billion. We expect to spend around £3.4 billion of capital across the NHS in England. We are currently awaiting, at the end of July, as discussed I think with this Committee before, a series of bids from the STPs across the country, a prioritised list of capital so we can get some further capital out this year, but also giving us some opportunity to prioritise going forward.

It is important to start with the recognition that significant capital is already being spent. However, I think it is also important to recognise that we have a significant need for further capital across the NHS. We have currently—well, 2016-17—around £5.5 billion of backlog maintenance across the provider sector. That is up considerably over the last three years. I look forward to receiving news in due course of the capital settlement we get for the NHS on a go-forward basis. It is clearly going to be important for us that not only do we prioritise our capital really well—and I accept your point about where we put it—but that we have enough to address some of the backlogs in the system that have built up over recent years. Alongside the revenue settlement that we have, we look forward to an opening of the taps on capital, which would I think be very welcome.

Q77 **Andrew Selous:** Moving on to workforce, may I ask specifically about GPs, which came up in our previous session? The number of GPs in full-time employment has fallen in the last two years, whereas the number of people working in CCGs, for example, has gone up. What do we need to do now to remedy that, to try to make it easier for people to get in to see a doctor and for primary care to start playing the sort of role that you have both spoken about very forcefully and publicly?

Simon Stevens: The main thing we need to do is improve the retention rate later on in their career for doctors who are retiring early. The reason I say that is that, actually, at the other end, we are being quite successful now at encouraging, as you know, young doctors to choose GP training. In fact, we have the highest number of GP trainees I think we have ever had. That is very encouraging. That is a turnaround from the situation we were in two or three years ago and a great credit to the Royal College of GPs and the General Practitioners Committee.

To hold on to the GPs we have, several things need to happen. One, there needs to be a sense that some of the workload pressures that are being experienced are going to be supported in different ways, and part of that is building out the multidisciplinary regime in primary care. We



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are not only on track but ahead of where we expected to be for expansion of clinical pharmacists and other staff working alongside GPs.

Secondly, we have to help GP practices network with their neighbours so that they are not small, isolated units having to deal with the pressures they face without that extra support.

Thirdly, we have to make sure that, when we have the capital discussions, we are dealing with the fact that a lot of GP premises are now not fit for modern primary care. We have made a good start on that, I think, over the last several years, with direct investment in GP premises across the country, but we are going to need to do more of that.

We are supplementing in the short to medium term with international recruitment for GPs, and over the long term the five new medical schools that are going to be opening with a 25% increase in medical undergraduates will at least help with future doctor supply.

Q78 Andrew Selous: Thank you. That is good. May I ask a specific point about the "Agenda for Change" pay deal? As far as we are aware, it is not going to cover nurses working in primary care, nurses working in social care or even nurses working in not-for-profit organisations. Have you done much thinking on what the impact of that is going to be if people are going to move from those areas towards the NHS in order to benefit from higher rates of pay within the NHS? We have had quite a lot of concern raised with the Committee on that area?

Simon Stevens: Yes, the "Agenda for Change" pay deal was an agreement reached with staff-side organisations for employees who are directly covered by "Agenda for Change" and who will be covered by the reforms built into the "Agenda for Change" settlement. For this year, NHS trusts that are employing staff on "Agenda for Change" are going to be directly funded.

I think I am right in saying that the Government have also said that, for those non-statutory and non-NHS organisations that provide NHS services where the staff are also on the "Agenda for Change" contract and where, as a result of the agreement, they are required to implement the "Agenda for Change" agreement, the Government would make direct funding available to those organisations. I think that that covers some of the social enterprise questions, although it does not in itself cover the primary care question, which will have to be addressed separately.

Q79 Andrew Selous: I have a final question on this area. I am conscious that I am moving about in different areas, but there is a lot to cover.

NHS Improvement is overseeing the GIRFT programme, which you, Ian, spoke about a little earlier. Some cautionary notes were struck by some of the panellists earlier, drawing attention to what is perhaps a lack of capacity within the system to implement some of the change because of current workforce shortages, which we take note of and are reasonable points. Sitting at the centre, how do you see us maximising the benefit of



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the GIRFT programme, both to save money and, most importantly, to improve patient care?

Ian Dalton: The Getting It Right First Time programme has started to make a significant impact. It will not be a short-term win; it is rolling out across more than 30 specialties, so it is a major change and development programme for the NHS.

It is also true to say that the NHS is facing significant vacancies—45,000 medical, clinical and nursing vacancies, according to providers, or thereabouts. If those capacity issues are true, the way forward is to see Getting It Right First Time as a mainstream activity for boards and organisations. Of course, I completely understand that the day job is very demanding, and I absolutely empathise with very hard-pressed frontline NHS staff and NHS organisations, which have to make the time to drive the improvements that we need for patient care improvements but also ensure that we balance the books. We have to recognise that there is a significant, underlying deficit in providers, which we also need to fund from the settlement. There is a need to do both those things at the same time.

Q80 Chair: We have heard a lot from previous panels about the need for transformation funding, and how that just disappeared in the past into the sustainability rather than the transformation side. Are you planning to ring-fence transformation funding this time, so that that does not happen again?

Ian Dalton: That is not something on which we have yet decided. Personally I think—and I am sure that Simon will have a view—you can argue this both ways. It is clearly really important that there is the time, space and resource to make the transformations that the NHS needs. I know that this Committee has had interest in that matter, and I support that. At the same time, we also need to reflect that we need to start from where the NHS actually is, and we have a significant underlying deficit in the provider sector.

Q81 Chair: But of course that has been the argument every time there is any kind of funding uplift, and it means that we are then baking in the current system rather than changing it to future-proof it.

Ian Dalton: I think that we have to think about phasing as well as resourcing here. The answer is that we have to use the new settlement to ensure that both those things are achieved. One debate that we have to have with the service as we prepare the plan is about the phasing for those two things to come together. It is absolutely agreed that we have to fundamentally transform care models in the NHS—otherwise we will have to build dozens of extra hospitals over the next 10 years, which, clearly, we will not be doing. Therefore, we have to do both.

Q82 Chair: Yes, but we hear time and again that there are systems such as Manchester, which can be successful partly because they have had access to transformation funding. When it is not available to other systems, it



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means that they cannot be successful.

Ian Dalton: And I completely understand that. The point I am making is that we now have the opportunity to use the new settlement, plus the efficiency and productivity that we will drive. We have to both do the transformation and resource it properly, but also address over this period the financial position of hospitals, to give them a basis for moving forward. So, it is an “and”—not an “or” for me. I do not know whether that is your view, Simon.

Q83 **Chair:** Yes, but it would be very helpful if you wrote to the Committee setting out how you are going to tackle that, because we have heard about those hard choices before.

Simon Stevens: Could we write to you in the form of the November plan, because that is really when we are going to make those kinds of trade-offs?

Q84 **Chair:** But you are absolutely clear that that will need to be there—the transformation funding. I know that Rosie had a supplementary point.

Rosie Cooper: Forgive me—I had to go out and take a call just now; I apologise. I was going to ask the question with which Sarah ended up about how you were going to align all the nice, kind, motherhood and apple pie with other aspects. Nobody is going to disagree about better care pathways and the mechanisms that we need to get to a better position on integrated care. In the Lansley time, Cumbria was held up as the vanguard. We were told that this was what we should all look like—but it got £26 million or £27 million to enable it to make those changes. We hear about Manchester and the £450 million.

I suppose that I am really asking how you align that policy and wish-list with your actual financial policy. How do you make that work? It is no good if we end up with everything not doing well, so we never achieve any bit across—we are just under everywhere, and nobody is happy then or seeing progress.

Simon Stevens: I take the spirit of the question in the way it was intended, Rosie. I think, frankly, we are likely to want to have some earmarked resource for the particular improvements that we set out over the five and 10-year goal. We have talked a bit about cancer; we have seen big improvements over 15 years in the proportion of people who are surviving more than one year. Eleven people per 100 extra are now surviving more than a year with their cancer than would have been the case 15 years ago, and that is going up year by year.

But we also know that we have diagnostic bottleneck capacity constraints, and we have to change a lot of our screening programmes. Frankly, we are going to need some specific money to do that, probably targeted at the redesign of the prostate pathway, lung cancer and colorectal cancers—other cancers need attention as well—and we will see a result on the back of that.



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We need to make sure that that happens everywhere. It is the same as the conversation we were having with Luciana around young people's mental health services.

None of that detracts from the fact that we also have to do what Ian said and make sure that we have stable services across the country, recognising the pressures that people are under right now. That is why the certainty of the five-year settlement really helps, particularly if we can link it to a 10-year workforce plan and 10-year capital, because then we can really sequence these things right. We can link the money with the workforce and the outcomes improvement.

Q85 Rosie Cooper: I absolutely see that at a strategic level. But the reason I am suggesting that the two things may not really be aligned—the transformation or strategic overview and the finances—is because of an individual case. I have a constituent who says that she has a very serious condition and talks about the products that make her life almost bearable. She has a colostomy, and she has just been told that the neutralising drops that prevent odour and the lubricant sachets that ensure that things are not stuck against a very sensitive stoma, as well as the protective powder, which prevents skin burning and prevents her from being in pain—items that are essential for her to function with this condition—are no longer available on prescription. So, we might be dealing with this on a really big strategic level, but, actually, we need to deal with it on the ground. This lady goes on to say that she is a pensioner, retired and unable to work, and these are items that she cannot afford.

So we have this big, strategic vision about how we are going to make it work, yet on the ground we have individuals who are facing things like that. As she says, if this goes ahead, her life will become unbearable. How do you reconcile those things?

Simon Stevens: If you let us have the details, anonymised in that situation, we would be happy to look at it with the local CCG.

Rosie Cooper: But do you see the point I am trying to make? Overall, in the country, how many more of those cases will there be? Those are the people who have paid and are paying for the service. I will happily give you the details, but, while we are dealing with this strategically and at a very high level, when it comes to it, it is how we do at the bottom.

I will not stray off into a totally different area, but, on governance, nobody thought that we would have Mid Staffs again, but we have had Liverpool Community Health and now Gosport. How do we know that those things are not happening on the ground? You would not know that they were happening. How do we get this to those people who are making the strategic decisions, based on which lives will be either bearable or unbearable? It is no problem to give you the details.

Chair: Luciana, you wanted to come in on public health and social care.



Q86 Luciana Berger: Thank you. Following the 2015 review, NHS England noted that your own tests that you set in the “Five Year Forward View” on prevention and social care had not been met. A few years down the line, do you believe that that remains the case—that your own tests have not been met on those two indicators?

Simon Stevens: I think that the assessment that we set out at that point has been a dispensation over the last several years, which is why it is so important that, as part of the next five years, we have acknowledgement on social care—that we cannot continue to see the erosion of public social care with the additional impact that that implies for people’s lives and the pressure it places on hospitals and other parts of the national health service. Similarly, there is recognition that, in the broad prevention agenda that we set and not just those services commissioned by local authorities, we need to step up a gear.

There are some encouraging signs of some new pragmatism in this area. The childhood obesity strategy mark 2 represents a significant intensification of effort compared with mark 1. Noticeably, it was described as “chapter 2”, so this may not be a book of just two chapters.

Q87 Luciana Berger: Forgive me, but on the issue of obesity, we have as a Committee looked at that, and we have seen obesity levels increase since 2010.

Simon Stevens: That is why it is so important that the Government have a goal to halve it, because then we can actually track very clearly whether the measures that have been put forth are putting us on that trajectory. If they are not, it will be very clear that other active measures are required.

Q88 Luciana Berger: You have touched on what it is important to focus on in these two areas, but can you expand a bit further on what you think is required for social care and in prevention to relieve pressure on NHS budgets?

Simon Stevens: On prevention, as I say, some of it is around broader public policy, including national regulatory and fiscal approaches, which were developed further in the most recent childhood obesity strategy. But some of it is about availability of clinical preventive services locally, in different parts of the country.

It is pretty clear that we will have to keep pushing harder on smoking, and smoking cessation is part of that. That cannot all be done through local authority commissioned services; we are going to have to look at whether the NHS can embed smoking cessation in more of the routine contacts that we have with vulnerable groups who are still smoking. ASH and the Royal College of Physicians have put out an important set of proposals in the last 10 days, which we will take a very careful look at.

On early years and children’s nought to five support, as part of the new or renewed focus on children and inequalities that we need in the



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November plan, we will need to have a careful look at what is happening to health visiting and school nursing services, and the integration with the rest of the community health services and primary care, which to some extent has become harder as a result of the 2012 changes.

Q89 Luciana Berger: In the first session we heard evidence that smoking cessation funding has decreased by a third in the past year, or 40%.

Simon Stevens: But smoking has still been going down.

Q90 Luciana Berger: But it has not been going down in line with the—

Simon Stevens: No, but the point is that smoking has been going down, and we want it to go down even further. ASH talks about 5% as being the smoking level at which you could say that we are almost smoke free. As a result of the judgments that Public Health England has made, we have a big hypothesis in this country that moving on a harm minimisation basis away from smoked tobacco to e-cigs represents a good thing to do. That is different from the judgment that some other countries have come to, but it is the judgment that our public health experts have come to. We absolutely have to look at smoking because of its obvious impact on cardiac disease and cancer. We know that two fifths of cancers are preventable, so, to the extent that we can give ourselves headroom for continued gains there, it means that whatever funding the country wants to put into health services we can actually deploy on new therapies for conditions that could not otherwise have been prevented.

Q91 Luciana Berger: I am sure that everyone on the Committee would agree with you. We touched on the fact that you acknowledged in 2015 that the tests that you set yourself had not been met, particularly on prevention and social care. We have gone backwards since in terms of funding.

Simon Stevens: When you say we set them ourselves, they are not actually within the ambit of the national health service—that is the point.

Mr Bradshaw: You did not have the power to deliver them yourselves, did you? That is the problem.

Q92 Luciana Berger: On that very point, can you share with the Committee what you have done yourself to impress on the Chancellor and Prime Minister the nature of the interdependencies of what goes into social care and prevention on your own budget?

Simon Stevens: The Prime Minister and the Health Secretary were both clear on both those points in the speech that the Prime Minister gave at the Royal Free, and the statement that Jeremy Hunt gave in the Commons. I think that there was explicit acknowledgement in both that prevention and social care would be an important part of a workable and improving care system over the next five or 10 years.

Q93 Mr Bradshaw: The Chancellor has made it clear that, with all this extra money for health, no one else is going to get anything, so, unless you find a way in which to divert some of the £20 billion we are told you will



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be getting to public health and social care, that is not going to happen. Have you had any conversations about how that could be done?

Simon Stevens: The £20.5 billion is funding that has been allocated for the national health service, and there is recognition that there is a separate process to be gone through to determine local authority budgets, of which adult social care is a very important part—and, also, preventive services. So, you are prejudging in a way, Ben, the outcome of the decisions that the Government will make in the spending review, and I do not think that we should prejudice those.

Q94 **Mr Bradshaw:** The Chancellor has made it quite clear that, given the state of the finances and the impact of Brexit, that is it—there is not going to be any more money for anyone else. You will either have to find some of what you have been given for public health, or we will see another five years of cuts. I think that we all recognise it and you recognise it. Amyas Morse said in his big valedictory that public health is the area, and that what you had been given is not enough money. Public health is the area, and if we are going to manage our health and social care system on these resources, we have to do better on public health and prevention. That is not going to happen without some of the money coming from what you have just been given.

Simon Stevens: That is a discussion that, obviously, local government will have with central Government as part of the priorities that are set in the Budget.

Mr Bradshaw: But public health is not a priority.

Simon Stevens: This is funding that has been allocated for a specific set of goals in the national health service. It is not going to deal with all the pressures in social care or other parts of the public service.

Q95 **Mr Bradshaw:** That is going to make your problems worse. As you have repeatedly acknowledged before this Committee on many occasions, pressure on social care and the cuts in public health cost money, and cost you money.

Simon Stevens: Your assumption is that the decisions have already been taken on those other aspects of public policy, and they have not.

Q96 **Andrew Selous:** Simon, is the NHS voice heard loudly enough in terms of the cost of air pollution on illness in this country, which NHS England and the rest of the NHS has to deal with? Are you listened to seriously enough across Government on the second biggest cause of mortality, which is air pollution?

Simon Stevens: Public Health England is the lead agency that lays out the evidence of health impacts from air pollution. Specifically, from our work across London, the London Mayor has made air pollution one of his main health improvement goals. Careful work has been done in mapping the number of GP surgeries and hospitals that are within air-polluted



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zones, and on the impact that that will have on respiratory conditions and other concerns as well. As part of the diesel transition, the question of nitrogen oxide and particulates has a very strong health resonance. So, yes, we certainly want to be a voice in that debate.

- Q97 **Andrew Selous:** Okay, but do you think that you are listened to with sufficient attention across Whitehall? This is a huge cross-government issue. The Department for Environment is notionally in the lead. With respect, Public Health England has not said very much on this issue; it issued a three-page guide when we were doing our report into this issue. If I go into my local surgery, I will see something about smoking cessation and giving up alcohol, and probably something to help me get off drugs, but I will struggle to find anything on air quality and what I need to do to try to stay on the right side of that. Does that concern you? You say that that is for Public Health England, but it is your budget that is dealing with the costs of this, isn't it?

Simon Stevens: Yes, absolutely. That is a very fair challenge. When you look at the comparative data internationally, actually, our avoidable hospitalisations for congestive heart failure and diabetes compare very well, but our avoidable hospitalisations for respiratory conditions do not. So that is further grist to your mill, and we probably need to do more.

- Q98 **Andrew Selous:** Okay. Just to change tack, we talked a little about childhood obesity. When you walk down a supermarket aisle, Simon, and you see breakfast cereals completely caked in sugar, with no traffic light packaging and saying that they are high in fibre and rich in vitamin D—trying to hoodwink an uninformed purchaser into believing that this is a healthy product for their family and children—does that make you angry?

Simon Stevens: It is very concerning, because on average children are having the equivalent of three sugar lumps at breakfast. That is on average, and for poorer children it is often much worse, which is contributing a lot to the childhood obesity epidemic. Calorie labelling and traffic lighting, and, frankly, a change of promotional approaches in the retail sector, must all play their part.

We will need to see much greater action on food reformulation over the next several years, in the way we have begun to see on sugar, sweets and beverages. If we do not get that, it will be obvious that we are not going to be on track for the childhood obesity goals that the Government have rightly set. So there needs to be a wake-up call for food manufacturers in precisely the way you describe.

- Q99 **Andrew Selous:** So would it be fair to say that you have food manufacturers in your sights, and you are watching them carefully in terms of their impact on the nation's health and the costs that fall to you to deal with the illnesses caused by those issues?

Simon Stevens: Obviously, it matters for the NHS, but, frankly, it matters for us as parents. They are our children who are inadvertently at



the receiving end of what you think is a healthy breakfast cereal but which often turns out not to be. We can change that, and we need to.

Q100 **Chair:** May I turn to an area that you have raised with this Committee before as a concern—high-cost drugs, and their impact?

Simon Stevens: We are doing a very comprehensive tour of the horizon this afternoon, are we not?

Q101 **Chair:** Indeed, a tour of the horizon. Many individuals would have a great deal of hope, given the funding uplift, that there would be money for drugs that are very important to them—for example, those living with cystic fibrosis in their families. When we look at the issue around hard choices and what the NHS can and cannot do, what would you say about what we can do about improving access to innovative therapies? How can we balance that fairly?

Simon Stevens: I think we have made a good start with the reforms to the cancer drugs fund. As a result, patients can now get almost immediate access to drugs that are not only clearly effective and cost-effective, but thought to be promising. We have 18 indications being funded now through the cancer drugs fund, two of which have come out of the cancer drugs fund into mainstream commissioning. We have been successful in doing a number of direct deals with responsible manufacturers outside the cancer area—BioMarin, PTC Therapeutics and Alexion. Although those deals are commercially confidential, I can say that we have saved hundreds of millions of pounds on the back of not just those deals but others as well.

That requires drugs manufacturers to be responsible in their pricing. In one or two cases, including a live debate around a particular cystic fibrosis drug and portfolio, NICE has already said no to the prices that the company in question wanted to charge. There is a further meeting this week, when we expect or hope to see a much-improved offer, but, right now, the company is a very long way from acting responsibly. The implication of the kinds of prices that are being talked about would either be to deny patients those drugs or to rip off British taxpayers, and neither of those situations is acceptable.

Q102 **Chair:** Thank you. Finally, this Committee in our recommendations—and we were very glad to see the Prime Minister refer to it in her speech—talked about amending aspects of the Health and Social Care Act to facilitate integration. We recommended that those recommendations come from the health service and other bodies. Are you now going to go away and look at how that process could work? As a Committee, we are very happy to conduct pre-legislative scrutiny, and we are keen to see the process move forward. Will you give us some pointers as to how you are planning to take that forward, and who you are going to be working with?

Simon Stevens: Thank you. First of all, we welcomed and I welcomed the recommendation coming out of the Committee's report on integrated



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care and the suggestion that that would be a good way forward. It was also very pleasing to see the Prime Minister confirm that the Government were up for that process as well. We would like to discuss with you as a Committee how that should best be orchestrated.

Our view is that the right sequencing is to develop the NHS long-term plan and then, as part of that, answer the question whether there are adjustments to the legislation that Parliament might consider and which would accelerate progress or enable better results on the back of it. We have a set of prior working propositions as to what that might be, but we want to use the next several months to test that, and work with you as we do so.

Q103 **Chair:** Right, so your formal response to us again will be in November as part of the long-term plan, but, in the meantime, you will work with other partners to make sure that they are involved, including patient groups and representatives.

Simon Stevens: Yes.

Chair: Thank you for that. We look forward to hearing your proposals, because we feel very strongly that it should come from the service and patient groups, rather than top down from Whitehall. Rosie has a final point.

Q104 **Rosie Cooper:** Bearing in mind the kind of thing that I have been talking about, do you have any plans to look at the amount of money that the service spends on auditing firms to ensure we are spending the right amount for the right and adequate auditing? I think you may already have heard this, this afternoon, but every time I see an audit report and we have a problem, the auditors have never once picked those problems up. I wonder whether we are getting really good value for money. As we are so desperate to get that money to the frontline, we need proper auditing. Are you looking at that?

Simon Stevens: Yes, we are going to. It is one thing that we have to do through this whole process. Although overall the NHS is very efficient, we still have variation and waste, and we have to look at that. Some of it is, frankly, around the use of consultancies and the value for money that we are or are not getting from some of the firms you describe.

As you also say, Rosie, we also want to insist on rigorous independent audit, so that we have checks and balances on the information available to us as the national stewards of the system. You are pushing at an open door with the point you are making. I do not know whether you want to add to that, Ian.

Ian Dalton: No, that covers it.

Chair: Thank you very much.