

SIMON STEVENS SPEECH TO NHS CONFEDERATION CONFERENCE 2016

17 JUNE 2016, MANCHESTER

++CORRECTED TRANSCRIPT++

Morning Anita and thank you everybody for dragging yourselves out of bed, I hope you had a good evening.

I did not have a chance to hear Jeremy yesterday, but I did hear Jim and I thought he was bang on the money, so really all I am going to do is elaborate on some of the themes that both he and I feel so strongly about, and that I think helpfully also pick up some of the feedback that I got as to some of the points that have not yet properly been addressed through the Confed conference this year.

CURRENT PRESSURES

I want to start where Jim started and I understand Jeremy as well, by acknowledging that it has been an incredibly demanding year, since we last met in Liverpool.

I know it's tough for front line staff across the NHS. I know certainly in my 28 years in and around the NHS there has never been a more complex time to be a health service leader.

So, let's just start by acknowledging that - and let me also thank you for the work and the leadership that you have shown in your communities, in your organisations, your parts of health, social care over the course of the last year.

The fact is that we hold ourselves to a very high standard, rightly so.

- And despite all of those pressures, there is no other major industrialised country in the world that over the course of the last year can claim to have treated 9 out of 10 of its patients within 4 hours in an A&E department, or provided 9 out of 10 of its citizens with access to needed planned surgery within 18 weeks.

- If you look at the ground-breaking study published in the Lancet a few weeks ago - the lead author being a guy who actually works for me at NHS England - the fact is that we have an NHS which has protected our citizens from the effects of austerity when it comes to cancer mortality, for example. Across the OECD, during this period of austerity, there have been 260,000 excess deaths from cancer - but not a single one of them in this country, thanks to the protective effects of the NHS.

- One of the biggest public health challenges we face in the world - antimicrobial resistance - killing 50,000 people a year in Europe and the US; last year we made one of the world's biggest improvements in the reduction of unneeded antibiotic prescribing.

I just use these examples because, of course we have a focus on A&E and a focus on elective care, but actually there is far more going on across the National Health Service than people pay attention to.

And despite all of the pressures, I challenge you to ask any doctor, any nurse, any patient in fact: "would you rather be treated now compared to 5 years ago or 10 years ago?"

And the fact is that anybody who knows what they're talking about would say: that the quality of care on offer to the people in this country, for the vast majority of conditions, is better now than it has ever been.

And that's not just true for the clinical quality of care; it is also due, I think, to the compassion and the sensitivity with which care is offered.

My mother gave me this newspaper article a few weeks ago - she's shares with me insights into how the National Health Service should develop! - and this newspaper article said as follows:

"Many people, disturbed by incidents which they feel should not happen, are beginning to wonder whether or not our hospital service is lacking in humanity. In one hospital until quite recently the relatives of a deceased patient were coldly informed of his death by a printed form, an example of administrative remoteness that is not uncommon. The hospital, which plays such an important role in the community, appears in many ways to be cut off from it. This form of institutional autonomy is inevitable, unless it is appreciated and guarded against."

And the article was titled "Humanity in Hospitals". It was written in 1960, and she sent to it my Dad, who around that point was working as a hospital porter in Birmingham. So the notion that history began with mid-Staffordshire hospital, I'm afraid, is not true. Progress has and is being made, and none of that is to deny or ignore the very real pressures that are being experienced across the front line of the National Health Service.

CHANGING CIRCUMSTANCES

And as I was talking yesterday afternoon to the group of graduate management trainees who are here at the Confed conference, it took me back 28 years when I started on the NHS management training scheme in Consett in County Durham, and the discussion we were having was how has the nature of leadership and the challenges facing the health service changed over that period of time.

And it clearly is true that - during the 2000s certainly - the big challenge confronting us was how to use a substantial wedge of extra cash and turn that into improved access and shorter waiting times across the NHS.

And you know what? We did that incredibly successfully.

As a result, waits - as we all know - fell from 18 months to 18 weeks. Public satisfaction with the NHS doubled. And to some extent, one of the biggest public frustrations with the NHS was taken off the table.

However, as we also know, the circumstances facing us now are different. The challenges are different, the financial circumstances are different, and therefore our response needs to be different.

As I was talking to these graduate trainees about the impact of the 2012 reforms, it struck me that in some ways they were the high water mark of the solutions to the previous set of challenges that we are facing. And so - when it comes institutional autonomy, or tariff-based component-ware, or a regulatory approach to improvement - actually that, to some extent, now is having to be superseded by an evolving set of arrangements.

And part of what I have been trying to do with colleagues in the two years since I came back to take on this role is both establish the shared consensus about how health needs to evolve in this country - which we have done with the Forward View - and create more alignment nationally between the various parts of the system. The creation that we put together last year, NHS Improvement, I think is going to be an important building block with that.

NHS FUNDING

And obviously then making our public argument for as strong a funding settlement as we can get for the National Health Service; and since we were together in Liverpool obviously we've had the Spending Review outcome.

So, I saw in the Twitter streams various critiques of the conversation here yesterday and the day before, suggesting that nobody had really talked about "the money" - or the lack thereof.

So let me just lay out what I see as a few home truths on that front.

First up, let's not rewrite history; in the Forward View we actually said that the National Health Service would need between £8 and £21 billion pounds by 2020 in order to sustain and improve. And to be at the lower end of that range, we would need to see continuing access to social care, relative to need; we would need to see enhanced effort on prevention and public health; and we would need to see transformation support in the way of capital and revenue. We have memorialised all of that - it is in the "Recap Briefing" available on the NHS England website, so everyone can see what we actually said when we set out our stall back in 2014 in the Forward View.

We made our case in the Spending Review. We have a U-shaped funding settlement which - against a very difficult fiscal backdrop - I think can be regarded as good as would be obtainable under those circumstances. And so overall NHS funding, as you know, will go from about £100 billion pounds to £119 billion over this period.

But there are three important consequences of the Spending Review which are really relevant for the conversations we are having now, through the STP process, and things we've got to get right this coming year.

First, the capital is incredibly tight. So as we think about our plans - our care redesign in the 44 geographies across the country - solutions that are heavy on capital expenditure, right now it is hard to see how they are going to be financeable.

The second impact is that a lot of the improvement we want to see in new funding programmes - be it mental health services, cancer, others - the extra purchasing power for that - regrettably in some ways, but just as a matter of fact, let's be honest about it - a lot of that extra purchasing power is back-ended towards the 2019, 2020 period.

The third consequence of this U-shaped funding settlement is that this year now really matters. We have got to use 2016/17 as the reset moment to get our finances, our performance, back in a place where we can then pivot off to the rest of what this 5 year settlement looks like.

So, times are clearly tight and tough.

I do not believe that it would be prudent for us to assume any additional NHS funding over the next several years, not least because I think there is a strong argument that were extra funding to be available, frankly we should be arguing that it should be going to social care. That is one of the arguments that I have been making publicly, and I think social care has a very strong case for that.

And of course, who knows what the circumstances are that we will face as of June 24th?

ACTION THIS YEAR

So, in practical terms, what are the tasks in front of us as leaders in the NHS over the next year?

I endorse what Jim said, and I would essentially put them into 3 categories.

First of all, there are a set of practical things we have got to do this year to stabilise our finance and our operational performance. Jim laid those out, I'm not going to repeat all aspects of that, but let's just be clear: finances do matter, the control totals that individual organisations will be accountable for do matter...and this is for a purpose.

The purpose is that we have had to strip out 1%, call it £650 million pounds of spending, from funding that would have been available from CCGs for Mental Health services, community health services, primary care and other things, to hold as a contingency reserve going in to this year, given what happened last year.

We want to be able to release that funding, and spend on mental health services and community services, so our delivery on these control totals will have a direct impact on our

ability to free-up that incremental spending for the priorities that we know we have got to resource.

People have talked about Carter no end. There are significant opportunities both inside and beyond individual institutions. We now don't have the luxury of time on that. And by the way, the same applies to CCGs, and the Right Care agenda. That is now absolutely mission critical for the sustainability of what the next 3 or 4 years look like. This is not any longer a special project or a hobby.

Secondly, we have got to get our sleeves rolled up, and get delivering on some of the key national priorities and strategies that we have laid out.

At NHS England, we are now out of the strategy business. We have the Forward View. We have a cancer taskforce report, and a mental health task force report, maternity, urgent and emergency care reviews. We are not doing any more reviews or strategy now; purely sleeves rolled up getting in to implementation, alongside you.

To help us do that, over the last several months I have appointed five of the most superb operational managers in the NHS. They happen to be women Chief Executives from different parts of the NHS: Pauline Phillips to lead implementation on urgent and emergency care review. Cally Palmer, Chief Executive at Royal Marsden, for cancer. Clare Murdoch for mental health. Sarah Jane Marsh for maternity services. Sam Jones, you know, on vanguards. Those five front line leaders are connecting the national implementation agenda with the local work that has got to be delivered in every part of the country.

We can talk specifically about what that will mean, but, on cancer services for example, anybody who has not got their sleeves rolled up looking at what is happening to endoscopy bottlenecks, that part of the care pathway, you will not deliver your cancer 62 day waiting times. And a broader set of changes Cally Palmer will be talking to the re-formed cancer alliances about.

Clare will be doing the same on mental health. On mental health, the practical things for this year are: the work to reduce out of area treatments and to connect secondary and tertiary mental health services that Stephen Firn will be leading. The two new mental health waiting times goals that we have around IAPT and early intervention psychosis services. And expanding child and adolescent mental health services, which is one of the parts of the mental health system that is most creaky. Alongside that we need 'open book' transparency from CCGs, so that their mental health trusts can see where mental health investment is - or is not - going, and then we can have an honest conversation about that.

For the urgent and emergency care review, we are going to be in the next several weeks setting out five key things that in 16/17 we need every part of the NHS to do. Part of it will be about stepping up the 111 and GP out of hours 'front end' with more clinical intensity of engagement there. Various other internal hospital process issues too, and a big focus on delayed transfers of care and the interactions with social care.

On learning disabilities, we are making quite substantial progress on reducing your chances of being institutionalised if you live in the top half of the country, with a clear programme to close the last of the long stay learning disability hospitals.

On GP services, even those of you that don't directly work on primary care, you are on the receiving end of the benefits of a well-functioning primary care system, and know the consequences of not having that. So we have a huge effort on to help to respond to the very genuine pressures that have been building in general practice, receiving far less attention than the pressures in other parts of the system. And so, on workforce, on work-load, on work re-design - if we don't get this right over the next 18 months, then as a headline in the BMJ put it recently: 'If general practice fails, the whole of the NHS fails'. We have a shared interest in really ramping up our implementation effort on primary care.

So, the three things for this year: Stabilising finances and operational performance, in the way that Jim described. Secondly, practical actions to implement the first phase of these national improvement strategies, similar in some ways to what we did with the National Service Frameworks in the early 2000s. And then thirdly, actually 'landing' these Sustainability and Transformation Plans - these STP processes - in every part of the country.

SUSTAINABILITY AND TRANSFORMATION PLANS

Now, let us just be frank about it: to some extent these are work-arounds on a set of institutional arrangements, a set of governance structures, and set of incentives that are pulling people apart, when actually we need to hang together.

And the reason that I'm optimistic about this, without being naive, is that I think that we have seen in some parts of the country some pretty rapid change over a relatively short period of time.

A year ago I talked about 'success regimes', and we kicked off the first three of those, one of which was in Devon. And, it is without a doubt I think, a dramatic change in the shared sense of leadership and purpose that has occurred in the space of just a year. When I sat down with Bob Alexander and the chairs of five of the organisations in Devon some months ago, and had a fairly straight conversation about the way to resolve their differences was not to be issuing press releases, which was essentially how they were doing contractual negotiations. If that was to continue to be the mode of operating, we would probably not all be in the same room together again in quite that way. Subsequently, the fact is that they have completely changed the dynamic. Angela Pedder has taken over leadership of that...and I see those kinds of changes under way in many parts of the country.

But, as we try to land these STPs, I would kind of think about three headlines, if you like.

First is '**Horses for courses**'. How the health and care system evolves in different parts of the country will look different. That is fine. One of my kind of guiding principles is that it does not all have to look the same everywhere; the solution for Lincolnshire will not be the same solution for South East London. That is OK - but it does need to be a solution. So! STPs are not a bidding process; again, as Jim said yesterday, they are a problem solving process. They

are a way of having a focused, honest, trusted conversation about some of the 'elephants in the room', some of the 'big ticket items', the difficult choices, that need to be resolved. How they are resolved will look different in different parts of the country. It is horses for courses.

But, I think the second phrase that comes to my mind is: '**If not now, when?**' In so many of these conversations - and I've had the benefit of sitting down with 24 out of the 44 STP leadership groups - in so many of these processes, it is not that people don't know what has to be resolved, it's often that people have known about it for years, just the time has "never been quite right". Well, it seems to me that at a point when our backs are against the wall, and where we are at this point in the political cycle, and where it is pretty obvious the money is not going to work if we carry on as we are, then "if not now, when?" And so, as we have a chance to sit down again in July, personally with Jim I'm going to go through all 44 of these. I blocked out a large chunk of July just to make sure that we are having these very specific and important conversations. If not now, when? We have actually got to face up to some of the changes that we can see are required.

So, horses for courses; and if not now, when?

Then the last of the thoughts it seems to me is: "**How big a team are we playing on?**" I have talked about the Devon success regime. I don't in any way do anything other than commend really effective organisational leadership. And some of our most successful leaders - think about people like Len Fenwick who as you know is celebrating 50 years as NHS manager, Newcastle hospitals just getting their outstanding CQC designation - I was chatting to Len earlier in the week, and he has a piece in the HSJ this week as well. Len probably does not want to do a 'population-orientated ACO construct' of some sort. You know what, that is fine. But if David Sloman at the Royal Free and colleagues think it's right for their part of London, or Pauline Phillips for Luton, Bedford and Milton Keynes, we should be supporting and backing that. But either way, this should not be the consequence of failed arm-wrestles; this should be the consequence of thinking more broadly than individual institutions. It is both, and not either/or.

So, in a nutshell for this year:

Yes I'm afraid there will be a reset on the money, and it is my job honestly to tell you that. That, I think, is something that the politicians will also come to more explicitly in July. So we might as well recognise that and be getting on with it, rather than waiting for it to come and bite us later in the year.

We know that there are a set of practical things to continue to show progress on - mental health and cancer and learning disabilities - and there are other national priorities.

And we have to make the STP process work.

It is going to be bloody tough; let's just be frank about that too. But that is what the nature of the leadership challenge is in front of us right now.

And as we do that, it is very important that we think about some of broader contexts in which we are operating.

OUR WORKFORCE

Our staff, our front line workforce, obviously this has been a difficult year - the junior doctors industrial dispute, pressures on staff, the agency cost cap and the implications of that. The attempt to move back from the de facto casualisation of parts of our workforce through locums, and the difficulty of converting that in to permanent workforce and so on.

But what strikes me as I do spend a lot of time out and about around different parts of the NHS, is that quite a bit of this is in the gift of individual organisations and employers. And you can sense that difference when you walk in the door.

One of the things that will make a huge difference is if all of our staff feel that they are getting a fair crack of the whip from the NHS. So, any of who you have not yet looked at the workforce race equality results for your organisation, I would really urge you do so. And what we see across the NHS as a whole, of course, is a huge difference in the experience between black and white staff across every part of the NHS, but with some organisations having really acknowledged and acted on that in a dramatic way.

The NHS unfortunately is not the world's best employer when it comes to the health and wellbeing of our own staff. We have put 450 million pounds of incentives through the CQIN scheme, available for staff health programmes over the course of the coming year. I would urge you to mainstream that as a central part of the dialogue that you are having with staff across the NHS.

As you do that, you can, you know, think about how you frame that message sensitively. Perhaps I had a slight misfire; this is the way that The Sun newspaper reported my efforts on this: "Weights up doc - fat medics ordered to slim by NHS chief". I'm not suggesting that is the headline in your staff newsletter! But, the fact is that there is opportunity there.

AN INNOVATIVE NHS

And, as we do that, let's not just let this be a kind of grim conversation about grinding out the money under difficult circumstances.

The fact is, the NHS is also an incredibly innovative organisation, and has been since the year dot. If you want to know where IVF, vaccinations and transplants came from, it was the NHS.

We are leaving money on the table and leaving opportunity unaddressed. We can see innovations, our clinicians can see innovations, that will make a difference but which we are not getting them out and about.

One thing we are announcing today is that, from April next year, we will add a piece to the national tariff system specifically for new med tech innovations that have been shown to be cost-saving or help patients with supported self-management.

This is not the 'be all and end all', not a solution to all that needs to get done - but it is a way of trying to fast track beneficial innovation in to front-line clinical practice; to take out the hassle of having to try to negotiate these things on a trust by trust or practice by practice basis.

The reality is that, actually, if you sort of begin to look at what some of these prospects are, it can get quite energising and quite exciting.

To give you one very simple example: here is my iPhone, here is an ECG machine now for under a hundred quid; we are probably going to put this on the national tariff for next year. Two million people in this country have got atrial fibrillation, and 20 percent of strokes are caused by that, a lot of it undiagnosed. We have different parts of the NHS beginning to use this technology, we should just make that a national reimbursable part of what we offer.

Likewise for COPD, we have health apps being used for the million patients with COPD, 90 percent of whom struggle to administer their treatments. So when we talk about the £22 billion savings and we talk about demand management and all of the rest of it, it is things like atrial fibrillation and COPD.

And things like intensive care units - 20,000 patients a year get ventilator-assisted pneumonia, with a 30 percent mortality rate. It turns out there is a small inflatable tube you can put in patients throats, and as a consequence that practically eliminates the risk of pneumonia-related death. We are using it in Birmingham - but not across the NHS - saving £700 a patient.

Again, let us get these kinds of innovations diffused much more quickly, much more widely. And I think that if we do that, we will see not only alignment with clinicians who generally are up for and excited by and can see the benefits of this, we will see the benefit for patients. And it is a much more inspiring and encouraging way to go about modernising our care delivery than simply the grind of cost take-out and reduction through conventional means.

CONCLUSION

So, in a nutshell: yes, it has been a tough year.

Yes, it is going to be tough sledding over the next 3, 4, five years.

Certainly I and colleagues will be making the case for the National Health Service and its resourcing forcibly and publicly.

But we should not kid ourselves that that by itself is going to buy us comfort in the status quo.

So, I think that, in our heart of hearts, we know what needs to get done.

Our job nationally, as national bodies, is to seek to support you in doing that.

At half term I took my kids away for a week down to Cornwall, my Dad was turning 80. My brother insisted we went out on one of these mackerel fishing trips - it always makes me feel slightly ill.

As we were pulling out of the harbour the skipper of this mackerel fishing ship, a little boat, said "I'm here to offer you every possible assistance...except for actual help!".

And it struck me that that might be the sensation that some of you sometimes have around the National Health Service. Well Jim and I are committed to changing that...and doing better than the skipper of that Cornish mackerel fishing boat.

Thank you so much.