NHS England
Annual General Meeting 2015

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The Kia Oval, London

Opening Remarks

Mishal Husain
Broadcaster & Journalist

If you could take your seats and then we will get the AGM under way. We do not have a huge amount of time and there is a lot to talk about. The sooner we get started the better. Please take your seats as swiftly as you can. Thank you very much.

Good afternoon and welcome to this Annual General Meeting of NHS England. It is a chance to hear about the Five Year Forward View, about some of the new initiatives that the NHS is working on, how it plans to address the challenges of today as well as the challenges of tomorrow. It is also a chance to put your questions to the key decision-makers in the NHS. Some of those have been submitted in advance. We will also be coming to you to put your questions in person, and we will get through as many of them as time permits.

Welcome to you all, and I would like to begin by asking the Chair of NHS England, Professor Sir Malcolm Grant, to get things under way.

Welcome

Professor Sir Malcolm Grant
NHS England Chair

Thank you so much Mishal, and thank you everybody for coming tonight. On behalf of the Board of NHS England I extend to you the warmest welcome. It is only two years since NHS England has been completely statutorily independent and operating as a full organisation. These Annual General Meetings, of which this is the second formal Annual General Meeting, are an opportunity for us to present to you, and beyond this room to the patients and the public that we serve, what we have done in the course of the past year.

The evening has two principal components. One is the retrospective which is the presentation to you of our Annual Report and our Accounts for 2014/15. The second is the prospect of what we are doing now and what we are taking through for the next two, three, four, five years which will we hope help to continue to improve the quality and safety and efficiency of care that we offer to the population of England.

Non-Executive Directors

One of the most important parts of a formal AGM is that the Directors of the Board are held to account. What I would wish to do tonight by way of opening is for me to identify each of the Non-Executive Directors and the National Directors of the Board of NHS England, and ask them to stand up and turn so that you can see who we are and understand what our respective roles are.

I would like to start with Ed Smith, who is the former Chairman of our Audit Committee. Ed has stood down just recently in order to take on the new role of Chair of the new National Health Service Improvement Body, which is the merger between Monitor and TDA. Ed, would you please mind standing up? Ed Smith, ladies and gentlemen, who is moving across into a relationship which will be very close between these two organisations.

David Roberts is a Non-Executive Director who is also Chairman of Nationwide Building Society, and brings a wealth of commercial experience. Ciarán Devane, former Director of Macmillan Cancer Support and now the Director-General of the British Council. Margaret Casely-Hayford,

now Chair of Action Aid and formerly Legal Counsel and Company Secretary to John Lewis Partnership. Moira Gibb, currently Chair of Skills for Care but also formerly the Chief Executive of Camden London Borough Council. Victor Adebowale, the Chief Executive of Turning Point and Member of the House of Lords. I am just looking along to Noel Gordon in the front row, formerly Head of Finance & Banking for Accenture. John Burn, one of the world's most distinguished scientific and clinical geneticists. It is a very powerful Board of Non-Executive Directors.

Executive Directors

We are supported by a strong Executive team. Ian Dodge, who is the Director for Strategy; Tim Kelsey, who is the Director for Patients & Information; Karen Wheeler, who is Director for Transformation; Barbara Hakin, Director for Operations; Jane Cummings, who is the Chief Nursing Officer for England; Sir Bruce Keogh, who is the Medical Director for England; Paul Baumann, who is our Finance Director and from whom you will hear a little more in a moment; and Simon Stevens, who is our Chief Executive and from whom again you will hear some more in a moment.

Just to be reassured, that is our team. Not all of them will be on display on the platform tonight. However, I wanted to emphasise that at the end of the formal business of the meeting we will be remaining in the room to mingle, and please do feel free to approach any of those who I have identified plus other members of our staff who are in the room this evening. Those who have submitted questions and we do not get around to answering formally in the course of tonight's events, we will give an undertaking. We will post those questions on the web and we will provide answers to those questions on the web as soon as we possibly can.

With that I am delighted to hand the floor back to you, Mishal. Thank you.

Mishal Husain: Thank you, Malcolm. Thank you very much. We are going to get the Chief Executive of NHS England on stage now. Once he is on stage he is not leaving the stage until 18.00 when the formal proceedings are over, because there is plenty to ask him about. Simon is going to say a few words to start us off.

Introduction

Simon Stevens
Chief Executive, NHS England

Thank you, Mishal. An AGM, as Malcolm has just said, is a chance to look back, a chance to take stock and a chance to look forward. Looking back, you can see that despite the enormous pressures across the National Health Service over the last 18 months, for the period represented by 2014/15, and over the last year since the NHS Five Year Forward View was launched, there has been enormous energy unleashed at every level of the system. We have seen, in amongst all of those well-publicised pressures, some very important progress.

A Chance to Look Back

On our key health goals we have, and we will be talking about these with the lead authors and key national experts shortly, set out a clear roadmap for improvement in cancer services. We will shortly be doing the same on mental health. On learning disability, we know that the NHS offer for some of the most vulnerable individuals in our country has often been lacking. We have committed to putting that right. At the end of next week, we will in fact be publishing a clear re-provision programme for the remaining institutional Learning Disability Services in this

country. Since the Health Service is a cradle-to-grave service we are also going to be talking about the cradle, in the form of the Maternity Taskforce that Julia Cumberlege and Cyril Chandler have been leading.

In the Five Year Forward View we made an argument that if we want to deliver the so-called triple aim of improved population health and higher quality individual patient care, all while being effective stewards of taxpayers' resources, then increasingly what we need is a so-called triple integration. Recognising that a lot of the fragmentation and the division that has existed in this country between primary and specialist services, between physical and mental health services and indeed between health and social care; those are increasingly irrelevant from the point of view of the people that we are all here to serve.

Part of what we have also set ourselves the task of doing over the course of the last year has been strengthening primary care with new investments in primary care infrastructure, new support for new skills, including clinical pharmacists, and an all-out effort together with GPs' national bodies to improve the attractiveness of general practice for new doctors. This is by no means mission accomplished, but this is a clear statement of intent.

We will have a chance to discuss this afternoon the work that is now under way in 50 so-called Vanguards across parts of the country. Sam Jones, leading that programme; Jim Mackey, probably the nation's embodiment of Vanguard-ism and now the highly welcome new Chief Executive of NHS Improvement, here with us this afternoon as well.

In parts of the country where frankly relationships have often been stressed, where the money is not working and where care is increasingly seen as problematic, we have launched a new way of working, the so-called Success Regimes in Devon and Essex and Cumbria. I think there is a spirit of optimism in those parts of the country. People are now willing to roll up their sleeves, take some of the hard decisions and work in new ways.

It goes without saying that the NHS is a people business, and although NHS England has limited direct responsibilities for the 1.4 million workers in the National Health Service we believe we have to play an important part in partnership with employers, Health Education England, many other bodies including unions and staff sides.

That in part means holding a mirror up to the fact that the NHS itself has not been a model employer when it comes to the health and wellbeing for our workforce. It means holding a mirror up to the fact that we have far too many parts of the country where we have not been a good employer when it comes to matters of race and opportunity. You will see on your seats something that I and NHS England and colleagues across the NHS are particularly pleased to have kicked off: the introduction for the first time of a Workforce Race Equality Standard which will chart concrete progress over the course of the next three years.

We know that frankly we have not been as good an employer as we can be for people, including people with learning disabilities, people with other needs, and so you will have a chance to hear from Lela Kogbara, the Assistant Chief Executive of Islington Council who is working with NHS England on precisely that.

In summary, looking back over the course of the past year since the Forward View, I think we can feel good about the fact that there is energy and there is progress, but all under particularly trying circumstances.

A Chance to Take Stock

Where are we now then? That was the past. What is the present? I just want to spend a moment briefly commenting on the questions that will arise around funding and efficiency over the next five years. Let me say that I think we all clearly welcome the government's support for 'the NHS's own plan' for the next five years, which of course recommended a minimum of at least £8 billion of real terms extra investment in the National Health Service by 2020.

I think it is, at this moment one year on, just worth reminding ourselves what the NHS's own plan actually requires. I think the way that the NHS will look at the outcome or the funding decisions that will be made on 25th November involve us thinking about five tests through which we will judge whether or not the Spending Review has delivered for the National Health Service.

The first is that we are going to continue to need some front-loaded investment in service transformation, to support the Vanguard roll-out; investment in technology; we are going to need flexibilities in how resources are used as between both capital and revenue. Secondly, we are going to need to phase the new asks that are made of the National Health Service consistent with the phasing of the new investment to deliver on them.

Thirdly, we are going to need continuing political support for the realistic but broad set of efficiencies that are going to be needed in order to deliver us the headroom to meet the demand and deliver on the opportunity over the next five years. That cannot all simply be directed at NHS providers. We want a realistic and deliverable tariff efficiency for the next five years, and we know that we are going to have to look at other aspects of the total cost base of the National Health Service with new eyes.

Those, if you like, are three of the five tests that relate pretty specifically to the NHS itself then: front-loaded transformation support, phasing of the new asks and support for a broad-based set of efficiencies. However, the other two of our five tests I think relate much more broadly. The fourth would be that it is the whole care system that matters here. We will not be able to deliver the transformation that the Five Year Forward View promises unless we think about investment in workforce and we think about protection for social care services. Related to that, fifthly, we know that it is not just the whole care system. It is health, not just care. Therefore we need all of us, including government, to make good on the public health and the prevention opportunity that we have laid out.

A Chance to Look Forward

Those are the five lenses through which we will assess the outcome of the Spending Review. In turn, we the NHS have got a huge job of work, which in my assessment people are entirely up for. That therefore brings me to, if we have talked about the past, we have talked about the present up to 25th November, what the next phase, the future, will look like.

We have got to now, in a very practical sleeves-rolled-up way, square three circles over the next several months. By 'we', I mean here the new NHS Improvement under Ed and Jim's leadership, working in close partnership – which I am confident we will – with NHS England, with Care Quality Commission, with other of the national leadership bodies. We need to make clear to our NHS and local government partners the work that has got to get done for 2016/17. We have a realistic set of plans for 2016/17. However, at the same time we also want people to be thinking out to 2020 and then reverse-engineering the kind of transformational changes that are required. We intend to jointly, Jim and myself, provide the NHS with the opportunity

through next summer to get that right. That is the first circle: 2016/17 versus reverse-engineering in the five years.

Related to that, the second circle is that we have a national system that for the moment principally looks at the performance of individual organisations, and yet we know that increasingly we want to look at the offer that place-based whole systems working provides over the course of that five-year period to resident populations.

The third circle to be squared is between sustaining the local energy which we have genuinely managed to unleash through the Vanguard programme with the changed behaviours, the aligned leadership that we need nationally. I am confident that those three circles are square-able, but that is the task before us over the next several months.

We now have an opportunity in much more detail to get into the conversation with a number of the national leaders and frontline experts who are driving change on health and on care redesign. As we do that I would just finally like to close on behalf of the Executive team of NHS England with our shared thanks to the Non-Executives; particularly to Malcolm Grant, but all of the Non-Execs for their leadership and their support for all of us over the course of the last year. Of course, a particular thanks to Ed Smith for taking on these important new responsibilities which again, in conjunction with Jim, I think provide the opportunity for a real new sense of shared national direction in the years to come. Thanks very much.

Five Year Forward View Panel

Mishal Husain: Could I then ask Jim Mackey, Arvind Madan and Sam Jones to all come and join us on stage where we will talk about how the care of the future is going to be delivered? Two of you, Jim and Arvind, have just been appointed to brand new roles. Sam has been working on the Vanguards for some time. Jim, Chief Executive of NHS Improvement, you are going to be the first person in that role. I know you do not start till November, but it is not long till you get into that role. What is it going to involve? What is your remit going to be and what do you want to do with it?

Jim Mackey (Chief Executive, NHS Improvement): As Simon has already said, we have got a bit of job about just stabilising and getting things in order next year, and then helping health communities to think about what the future is. A big part of that is just getting back to basics about improvement and stuff. There will be a process through the planning process where we will put a framework in place that will give people a chance again to manage the money and basic performance.

I think at the moment that is crowding out a lot of the long-term sustainability and quality improvements that we need to make. Going back to the Forward View, as Simon said, next summer, next spring, really helping local systems to think about where they want to be in ten, 15, 20 years' time.

Mishal Husain: In terms of the local systems, your present role in Northumbria as Chief Executive of the healthcare Foundation Trust there; how much is that going to inform what you now try and do on the pan-England stage?

Jim Mackey: Some of the things we have done in Northumbria I think are replicable but others will not be. There are fantastic things happening all across the country. I think a big part of our job is helping connect that to people. It is actually quite hard to see what people are doing.

Mishal Husain: Give me an example of something you have done in Northumbria that you would love to see everywhere.

Jim Mackey: A specific thing would be we opened a new emergency care hospital in June which has transformed care, delivered seven-day services, more consistent consulting presence, which has improved quality. It has improved patient experience. It has actually also improved the financial position of the local system. That is not entirely replicable elsewhere but the core principles can be. Also I think our integration between health and social care is absolutely required across the country. There will be different ways of doing that, but I do not think anyone really argues with the need for better integration. It is more about how.

Mishal Husain: Let me turn to Arvind and particularly talk about the integration there between primary care, which is what you will be responsible for as the new Director of Primary Care, and secondary care. How do you plan to approach your role?

Arvind Madan (Director of Primary Care, NHS England): I am coming from a background of 20 years as a GP in an organisation in London where we run a number of practices. The interesting lessons that we have learned in terms of scaling up some of the benefits of working across a number of practices, I think, are lessons that can be learned from in other organisations that are emerging, such as Federations and MCPs and PACs. I think there are lots of challenges in the system at the moment, but equally lots of opportunities around workforce planning, the use of skill mix and how we reset the imbalance of recruitment issues in certain aspects of primary care.

Mishal Husain: Particularly in certain parts of the country.

Arvind Madan: Yes, indeed.

Mishal Husain: People might say, as a London GP, perhaps you have not experienced as much as people might have seen elsewhere.

Arvind Madan: I am not sure London practices would agree with that. I think we are as challenged.

Mishal Husain: I mean in terms of recruitment.

Arvind Madan: Yes, indeed. I think there are opportunities around integration and learning from the best of what is going on around the country, from MCPs and organisations such as that, and the possibility of building a blueprint or a model from which we can learn and encourage fast followers to join and create the critical mass of movement that we need to address the scale of the issues. I think there are benefits to be brought to the table around a revision to the operating model of general practice and primary care, and the use of technology within that. There may be work to be done around alignment of incentives within the system.

However, I think one of the key things that I would say is actually we are not yet tapped into the potential of patients being empowered and managing demand in partnership with them.

Mishal Husain: I am sure we will talk more about that later on, because it is an intriguing idea. Sam, the Vanguards? There are many of them, work in many different areas. What are the most promising aspects that you want to highlight?

Samantha Jones (Director of New Care Models, NHS England): I think it is interesting that Simon talked about unleashing the excitement, and over 400 health and social care systems applied to be Vanguards. 50 of them are taking forward the care models in practice.

What is interesting through all of the Vanguards – whether it is in Cumbria having a different conversation with the local communities to get into hard-to-reach groups, designing it differently; whether it is the Isle of Wight on integrated teams working around individuals and supporting them in practice – what is coming through from all of the Vanguards is a different type of relationship and conversation with the population that is served. Unanimously across, our job is to support that happening, whether it is in Northumbria learning the lessons for Northumbria, working with individuals and making it happen. There are many examples up and down the country that that is already happening through the Vanguards, and also wider than just the Vanguards.

Mishal Husain: Explain what you mean by a different kind of conversation with the patient.

Samantha Jones: Rather than being 'done to', it is being 'done with'. We have local patients, we have local citizens actually designing those services in practice. So Dudley, which is represented here as one of our Vanguards, has some fantastic examples of young people and adolescents designing the services that they are going to be using in the future. Tower Hamlets are doing the same thing.

Mishal Husain: When you say designing services do you mean, 'I would like my GP to be open,' this sort of thing?

Samantha Jones: Yes.

Mishal Husain: What else?

Samantha Jones: Making it so that it is real for the people who use the services. Whether it is people being supported at home, so 89-year-olds being supported at home as long as they want to be in a way that makes them feel safe. Or through teenagers providing and designing the services themselves. What is important, though, is the focus across the whole of the system working together, not individual institutions. That is happening.

Q&A

Mishal Husain: I am going to open up the floor to questions now. David Hegarty, perhaps you could talk from your perspective about what is happening in Dudley?

David Hegarty (Chair, Dudley Clinical Commissioning Group): I agree with just about everything that people are saying. We are talking about whole care systems and understanding really what the population needs by engaging with them. Samantha was talking about how we engage with young people. We did it last year. We will be doing it again in a few weeks' time, bringing children from all over Dudley together. Also, not making assumptions. Not making assumptions about what they generally believe that they want and how you can try and make that happen for them.

However, we also have to try and understand that there is a significant way to go. The roles we have heard from Jim in particular – I think the phrase was 'the alignment of incentives' – and how we understand what is existing in the system at the moment that disincentivises organisations within health, social care, the third sector coming together to make a real difference for the population. How we can actually turn that around.

Mishal Husain: Thank you. Simon, it all makes perfect sense.

Simon Stevens: Let us stop there then! That concludes this AGM.

Mishal Husain: If only. The latest that we have today is that junior doctors are going to be balloted for strike action. There are obviously so many manpower challenges that you have in the NHS, so I am wondering about the extent to which you can get your workforce behind you at a time like this when their own pay and conditions are so much in the news?

Simon Stevens: I think we have got two things going on. One is that real sense of intense pressure right now, and anybody who denies that is away with the fairies. On the other hand, also a pretty broad agreement that a lot of what needs to change about the system to enable it to work better for patients, and indeed for staff themselves, is the kind of direction of travel we talked about. It is having both those truths in our mind at the same time, and charting a course from where we are now – without denying all of the pressures that exist – to where people can see better is possible. That is actually what Arvind has done. It is what is happening in Dudley. It is what is happening in many other parts of the country. We have got to get there quite quickly because people's pressure and pain is now.

Mishal Husain: If you could raise your hand if you have got a question and we will get some microphones round the room. Yes, sir?

Question: My name is Brian Mackineer[?]. I just volunteer in a social enterprise in Gloucester. It is a question for Sam. Two points are: good on you for your leadership that you have shown going on this, it is so important. The bit I would like to ask a question on: with all the Vanguard sites and the New Care Models, what do you feel the impact on the health and social inequalities will be from all that programme in terms of significant demonstrated impact for people and communities by next year?

Mishal Husain: Thank you. We will come to you in a second for that, Sam.

Nina Pearson (Chair, Luton Clinical Commissioning Group): Hello, yes. Mine is about inequalities as well. It is about the inequality in funding in order to commission service and for the social care package in different areas, and how that is going to be addressed in terms of provision for local populations? We are under-funded, both social care and for commissioning. The direction of travel is not fast enough as far as we are concerned. I would like to hear how you intend to address that and the needy populations.

Mishal Husain: Thank you. I see that there was a question submitted in advance from Harold Braun. Harold, are you here? The reason I mentioned it, Sam, is because it is similar to what the gentleman there said about the Vanguards, and particularly how you are measuring progress and success in that. Perhaps you could start with those two points relating directly to the Vanguards?

Samantha Jones: Thank you. The Vanguards have to deliver the revised care models that deliver against the triple aims Simon articulated; so prevention, health inequality and also the additional efficiency requirement. The answer to that question is: we are not measuring the Vanguards; the Vanguards are measuring themselves against those areas. In the next couple of months we will be publishing the outcomes and the metrics that the Vanguards have designed, including those areas for national replicability such as emergency admissions or across the population, and including where inequality takes place. That has been designed by the Vanguards with the Vanguards, and being published in the next couple of months.

Mishal Husain: Is there a certain proportion of reduction in health inequality that you are looking for as a gold standard?

Samantha Jones: We are not setting a target for that.

Mishal Husain: Obviously the target is no health inequality, but everybody is realistic.

Samantha Jones: Every Vanguard has to be able to demonstrate improvements against the triple aims designed against where they start locally.

Mishal Husain: Is any improvement good enough?

Samantha Jones: It comes down to where we have innovation happening in practice. If we start with the principle that they have to deliver an X%, that does not work in practice. Each of the Vanguards has to be able to demonstrate how they are delivering against those improvements that they have articulated and we are supporting.

Mishal Husain: Simon?

Simon Stevens: Just on the question from the CCG about the rate of getting to a fairer funding. This year we are in, 2015/16, NHS England was able to halve the number of CCGs who were more than 5% below their fair share of the money from 34 to 17, and the Board's ambition is to be able to finish that job off next year in 2016/17.

Alongside that we are also trying to ensure that we have fairness by bringing together the CCG commissioned services, the primary care, the specialised commission, and think about a place-based approach to fair shares. Doing that may then mean that that sets us on a further journey to narrow those gaps, but that I think is something the Board is committed to. The Board will be making the allocations for 2016/17, and potentially indicatively then for the next three or four years after that on 17th December. That will be one of the key considerations in that decision process, which will be debated publicly and seen transparently.

Mishal Husain: You talked about the integration of the NHS and social care. The idea that was put forward this morning, in the Carter Report on efficiency, was that the NHS should be funding at least temporary care homes in order to help get people discharged from hospital. I wonder whether you, Simon, and you, Jim, think that those are worth investing in?

Simon Stevens: I will be slightly controversial on that in that I think that the reason for the pressures in the care home sector is not principally a real estate problem. It is principally funding, workforce and the way different parts of the system connect. Is there a case for more intermediate care, better connectivity between the hospital, community health service and social care? Yes, there is. Might at the margin that be an idea that some places might want to explore? Yes. However, by itself let us not kid ourselves. That is not going to solve the social care pressures that rightly were identified today by Age UK and by the King's Fund.

Mishal Husain: However, Jim, I think the point that Lord Carter is trying to make is that it hopefully would help free up beds in hospitals.

Jim Mackey: Yes, I agree with all of what Simon has just said. We need to look at each individual health community; all of the money, all of the resource, all of the capacity including the people, and try and make the best value decisions. In some places that might be the answer. It is not as simple as saying it is a single answer everywhere. It might be an answer for local trusts to go into nursing home provision at some point in the future, but that needs to be tailored by their own local circumstances, does it not? You have got to look at how flow works and how capacity works right across the system rather than just isolated pockets of it.

Mishal Husain: Could we turn to the gentleman there, and while he is speaking if we could get the second microphone to the gentleman there?

Duleep Allirajah (Policy Manager, Macmillan Cancer Support): Just picking up on the point, Simon, about front-loading investment in the Vanguards, which I think is really, really important. One of the things the system has stripped out is the local improvement capability. I think there is an issue about, once you have proved something works, you need that capability to spread and sustain the good models of practice. We are thinking obviously very much from a cancer lens, and the Cancer Strategy talks about reforming follow-up. That really needs an investment of local improvement capability. The strategic clinical networks do not have the capacity, the capability to do that. A lot of the CCGs and CSUs are very, very limited in their ability to do real transformational change. I would be really interested to hear what you think about building that capability to spread works in the system.

Mishal Husain: Thank you. I am just going to take a few. Gentleman there and then can we get the microphone to the lady here please?

Peter Pinfield (Chairman, Healthwatch Worcestershire): Hi, Simon. I am actually here as a patient and a long-term condition person. I just wanted to emphasise the past 12 months, the Five Year Forward View panel was the right journey. I have got to say that we are all half-full people, very positive about it. However, it is the movement the patient direction for the next 12 months we are obviously keen to up the game on, Simon, if possible.

I think I would make a plea to everybody. I am not a professional. I am just an ordinary person representing my community. There is a vast amount of untapped knowledge, experience and passion out there, patients who are using the services. The way we go forward to the next 12 months is to tap and use and involve us on that. We will start changing the face of this country's health and services.

Mishal Husain: Thank you, and the lady here?

Patient (Brent): Mine is a bit more basic actually. I am again, like the other gentleman, an ordinary patient from Brent. I have got real worries about this business of integrated care, because in reality, particularly in my borough, the local authority funding is virtually down to only being able to provide compulsory adult social care services and will not have any more money for anything else. I suppose my concern is: when you integrate NHS and social care – NHS allegedly free at point of use, social care predominantly funded – how are you really going to be able to deal with this for integrated care?

If I may just ask one supplemental question, because it only came in this morning? My GPs are on an APMS contract which my own patient group fought very hard to get over the course of nine years, they got under Right to Request. All the patients this morning, a day after the meeting was called, NHSE declared that they were being tendered out. So we are now facing – in London, as Dr Madan said, there is a GP shortage. What is NHS England doing spending resources on tendering out GP practices which are well-loved?

Mishal Husain: Thank you very much. Simon?

Simon Stevens: Can I just ask what borough are you in? Brent, yes, okay. Brent, Enfield, a number of those boroughs have got high population growth, and so we clearly actually need a big expansion in GP capability and resourcing. I do not know the particularities of the practice question that you raised. We will certainly look at that and we will specifically come back to

you. We do need a fair process obviously when a particular contract expires. We need a fair process for looking at that. However, more generally frankly we do not see that as being the principal way in which we are going to drive the expansion and the modernisation of primary care. Instead, what we are really seeking to stimulate are more primary care at scale with a new voluntary GP contract to be developed with GPs by April 2017, so that the kind of things that Arvind and in fact many of the other practices around this country – Birmingham, Manchester, not just cities but also towns and counties – are doing is working out how you keep the strength of general practice, which is its personal relationship, its population list, but also get some of the benefits of bigger multidisciplinary team working, the ability to use technology and so on. That is the vision. It sounds like that is the sort of thing that we need to build upon in Brent.

You asked a related question which is: when you put together health and social care funding, how do we make sure that we preserve the very important principle that NHS care should be free at the point of need, and based on patients' requirements not their ability to pay? What I would say is that there are many parts of the country that have figured this out. It can be done. if you go to, say, Plymouth you will see that there the Plymouth local authority, the Plymouth CCG, using long-standing powers introduced by the last Labour government in 2006, have found a way of blending the budgets and indeed blending the care delivery without giving rise to the problem that you rightly highlight we need to be careful about.

On the question about the improvement capability, I really deflect that in two ways. For cancer I will deflect that to Cally Palmer who will be up here talking shortly about how she is going to do exactly what Macmillan continues very effectively to argue for. On the need for an NHS Improvement function, I think we should just turn to the man in charge of NHS Improvement.

Jim Mackey: Thanks, Simon. I think the two gentlemen over here really summarised what we have got to do. There is great passion with patients and citizens to change the service. We have got to harness that. If there is a lack of capacity to improve things we need to use our collective capacity as best we can, and not be precious about whether that is in primary care, secondary care, social care or whatever. That is a mix of building some national specialist capability but definitely building regional specialist capability and support good ideas on the ground.

In Northumbria we have this thing: no improvement is too big or too small. I think a lot of people rule improvements out as being, 'That is not worth it. It is just a very small thing.' Actually, all these things count. They all add up. Find methodologies that support people to turn things into action. If in doubt, have a go. We will be really pushing that. We will try and support it.

Mishal Husain: Arvind, I want to go back to what Simon was saying specifically about GPs. There is a voluntary new contract on offer. What happens if not enough GPs want to take it up? Where does that leave your plans?

Arvind Madan: Given that I am starting in December, I probably should not be drawn too far on this until I understand all the detail. However, I think what is being discussed is the fact that actually there seems to be an ambition to move from time-limited contractual models which are, through potentially procurement law and the like, being bounced back into the marketplace for re-procurement in a way that is rather mechanical; and a move towards a new model of contracting which is population-based across collective groups of GPs to make more

impact in the system. It is to be encouraged that there is a willingness to explore new models in that way.

Mishal Husain: Thank you.

Gyles Morrison (Enterprise & Technology Fellow, Health Innovation Network, South London): Afternoon, everyone. First point I wanted to make actually is that: anybody that is not working for the NHS and sees themselves as a patient; to anybody in the NHS services, you are actually the most important people in the room. I just want to highlight that. My name is Dr Gyles Morrison. I work for the Health Innovation Network, one of the academic health science networks for South London. I actually left work in clinical practice. I did that for three years and now I am in user experience looking at user-centred design, specifically in the way we deal with technology. Any talk about us supporting our involvement of digital and technological innovations in healthcare is right up my street. That is what I do now.

However, crucially what are we doing to get more doctors involved with this as a formal process that is not them being a clinical fellow, academic fellow or some other sort of fellow? Them actually having it as part of training somehow, so there is actually a workforce of doctors who are IT-savvy and actually part of true user-centred design of IT innovations?

Mishal Husain: In your experience, are there very few doctors who are IT-savvy enough to play a role? Or are they just not being used?

Gyles Morrison: To explain my situation quickly, because I know we are pushed for time. I have had CCIOs tell me they did not know they could tell doctors to go into IT. I have had virtually no formal support from any clinician or careers advisor to go into IT. I had to do it off just faith.

Mishal Husain: Okay, thank you.

Owen[?] O'Donoghue (Volunteer, Brighton & Sussex Healthcare Trust): I wanted to ask the Panel about what they think the role of volunteers will be in this Five Year Forward View? For me as a volunteer, I was on a volunteer waiting list for six months to actually volunteer in the NHS. I wondered if there is a place that will be faster?

Mishal Husain: No one got in touch with you? No one took you up on your offer?

O'Donoghue: I was on offer but I was on a waiting list for six months.

Mishal Husain: Sam, how typical is that?

Samantha Jones: In practice, both within the Vanguards and outside of the Vanguards we have volunteers and carers shaping the future. Just going back to the points that were made earlier on, I absolutely agree with our colleague from Worcestershire. We have talked about it previously: unleashing and supporting carers, volunteers, the unsung heroes in practice. Up and down the country in the Vanguards that is already happening. However, not just in the Vanguards. There are so many examples, and certainly understanding from Brighton & Sussex's perspective, how we can share the best practice that is already happening.

Mishal Husain: Okay, so how – people should not be on waiting lists waiting to help.

Simon Stevens: We have got about 3 million people who are giving their time freely as volunteers in some way connected with health or social care. There is something rather bizarre

about being on a waiting list. The NHS does waiting lists but why we should have to do a waiting list for volunteering is another matter altogether.

I think one of the conversations we have been having with a national group of organisations who marshal the engagement, because finding support for people who want to volunteer is a professional activity in its own right. It does not just happen by accident. A lot of the volunteering effort has been linked to hospitals which is desirable and great. However, a lot of the further opportunities we have might not be in hospitals at all. Think about Yorkshire ambulance, first responder schemes. Think about some parts of the South West with heavy volunteering opportunities with individual long-term users. Think about the work the Red Cross has done with volunteers looking in on people discharged from hospital when they go home just to see that they are doing alright, to reduce the likelihood they end up then being readmitted back to hospital. There are myriad opportunities here.

Come and nobble me afterwards, and I will put you personally in touch with some of the people nationally who are trying to figure this out. Your experience I think will be very illustrative of what we have got to get sorted.

Mishal Husain: The point about doctors and technology; not enough has generally been spent on technology in the NHS over a period of time, would that be fair?

Arvind Madan: In our model of care we have used technology, and one of the very enlightening things I have found during the process of doing that work was that actually, probably before that point my involvement of patients in pathway design was largely lip service. The ability to actually understand using measurable tools and metrics on how, for example, patients navigate websites, brought a whole new enlightenment to my thinking on how you can design services to create a win-win for both patients and clinicians if the system is designed intelligently.

The trick is to sit within that fertile territory of creating a win for patients and a win for organisations providing that care. Make the patient's preferred way to access the system the one that makes us most efficient in providing that care as well.

Mishal Husain: Right. Sam, we are nearly out of time in this section but is there a Vanguard, a part of the country you can point to where doctors are harnessing all the data in a really useful way, and technologically it is really working as a model?

Samantha Jones: Vitality in Birmingham have redesigned their services.

Mishal Husain: What is Vitality?

Samantha Jones: It is a group of GPs in primary care working together. They have redesigned their services so that over 60% of their patients no longer need to come to the surgery for their appointments. That is by using clinicians working with patients to redesign the service. That is happening in practice. That is one example.

Mishal Husain: This is Skype consultation or telephone consultation?

Samantha Jones: Skype consultation, email consultation, actually doing it on the phone; but with GPs doing it as opposed to others. As I say, over 60% happening in practice.

Mishal Husain: Thank you very much. There is so much more that we could ask you all, although I appreciate Arvind and Jim are not yet in their roles. Thank you very much. I am going to ask Simon to stay on stage. Thank you Arvind, Sam and Jim. Thank you very much.

If you did have any specific questions for them, all the NHS leaders will be around after 18.00 so I think you can feel free to put your question directly to them.

Now, the finances. I would like to invite Paul Baumann up to give us the figures.

Annual Accounts

Paul Baumann
Chief Financial Officer, NHS England

When you go to the theatre the interval is the opportunity to go and grab an ice cream and a glass of wine; at least it is when I go anyway. This being the NHS England AGM of course, that would be a rather unhealthy thing to offer you in the brief pause between the two entertaining parts of the evening. Instead you have got the Finance Director talking to you about this, which is the Annual Report and Accounts for the Commissioning Sector of the NHS.

I am sure most of you will have eagerly scoured it from cover to cover. I rather romantically hope that you stopped particularly on page 119, and slowed down at that point where the numbers begin. However, I suspect that like most readers you will have been much more captivated by the most important parts of it; the bulk of the 212 pages or so that we have written, which is dedicated to the many and varied ways in which we are changing the lives of patients. That of course is the theme of the bits which I am rather neatly sandwiched between. However, this being an AGM we do need to dwell for just a few minutes on the accounts, partly as a historical record but perhaps more particularly to see what they tell us about the future.

Last year I described the task of maintaining financial control in our first year as a Herculean effort. 2014/15 has seen the maturing of that financial environment, enabling us to run a rather more orderly year-end process, delivered to a significantly accelerated timescale and maintaining our clean-sweep of positive audit opinions. The NAO, the National Audit Office, not a body known for its spontaneous and lavish compliments, described this year as a major achievement for such a large and complex organisation. Before I go on to the content I would just like to pay tribute to the CCG, CFU and NHS England teams around the country who have made this possible.

What of the financial performance it reports? I am pleased to say that as in 2013/14, the last financial year I reported in, we met all of our financial performance targets across the complex array of measures on which we are held to account. See page 178 for details, or if you are particularly excited by the technicalities do come and join my team. We have a few vacancies. Just as importantly, we responded to the Department of Health's request to defer discretionary investments towards the end of the year last year to compensate for the well-publicised cost growth issues in the Provider Sector, and thus enabled the health group overall to stay within its spending limit, even if only by the slenderest of margins as some of you will have seen reported.

Turning to the actual numbers, you can see that the Commissioning System showed a small underspend of 0.3% against our main financial limit, which accounts for about 99% of our expenditure. This is well within the forecast range that we had been predicting for much of the year, and I have to say constitutes something of a point landing in a year when the strain started to tell across the system.

Picking up briefly the three main components within this performance: Clinical Commissioning Groups ended the year with a small underspend of £182 million, also equivalent to about 0.3%

of their allocation. We do need to be a bit cautious in interpreting this though, for three reasons. Firstly, it reflects in part the investment re-phasing I mentioned earlier, which in turn increases the pressure on expenditure in the current year. Second, it is flattered by a number of specific items, particularly in terms of reduced spending on the continuing healthcare claims, which were inherited from the PCTs. Thirdly, perhaps most importantly, there is still quite a bit of variation in individual CCG performance. Whilst the vast majority of CCGs delivered their financial plans and lived within their means, 19 CCGs ended the year in cumulative deficit having clocked up a total of £213 million of in-year deficit between them, just over half of which was unplanned.

In part, those deficits reflect individual CCG allocations which are significantly below their fair share of budget, which is why we significantly accelerated the pace of change in our decisions on allocations last December, as Simon rather annoyingly has already mentioned. However, part of the problem is a steady stream of individual organisational performance issues which led us this year to develop and roll out an extensive toolkit and process to prevent, detect and then rapidly intervene where necessary in emerging problems.

Direct Commissioning ended the year with a slight underspend of 0.1%. The grip on cost and activity in Specialised Commissioning has strengthened considerably over the last year. However, there have been new pressures in the form of the rapid growth of the Cancer Drugs Fund and the appearance on the horizon of a considerable volume of exciting but extremely expensive new drugs across the clinical spectrum. While this year we were able to cover the impact of these pressures with operational underspends in other areas, we are having in 2015/16 to exercise even tighter controls to ensure that our planned growth of investment in strategic areas like primary care is not compromised.

Finally, NHS England's running and central programme costs were underspent by £172 million, largely as a result of a rigorous internal review to drive out savings and prepare for the much tighter spending limits in these areas in the current year.

I said last year that we were engaged in a financial marathon which will test our resilience to the full; not a particularly insightful prophecy, I guess. The good news is that we have survived the first few miles, but it is pretty clear from the underlying trends visible in 2014/15 that I have just been describing, and the modelling work that we have done for the future, that the remaining distance is going to be even tougher, with the first major uphill stretch already with us in 2015/16.

On the Provider side it now seems inevitable that the deficit will be significantly higher than the £800 million or so reported last year, underlining the importance of the measures currently being adopted to control the burgeoning agency spend which accounts for much of the financial pressure in the Provider Sector. However, it is important to remember that the Commissioning side faces significant challenges too. Our plans for financial balance this year have again required the deployment of significant amounts of historic reserves; £582 million to be precise this year. Partly to fund investments in transformation of the type you have been hearing, which I think is a good thing, but also to cover the in-year deficit of about 20 challenged CCGs whose return to breakeven cannot be completed this year.

We are of course completely committed to bringing the overall Commissioner position in on breakeven at the very least. However, half way through the year I have to report the balance position is looking distinctly fragile. I suppose it is no great surprise that 2015/16 is a tough

year. The combined operational deficits are easily explained by just two factors. Firstly, as I have mentioned, the dramatic and increasing Provider overspend on agency and temporary staffing; and secondly, the £1 billion of net transfer from CCGs to local authorities in the form of the BCF.

It is easy to analyse why it has happened. The obvious question is: can we complete the next leg of the marathon without stumbling? If commissioners, providers and regulators pull together, nationally and in every single health economy around the country, it is still just about possible to make the sums work overall in 2015/16. However, it is going to take all the discipline, the determination and the creativity – and here I must stress, I mean creativity of the non-accounting variety – if we are going to survive this particular test of our uphill running.

There are of course good reasons for optimism as we look forwards. We have got a plan in the form of the Forward View. We have got a firm commitment from government to fund the plan, starting with the £2 billion extra we received in 2015/16 and continuing with the promised real-terms growth funding of at least £8 billion over the next five years. Simon's comments on the phasing of that are clearly salient in that context. Finally, we are mobilising across the NHS to deliver the annual efficiencies needed to give us the headroom to manage the extra demand we will face over the coming years.

Every single part of the system has got a role to play in this. From providers focused on clinical productivity and procurement, to commissioners leading the charge for maximum value from every pound spent; by rapidly rolling out the Right Care Programme, which I hope many of you will have heard about and started to see in action; by implementing New Models of Care in the Vanguards, and of course beyond. Also, by liberating the power of patients themselves through major initiatives on prevention and self-care. There is also a significant contribution from pay restraint and reduced spending on central functions.

It can be done, but I hope this rapid canter in every respect through the financial challenges of the sector – past, present and future – has demonstrated the urgency of the task. Delivering this year is essential but it is only the start. Delivering in future years will keep us ahead of the funding curve and enable us to invest to build the momentum we all want to see behind the Forward View. Thank you.

Mishal Husain: Thank you, Paul. Thank you very much. Thank you. Just before I invite the next panellists on the stage, Simon, I want to ask you to comment directly on what Paul just said.

Simon Stevens: I agree with everything Paul just said.

Mishal Husain: Naturally, he is in charge of the finances. When we talk about this firm commitment from the government in terms of funding: the way that you talked about how you are going to scrutinise what happens in November with the Spending Review, it did not sound as if you were that confident that what you need and what has been promised is going to be there.

Simon Stevens: I do not think you can draw that inference.

Mishal Husain: The way that you talked about all the different measures of which you are going to look at everything that comes out of that Spending Review.

Simon Stevens: It was simply to remind us all that, when a year ago in the Forward View we said a minimum £8 billion, there were some five related aspects to that which we needed to get

right. I detect great willingness to understand and move in that direction on a shared basis, and that is what we will be looking for.

Mishal Husain: Will that money, that £8 billion figure, cover what you have in mind for the future? Or is it covering the day-to-day needs of the NHS now?

Simon Stevens: It is a combination. We want an NHS that is bigger and better, but therefore an NHS that in some respects is going to have to be different. How is it going to have to be different? The next panel is about to tell us, Mishal. It is going to have to be different in mental health. It is going to have to be different in cancer. It is going to have to be different in the way that we employ people who need to interact with the Health Service itself. When you get to talk now to the team that are about to join us on stage, you will see the fire in the belly for the improvement that we require.

Mishal Husain: You are very keen to get them on stage, and that is fair enough. They are all very important areas that we want to talk about.

Delivering for Patients Panel

Mishal Husain: I am very pleased to have you all with us. Paul Farmer is the Chief Executive of MIND, the mental health charity, and Chair of the Mental Health Taskforce which is about to report very soon. Cally Palmer is the Chief Executive of the Royal Marsden Hospital. She has just been appointed NHS National Cancer Director, and she is going to lead the implementation of the five-year plan to improve cancer care. Chris Askew is the Chief Executive of Diabetes UK, and Lela Kogbara is the Director of the Learning Disabilities Employment Programme at NHS England.

Paul, why do we not start with you because I think we are a few weeks away from the publication of your report? Give us a sense of the direction of travel. I am not asking for the headlines now.

Paul Farmer (Chief Executive, MIND and Chair, Mental Health Taskforce): Far be it from me to reveal all at this particular event, but I suppose our starting point has been to listen to what people with mental health problems, their families and mental health professionals and the wider public want to see from mental health services in general. Around the time of the election 20,000 people responded to our online and paper-based consultation. We have got a very clear view from people with their own experiences about what they want to see. They align into four really major themes for us.

The first one is around prevention, about how do we help and support people to get the right kind of support at the right kind of time, and to be able to prevent mental health problems happening in the first place. Secondly, around access; likely to be a very key part of our recommendations. We know that there are good quality treatments available and support for people, but for too many people they are not available everywhere and that aligns with what you have already heard from Simon and others. Thirdly, integration. We operate in this world where quite often mental health and physical health seem to operate in these twin tracks. How can we ensure that in that place-based approach, mental health is a key part of what happens? We are already seeing great examples of this in the Vanguard programme. Finally, quality, so that people believe and feel that the experience that they receive from mental health services is transparent and visible to all.

Those are our emerging themes, and I think the gain here is to really give people who experience mental health problems a real chance to not just have a good experience of mental health services but, of course much more importantly than that, to be able to achieve the kind of outcomes that they want. On the whole people tell us they do not really want to spend very much time in the NHS. They want to get out there and get on with their lives; find a job, have decent housing and have good-quality relationships.

Mishal Husain: Thank you, and I should underline that the reason that these four areas have been chosen is an acknowledgement that these were areas where outcomes or performance of the NHS have not been good enough. From mental health let us turn to obesity, and to Chris Askew. I know that is only part of what you do at Diabetes UK but it seems to me that there is a real momentum now building around, particularly campaigning on sugar.

Chris Askew (Chief Executive, Diabetes UK): Yes, I think that is absolutely right. Of course, it is a key interest to us in diabetes. We have 3 million people in the population with diabetes. That is twice the level of incidence that we had 20 years ago. We know the main modifiable risk factor is being overweight, being obese. 62% of the population are overweight or obese. 90% of people with type-2 diabetes are overweight or obese.

We have a significant challenge coming towards us on this. I think you would say things that are not going well; one thing we are able to applaud and acknowledge is the National Type-2 Diabetes Prevention Programme, which is an activity at real scale, at real pace which is drawing into its vortex of energy a lot of insights and a lot of activity. We will get a chance to roll that out very rapidly, and understand what role that has to play in a major public health activity.

While I have got the mic I am going to move on from that, and say of course prevention is important, but there is much we need to do as well for those very many people that have type-1 and type-2 in terms of preventing onward complications. Back to the Future is in the news today on the same day the National Audit Office have published their update on progress on improving diabetes services, and there is some depressing circularity of going back to the future in that report. Yes, we have made some progress in some key areas. We have managed to bring down premature mortality in type-2. However, in many areas we seem to be stuck in a cycle.

Mishal Husain: Pick one that is the most important thing that you would want the NHS to focus on.

Chris Askew: Certainly I will, yes, absolutely. If we look at structured education, we have an offer that is still in the teens. We have take-up that is in single figures and that figure has not moved since 2012. We really have to understand how we can provide a more structured support and education. I believe there is a strong appetite amongst those I have spoken to with diabetes to have access to that structured education. However, right now at the moment, we have clearly got a problem which we are not tackling. Very interested to hear about where we bring users into the design of that, and clearly if we are talking about activating patients to take a role in managing their diabetes, we are going to need to make sure that design of those educational opportunities very much has their insights built into it.

Mishal Husain: Lela, give us a sense of what you are trying to do with employment opportunities within the NHS.

Lela Kogbara (Director of Learning Disabilities Employment Programme, NHS England): The Learning Disability Employment Programme really is about trying to get the NHS itself to be a more diverse employer. Obviously there are lots of ways in which it can be a more diverse employer, but looking at people with learning disabilities they have got one of the lowest rates of employment across the country. Less than 7% of people with learning disabilities are employed, and yet the majority do want to be in work, so about 80% or so want to work.

The idea is that you can have a win-win for the people themselves, letting them be able to earn a living and live a fulfilling life like anybody else; and a win for the NHS in terms of not just having a diverse workforce, but really can deliver better results for patients. The Five Year Forward View talks about the need to employ people with learning disabilities in the kind of roles that would have made Winterbourne View less likely to happen, for example. Thinking about how the fact of being diverse makes us think about the people who we are serving. That is a really key, important point.

Mishal Husain: What stage is the programme at?

Lela Kogbara: We have launched guidance which is on the NHS Employers website. This is jointly with NHS Employers and others. We have launched a pledge, so if the pledge spikes tomorrow morning that will be a good indicator for the success of this conference. If you go on NHS Employers, you can pledge. There are three stage pledges. The first stage is just to say, 'I am up for it.' That is all you have to do to sign up to start with. Then you try and do something. There is guidance, there is a pledge, and then NHS England itself has employed some people with learning disabilities to do jobs, for example, in the patient and the public engagement team. We have got good examples across the country of some places, some hospitals doing brilliant things where people with learning disabilities are employed in laboratories, getting fantastic results.

Mishal Husain: Have you got a target number in mind?

Lela Kogbara: We have not set a target. There is something we need to think about whether we eventually do. The idea is that we try to get uniformly better. There is some good practice but we have not got enough of a good base line at the moment to know exactly where we are. There are some data challenges about the employment statistics in the NHS.

Mishal Husain: Cally Palmer, very big job ahead for you in leading the implementation of the plan to improve cancer care. How are you going to do it? That is the $1 million question.

Cally Palmer (NHS National Cancer Director and Chief Executive, Royal Marsden Hospital NHS Foundation Trust): The good news is we have a roadmap, because the Independent Cancer Taskforce published recommendations. There are over 90. One of my jobs is to ensure that we make progress on some early priorities. We know there is much to be proud of in the delivery of cancer care in this country. The majority of patients say that their care is very good or excellent. We are closing the survival gap between England and the best countries in Europe and elsewhere. However, we also know that there is a lot more to do. The ambition is set. The roadmap is set to ensure that 30,000 more patients, more people, survive for ten years or more by 2020. One of the big tasks for me and the team that I work with is to make sure we shift resource from late-stage disease to prevention, early diagnosis and early-stage treatment.

Mishal Husain: Early-stage diagnosis being the Holy Grail, I suppose, if there is one after prevention. People say their care is good once they are in the system.

Cally Palmer: Yes. I have been at the Royal Marsden for a long time. I have talked to cancer patients over the years, and what they say is their care is not seamless. There is a lot more to do to integrate it across care boundaries, between hospital, community and home. They also feel that when they are in a hospital they are protected, they are safe. However, we need to make it safe for them to work across the whole boundary, and to get into the right service to have the right treatment in the right place first time. Not to bounce around the system, which I think is an experience for too many patients today.

Mishal Husain: Yes. Some of that obviously goes back to what we have been talking about in terms of integration, is where people might fall between the gaps between primary and secondary care, or indeed elsewhere in the NHS.

Simon Stevens: Yes, it does. Cally is being typically modest in that one of the Vanguards that has been kicked off relates to cancer services in three parts of the country: one in South West London that has the Royal Marsden at its hub; another, University College Hospital, also here in London; and another up in the North West, the Christie Hospital. The idea there is that we blend the funding for cancer surgery, for radiotherapy, for cancer drugs, oncology, and get the clinicians and the patients to say, 'Here is how we want to improve outcomes over the next three or four years' and we will just use the money to invest to do that as against paying for every click of the turnstile or on tariffs and all the rest of it. That is part of how we are going to enable that integration. As Cally says, there is a big prize on offer here which is that the Cancer Taskforce estimated there are 30,000 lives that could be saved by 2020 if we get this right. Of which, up to 11,000 could be on the back of prevention and early diagnosis.

Mishal Husain: On this point about how you pay for things, someone submitted a question saying: 'To what extent is the internal market and the NHS in England a thing of the past?'

Simon Stevens: That is a sort of theological question for another day.

Mishal Husain: Maybe for the next 30 seconds at least.

Simon Stevens: Yes. Is there going to be a planning and funding function that is separate from the job of delivering care? Of course, because we know that we want to improve services and that means sometimes taking a step back from what we have currently got and saying, 'Here is how we want it to look differently.' What do you call that? That is the theological question.

Mishal Husain: Would you call it the internal market? Is that term out?

Simon Stevens: I do not. I call it implementing the NHS Five Year Forward View.

Mishal Husain: Of course you do.

Q&A

Mishal Husain: The remainder of the time we are now going to devote to questions, so please raise your hands. We will try and get through as many different ones as we can.

Mike Smith (Chairman, The Patients Association): We constantly hear on our helpline that integration is the answer to a satisfactory 24/7 community care service, of the kind that we do not have and have perhaps not had for the last 12 years in the way we did before. Now we

hear that more of the same is not the answer. Is anybody willing to put their head above the parapet and tell us what more of the same could bring it about? One constantly hears that it is so much cheaper to deliver a community service; sometimes it is said a third as much as it is as a hospital service. The hospitals are bunged up with people who cannot get back into the community blocking a bed at £2,500 a week, when it might only cost £700 in a social care bed. What is stopping this? Let us say that the Vanguards are a way forward and everybody is looking to those. The Five Year Plan seems to be a good thing, but from the patient's point of view it seems to be going so slowly. Can anybody tell us, and are they willing to say, what could be done to provide that? We are not going to give you more of the same because that does not work, we know. Thank you.

Mishal Husain: Thank you very much. Lady over there?

Sarah Prema (Director of Strategy, Leicester City Commissioning Care Group): I am really interested with an issue that we are grappling with at the moment in the city, which is about bowel screening. We are grappling with how we can increase uptake, particularly within our ethnically diverse population. Within the cancer work I was wondering whether there was going to be a place for shared knowledge, with places who have tackled this question and got a good answer, and whether that was part of the cancer work that you are leading on?

Mishal Husain: Thank you. Cally, before you answer that let us just turn to this gentleman.

Gordon McFadden (Chairman, United Amputees): Good afternoon. My name is Gordon McFadden and I am the Chairman of United Amputees, which is a peer-led charity. You spoke, Chris, about the rising numbers of diabetes in this country over the last 20 years. That obviously results in a higher number of complications, in my case amputation. Since the Morrison Report of 2012 NHS England have been quoting 5,000 amputations in England per annum. Recently, we have heard of the 135 shoes which is 7,000 per annum. I would suggest that we are more like, if you look at the All-Party Parliamentary Group on Vascular Diseases in 2012/13, they looked at 14,000 per annum. Yet we are still being quoted 5,000. Is that prosthetic service being wholly under-funded for the 400,000 amputees in this country?

Mishal Husain: Perhaps you could answer that first, Chris, and then I will come to you Cally? Then I will ask Simon to answer the question about the pace of integration.

Chris Askew: I am going to profess to not have all of the answers for you on that one. It is partly to do with my time in post and partly because that is not a piece of work we have really investigated. I am certainly happy to come back to you on that. What I do know is that complications that lead to amputations carry a huge cost and burden, both financially but also to individuals. There are some relatively straightforward upstream interventions that can be helpful. I joined a day seminar earlier this week in Milton Keynes; 80 people living with type-2 diabetes who had a day hearing from the local podiatry team, a diabetes specialist nurse. We were sold out on that event, turned people away, and we did the same last year. That event cost, I think, £2,000 to stage. If we prevented one complication in terms of lower limb amputation we would have paid for that session many, many times over. However, we do not have the resources to do it.

I am not deflecting. I do not have the answer for you around levels of funding but others might. I would certainly applaud the fact that we must look at how we avoid these complications much earlier on.

Mishal Husain: Thank you. Cally?

Cally Palmer: Just on bowel screening, I said earlier, and I will just repeat the point, that I think it is incredibly important to move the resource from late-stage treatment to prevention, screening, early diagnosis and treatment to really save those 30,000 more lives and 11,000 through improved diagnosis. I think we are making progress on screening programmes, including bowel screening, but what we do not need to do is reinvent the wheel. I think it is very important in my national role to make sure that we can share information about beneficial screening. It has been one of those controversial subjects in terms of how best to do it, which tumour types, what works, what does not work over time. I think it is absolutely essential that we look at it in a national way so that we do not try and reinvent the wheel in local areas. I have really enjoyed talking to colleagues in Manchester over the summer about the approach to improving cancer care nationally. You can see how nationally you could roll out screening better, early diagnosis better, starting with some sort of pilot system. It would be good to talk to you about your experience. Thank you.

Mishal Husain: Simon, the point from the perspective of the patients about how slow it feels the change is.

Simon Stevens: There are two ends of the telescope here, and I think how we have got to measure whether any of the triple integration that I talked about is happening – around health and social care, and physical and mental health and primary and specialist care – is from the patient end of the telescope. National voices and a consortium of patient organisations – and I pay tribute to the work of the Patients Association, Mike, as well – have come up with a series of so-called 'I statements'. This is what, from the point of view of individual patients, they would be looking for to see whether integration really is or is not working. I think we are going to be measuring that in the Vanguards and elsewhere, to see whether from the patients' or the consumers' point of view it is real and whether we are getting genuine improvement, over and above all of the gubbins that goes with funding flows and teams of health professionals and joint working with local authorities.

Mishal Husain: Thank you.

Deborah Alsina (Chief Executive, Bowel Cancer UK): Hello, Deborah Alsina, Chief Executive of Bowel Cancer UK, and particular welcome to Cally into her new role. Firstly, I absolutely agree that it is very important that we focus on shifting resource from late-stage disease into early-stage disease. Just to pick up on one comment about how we can increase bowel screening uptake, actually the sharing of information has been appalling over recent years. There has been an incredible amount of recreating the wheel. The very quick win, which is in the Cancer Taskforce recommendations, is the implementation of FIT screening: Faecal Immunochemical Test. It shows about a 10% increase in uptake. Let us bring that in quickly please.

However, what I really wanted to say was that whilst I agree that we must focus on early diagnosis, we must not forget the many, many cancer patients who are diagnosed late. Actually, there are some wins both in terms of prolonging and improving quality of life for people with advanced disease, but also to save lives there. For example, it is not acceptable that there is such a postcode lottery around access to liver surgery or even referral to liver surgeons within this country; that there are bowel cancer patients and many others across other cancers who are not being reviewed by a liver surgeon and being put onto palliative care

pathways, if you look at the research from Aintree. I really wanted to ask Cally, and Simon actually: how are you going to tackle that so that we are not forgetting those who are most vulnerable and who need our help now today?

Mishal Husain: Thank you. That is an unacceptable variation in our country.

Cally Palmer: Yes, I absolutely agree. We know those differences and variances occur, and we need to deal with those. Although I was emphasising prevention and early diagnosis I would not wish you to feel that that precludes the real focus on survival, quality of life, quality of patient experience for patients across the spectrum. It absolutely does, and I think that is an incredibly important part of the work that I will be doing.

Mishal Husain: Is there a particular cancer where you look at the figures and think, 'We are doing so poorly on that, this one is my number one priority?'

Cally Palmer: You have to create a balance between impact for the largest number of people with some of the commoner cancers, and just making sure that with some patients with very specialised rarer conditions that they have access to the right specialists. The comments I made – and I borrowed it from Tim Briggs – of treatment in the right place at the right time. first time. means that we need a system where those with the most specialised conditions get the right support at whatever stage they are going through the system. As well as making sure that we target some of the priorities on areas where you can make big change quickly. You are talking about large-volume impacts on patients with, for example, breast cancer.

Mishal Husain: Yet, Simon, if you take that 'postcode lottery' term you could have improvements everywhere and yet you could still have tremendous variations depending on where in the country you live.

Simon Stevens: I think just building on Cally's comment there: half of cancer deaths are four main cancers, and so the supplementary I would give is that bowel and lung are the two where we need to see a big improvement in early diagnosis and the consistency of treatment. Far too many people, as you would know much better than me, are being diagnosed at stage 3 or stage 4. In the case of bowel cancer that means your chances of being alive at five years are less than one in ten, compared with a nine in ten chance of being alive if you are diagnosed at stage 1. We have got to track the stage of diagnosis for each of the main tumour groups. We have got to track one-year survival rates, and hold CCGs and local health systems to account for that as proxies for the broader quality of care and the consistency that is then offered. The Independent Cancer Taskforce, as you know and I know we are involved in, has a set of proposed metrics that we should be using to hold each part of the NHS to account for consistent quality of care. That is what we need to do.

Mishal Husain: Just before I turn to our final few questions, Paul I want to come back to you and just talk a bit more about mental health. Do you believe that we are heading towards a point where we have parity, either in perception or indeed in the care that is actually delivered for mental and physical health?

Paul Farmer: I think that has got to be our ambition, and we have seen a significant shift in the way the general public is thinking about mental health over the last five or six years. The visibility is higher, the awareness is higher, and with that comes a pressure in the requirement to deliver on that parity ambition that is set out very clearly in the Five Year Forward View. In some areas the mental health system is starting from a point that is further behind other

aspects of the NHS, so we have to map out what we need to do now to really lay the foundations over the next five years.

I think that is absolutely an achievable objective, and particularly if we can really think about the way in which we integrate. For example, we know that people with long-term physical health conditions can really benefit from access to psychological therapies. It saves money to the NHS but it also improves outcomes. One of the areas we are looking at is how we can hardwire those opportunities for people to get those kinds of care, so there is a win-win in terms of achieving benefits for individuals but also for the system.

Mishal Husain: Thank you.

Victor Bolter (Bowel Cancer Survivor): My name is Victor Bolter. I am a bowel cancer survivor. I am on the statistics now because it is over ten years. I believe that we are being too nice about cancer. We have got to convince people that cancer is curable, and the earlier you get it and you get it discovered the more chance you have got of success of living on. Being a bowel cancer survivor I ask people when they quiz me, 'When did you last look into the toilet bowl?' They go, 'Why?' I say, 'Because that tells you a lot about your health.' I think we have got to look at basic things to get people more aware of cancer, and generally for the whole of the National Health more aware of all things that you can do to give yourself a better chance of reaching 100. A lot of people at 20, 25 are happy to die. They do not think they will, but gradually it catches up with you. The forms that we give people are not brutal enough. 'If you do not go for this test you might die, sooner rather than later.'

Mishal Husain: That would be a hard message to send out, but it is an important point. Let us take this gentleman's question. Then we will come back.

Gary Jevon (Head of Pathway Development, InHealth Group): A question for Simon is how do you envisage the role of independent and third-sector providers evolving over the next few years to support the Five Year Forward View? Do you think it is of increasing or diminishing importance?

Mishal Husain: Thank you. Perhaps we could just, Cally and Simon, talk about cancer for a moment and this gentleman's experience? Would you, Cally, support more alarmist health messaging?

Cally Palmer: I call it giving patients confidence to come in early. I think one has to be quite careful with the messaging. I agree there is an educational role. I agree we need to get the message out there and your experience shows that. What I like to do is work on the basis of confidence; that if people come in early, if they get screened early or they get diagnosed early, then that can make such a huge difference. It is getting those stats and that evidence out there to give people the confidence and the courage to come and get tested, get diagnosed, get seen. Alongside that we are looking at a new fast target of four weeks to definitive diagnosis from GP referral, and again I hope that will give patients confidence that they get a definitive cancer diagnosis fast or exclusion that they have no cancer, they are fine or they may need some other kind of specialist support.

Rather than alarmist – I understand exactly where you are coming from – I think it is giving patients confidence and evidence about fast access to the system and how much difference that can make, so people can feel really reassured about coming into the system at the right points and quickly.

Mishal Husain: Do you think, Simon, that there is a case for adding more urgency? Getting it in people's ideas, 'You really need to have this test.'

Simon Stevens: Really I have got very little to add to what Cally said, which is that there is a whole series of expertise about what is the best way of engaging people to get them to have the relevant check or to take account of their own health. There is one area, perhaps not in the cancer domain however, where I do think we are actually turning the volume up nationally and being more explicit, and that is on obesity. I think that is a good thing, and part of that is having a very straight conversation with parents about what is happening to their kids. I think that is a very welcome development and we need to go further with that.

Mishal Husain: Making fizzy drinks more expensive, aka the sugar tax?

Simon Stevens: As I have previously said, I think if retailers or the food industry are worried about the funding of the National Living Wage, then why do they not just stick it on the prices of the junk food and the fizzy drinks that they are attempting to sell? I have also said that I think as parents we should have a pretty clear 'no fizzy drinks' policy with our kids. It's an entirely discretionary, nutritionally-useless, health-damaging choice that we could just choose not to make. That is an example of direct communication.

Mishal Husain: Yes. The gentleman's point there about the role of independent and third-sector providers, how they come into the Five Year Forward View?

Simon Stevens: They have obviously always been a part of the offer to NHS patients, both in terms of planned surgery and other parts of the health system, including mental health. I think frankly we are taking a more sophisticated look at what that should be in a whole range of areas. In the case of the work that Paul is leading on mental health, I think frankly we have not been as smart as we need to be about the circumstances under which we do end up relying on distant medium-secure services that might be provided by the independent sector or by the NHS, when we could have built up local NHS and further sector services and avoided patients needing that. It is a very small part of the NHS expenditure, £0.06 on £1. My personal prediction is that the vast majority of NHS-funded care will continue to be provided by NHS providers.

Mishal Husain: Thank you.

Liam Brennan (President, Royal College of Anaesthetists): I will very quickly. My name is Liam Brennan. I am President of the Royal College of Anaesthetists. I am not speaking in that capacity, but I am the father of son with profound learning disabilities who is now an adult. I am very delighted to see Lela here talking about employment opportunities. However, I would like to know what the plan is from Simon and others about improving equality of esteem and access to health services for those with learning disability, because I have spent my whole son's life making sure that happened. I am articulate and can do that, but I do fear for people who cannot.

Simon Stevens: Yes, you are absolutely right, obviously. Jane Cummings here, Chief Nursing Officer, leading the work nationally on exactly that, so I am sure the two of you will connect straight after. All I would say for now though, is that as part of the work that we will be again publishing at the end of next week, one of the things we are clearly going to be addressing is the fact that the physical health of people with learning disabilities is systematically neglected, as you know. When it is health checks, primary care – and the same, by the way, also goes for

people with severe enduring mental health problems, where the 15–20-year life expectancy gap exists. Again, if integration means anything it has to mean doing things about that.

Mishal Husain: Lela, did you want to add something briefly to that?

Lela Kogbara: The only thing I would probably add is I think the point I made already, which is that actually some of the challenge is about having people within the organisations that are attuned to the issues for those people. You exclude people from the workforce and you do not know them. You do not know who they are. You do not know what they want. You know nothing about them. I think part of this drive is to say, 'They are people who are not invisible, who have real needs, where there is a massive inequality in health.' If they were part of the workforce we all would have them on our radar and think about their needs in a different way. We just would, because they would be people that we know and work with, and they would have opinions that we would listen to. It is just fairly basic really.

Mishal Husain: Thank you.

Camilla Child (Principal Consultant and Researcher, The Tavistock Institute): I just wanted to make an observation about some of the things I have really heard coming through this afternoon, which is about really involving patients, public citizens in decisions at all levels of decision-making. I have already met several people this afternoon, and we really need to join up all those professional voices with citizen voices, and shamelessly plug another programme that is funded by NHS England which is called NHS Citizen, which is about bringing public voice closer to decision-making.

Mishal Husain: Is it a way that you can communicate your experience?

Camilla Child: It is a way of putting public views into a process, which will result on 25th November with the Board members here engaging in different kinds of conversations with citizens.

Mishal Husain: NHS Citizen. So use that service, if it is online presumably.

Camilla Child: Use that, yes. It is, yes. Thank you.

Shali Tulsani[?] (General Practitioner): Hi, good evening. Shali Tulsani[?], I am a GP. The pace of change has been phenomenal. I am just wondering what practical advice you would give to the patients in the audience this evening about how they can influence their healthcare going forward?

Mishal Husain: Thank you. How do you influence your healthcare going forward? Simon?

Simon Stevens: Why do we not start with Paul and Chris?

Paul Farmer: I think the way to think about influencing is the personal, the local and the national. Initiatives like NHS Citizen are hugely useful in bringing together communities of interest, people who want to participate; not just as 'patients' but as citizens. At the local there are increasing mechanisms where we want to encourage people with their own experiences to engage with it, whether it is at CCGs or in Health & Wellbeing Boards who play a really vital role in this. Jacqui Dyer, my Vice Chair, has been absolutely brilliant at making sure that we tackle issues around inequality of access but also inequality of voice, as you have heard earlier. Then at the personal, every single interaction between a patient and the system has an opportunity to comment, to improve and to change the nature of those relationships. I think whether it is in a formal structure like Friends & Family or in much more informal ways, that is the kind of

dialogue that I think increasingly we are going to see. This is an evolution into a revolution around how people are able to engage with their services. That is the shift in balance of power that to me is at the heart of what the Five Year Forward View is all about.

Mishal Husain: Chris?

Chris Askew: I think in the case of diabetes it is absolutely crucial. This is a self-managed condition. On average somebody with diabetes will see a specialist for one or two hours a year. The other 3,800 they will be managing the condition on their own, which is why an uptake of structured education of around 4–5% just simply is not good enough. We really have to understand how we connect people with diabetes with the information that they need to fully be able to manage their condition. There are plenty of resources available to that. As Paul said, some of that is individual; some of it is connecting, for example in our case, with Diabetes Voices to play a wider role.

Clearly, I think we also have a duty to think about what we can do in support of people knowing more and managing themselves in a condition like diabetes, because clearly with the huge costs that we know accrue in terms of complications, there is a huge avoidable, preventable opportunity. It largely comes down to empowering patients and activating patients to take a role in that.

Mishal Husain: Thank you. Simon, just one final thought from you before Malcolm Grant comes up and concludes. I do not want to put a downer on all of this, but the winter is coming. There are good hospitals who are facing terrible binds in terms of deficits and staffing. It is such a difficult climate. Do you feel that at this point you are on track? It is admittedly early in the Five Year Forward View.

Simon Stevens: I think both Jim and I have acknowledged a number of times this afternoon that it clearly is difficult. Anybody who says it is not, as I said, does not know what they are on about. Let us be clear about that. The question is, where do we go from here? Do we have a sense of direction and mobilise behind it? Can we look beyond the end of our noses? People want to look beyond the end of our noses because they can see that more of the same is not going to work. Therefore, let us get on with the journey we are all committed to.

Mishal Husain: Thank you very much. I would like to thank you all, and to thank you for your questions whether they were sent in in advance or submitted here. Everyone is going to get an answer which will be published on the website. Thank you very much and I would like to invite Malcolm to close the AGM.

Closing Remarks

Professor Sir Malcolm Grant
NHS England Chair

In closing tonight's AGM it falls to me simply to say a few words of thanks. First of all to Mishal for her excellent compering of this evening. Thank you very much. Coupled with that, to the members of our panels who I think have set the tone, and I think explained so accurately what it is we are trying to do within NHS England. Albeit at least two or three of them have not yet started in jobs yet. Next year we will be able to confirm promise against reality of delivery.

It also allows me to say, on behalf of the whole Board, something that is absolutely essential, which is how much we value the work of our own staff. This pace of change is relentless.

There are big wheels of change intermeshing, and we have not even tonight touched upon the devolution agenda which is another great change that we know will bring about improvement of experience to patients. For all of our staff who have worked to make this possible, who have worked long hours under pressure and who have been very stretched by this agenda, we the Board are immensely grateful. I do wish that message to go out.

I would couple that in particular with our thanks to Paul. The brilliance of his presentation tonight should not obscure the brilliance of his technical capability as our Finance Director. The team that he has led, the production of our Annual Report and Accounts on time, filed with Parliament on time with as positive as possible a review from the National Audit Office as we could expect, are a great tribute to the quality of the staff we are fortunate enough to employ.

I want also to couple that with my own personal thanks to members of the Board, particularly the Non-Executive Directors who have been true in providing unswerving loyalty to their Chairman for some of the time; but also have provided excellent challenge to the Executive team led so brilliantly by Simon. Tonight I want publicly to acknowledge the contribution made by those who are standing down from the Board.

Ed Smith, who I mentioned before, and I could not be more delighted that he is taking on that really difficult role with NHS Improvement. Ciarán Devane stands down from the Board at the end of the year. Amongst the National Directors we are losing Dame Barbara Hakin, who has had over 35 years as a full-time loyal servant of the National Health Service and I think is in need of some reprieve. Barbara, a fantastic contribution, we are grateful to you. Tim Kelsey of Patients & Information, who has decided against all the odds to accept a job in Australia for some reason. Cricket and rugby – someone had to mention cricket tonight, given where we are. However, Tim we are grateful to you for all you have done, and they will both leave us at the end of the year.

Finally, my very grateful thanks to everybody who has come tonight. We have had, I think, an immensely instructive and informative Annual General Meeting. It makes me personally immensely proud of the organisation that I am privileged to chair. In closing the AGM, may I remind you that questions and answers will continue informally as we mingle now, and those we have received in writing we will put up on the web and we will provide answers to those. With all of that, thanks again to everybody and I declare the Annual General Meeting closed. Thank you.

[END OF TRANSCRIPT]