HOUSE OF COMMONS

Health Committee

Oral evidence: Public expenditure on health and social care, HC 793

Tuesday 17 December 2013

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Written evidence from witnesses:

- Department of Health

Watch the meeting

Members present: Mr Stephen Dorrell (Chair); Andrew George; Barbara Keeley; Charlotte Leslie; Grahame M.Morris; Mr Virendra Sharma; David Tredinnick; Valerie Vaz; Dr Sarah Wollaston

Questions 239-374

Witnesses: **Rt Hon Jeremy Hunt MP**, Secretary of State, **Una O'Brien**, Permanent Secretary, **Richard Douglas**, Director General, Finance and NHS, and **Jon Rouse**, Director General Social Care, Local Government and Care Partnerships, Department of Health; and **Sir David Nicholson**, Chief Executive, NHS England, gave evidence.

Q239 Chair: Secretary of State, you come with a big team. You are extremely welcome. I do not think Mr Rouse has been before—you are very welcome—but others have, so they probably do not need an introduction.

I would like, if I may, to open the questioning by referring to some evidence John Appleby from the King's Fund gave us when he came to talk about public expenditure in health. He said: "…the real issue is not about saving money…but what you spend that money on." That is where I want to open the discussion, because, whenever we talk about rising trends of demand for health and care and the resource constraints that exist, there is a sort of orthodoxy these days that demand grows by 4% per annum—that is a total—and that somehow we have to meet that growth of demand.

The proposition I want to open with is that it is not just about totals; it is also about who is in that demand and what is the changing nature of the demand that is going to be placed upon the system in the projected period to 2020 that NHS England are now talking about. I would be grateful if you could tell the Committee what work is being done either within the Department of Health or within NHS England to understand the changing shape of demand and, therefore, by implication of course, the changing nature of the services that the system is going to have to provide.

Mr Hunt: This is the central debate and the discussion that we need to have if we are going to secure a long-term sustainable future for the NHS, which is what everyone wants. I have been doing the job for just over a year, and my own view is that, because of Mid Staffordshire and Francis, inevitably the national spotlight has been on hospital care and how we deliver hospital services, but I think a much more fundamental issue that we have to wrestle with is out-of-hospital care. That 4% figure is not fixed. If we spend our money more wisely, and in particular move to prevention rather than simply thinking about cure, we have a chance to reduce that demand growth, but of course that is not a novel thing to say. People have been saying that for a very long time and so we have been doing a lot of thinking about what needs to happen. NHS England are developing a primary care strategy and I work very closely with them on the new GP contract, which is the first step—but only the first step—in that process.

There are still significant efficiency savings that can be found throughout the system—and we can talk about those—but in the end we need to think about the nature of services we provide. The very big and challenging question, which we have not really had a public debate on in the way that we should, is how we maintain and improve the levels of service offered by hospitals at the same time as transferring more resources into out-of-hospital care.

Q240 Chair: But is there not a trap always in thinking about what this means for hospitals, GPs or pharmacists, rather than, as we were saying in the debate yesterday on the Care Bill, starting with the patient and identifying what morbidities the patients of the future will suffer from, and how the system meets their needs and reflects the changing nature of demand, so that it is not national, global numbers, but within a locality? How many people in this area are going to suffer from diabetes or from dementia? What are we going to do to risk-stratify in this community, to meet the demands placed on the services in this community? Can I push you on the extent to which there is real research being done, rather than assumptions being made, to inform the policy-making process, otherwise we shall be here in two or three years' time saying, "We ran out of money"?

Mr Hunt: Yes, it is the right thing to push me on. I am sure we can do more, but we are doing a lot already, and particularly through Public Health England, with which I had a meeting this morning.

We need to address one of the central challenges with out-of-hospital care, which is where the accountability line lies. When you have frail elderly people or disabled children with complex long-term conditions, it is not always clear where the buck stops in the NHS. That is something that we need to address if we are going to make sure that they get the wrap-around care they need, which, in turn, will minimise their hospital bills and mean that they get the best care they possibly can.

But there is another responsibility as well, which is the responsibility for people who are healthy, whom we want to stay healthy, whom we do not want to get diabetes or develop other long-term conditions until the last possible moment. One of the things we are looking at is population-level health statistics held by GP practices—for example, whether it is possible to track by GP practice the number of cancers that are diagnosed at a late stage rather than an early stage and what more can be done. You, Chair, talk a lot about integration. I am not sure that we are integrated enough between the activities of Public

Health England, who are responsible, for example, for health checks, and GP surgeries, who have a responsibility for early diagnosis as well.

Q241 Chair: I will have one final shot and then I shall go to Sarah. If people are going to understand in their local community the need for services to change, surely step one of that process is to show that, in a locality, not just the GP services but the whole health and wellbeing structure are asking themselves questions about what demand is going to look like two, three or five years out and create a narrative around what these individuals living in that community are going to need to enjoy a fuller life in five or 10 years' time, and explain it at a personal level. Until that exists, they will not accept the need to change the services that they have inherited and trust.

Mr Hunt: Yes, and perhaps I will ask Sir David to come in on that point as well because he has done a lot of thinking about service change; but I agree with that. There is one encouraging example where that did happen, and that is the reconfiguration for north-west London, which I think, in the end, turned out to be a lot less controversial than people thought it would be precisely because it was locally led, and local commissioners—local GPs, in particular—were able to make that very case to their local populations and were able to present the upside of the changes very clearly to go alongside any of the changes that people might have been concerned about, but in particular the fact that part of that package is seven-day GP surgery opening, which I think people could immediately relate to as something they would benefit from.

Sir David Nicholson: Underpinning this—and without boring you to death with process, which I know can happen—is that it is at the heart of that planning process that we kicked off today, as far as NHS England is concerned, in the sense that, for the first time, we are saying to every CCG that they need to come up with what their services will look like in five years' time. That sounds relatively trivial at one level, but it is quite a significant issue when you think about how you have to build that understanding on both what the population is saying but also on a joint strategic needs assessment over a significant period. Out of that will come a whole set of issues around local demand that we do not really understand at the moment but we will get out of that. I think we have the beginnings of a process to enable us to do that in the planning that we did today.

Q242 Dr Wollaston: I state for the record that I am married to a forensic psychiatrist, who works full time in the NHS.

My question is about the shift that everyone recognises needs to go into community services, and particularly into areas like parity of esteem for mental health. Could the panel comment on how we are going to establish parity of esteem for mental health, when in fact the funding is going in the other direction in that the hospital acute sector is still hoovering up the vast majority and increasing its share of total spend in the NHS?

Mr Hunt: I will make a brief comment and then hand over to Jon Rouse to add to it, if I may. This is a problem that, at its heart, is caused by the fact that we have an 18-week waiting time target for physical health but no equivalent target for access to mental health. Unintentionally, because I am sure this was never intended, that has tended to suck money into the area where people are being measured and highly accountable in a public way and away from mental health. We have seen the consequences of that in additional winter pressures over the absence of easily accessible psychiatric liaison services, for example. In

the new mandate we have committed ourselves to working towards fully costing out a mental health waiting times target in the next few months. Jon, do you want to add to that?

Jon Rouse: Yes. You have to tackle this in a multifaceted way. Some of the things we have to focus on are as follows. The first is information. We have a lot of information on mental health that is not properly analysed, understood and disseminated to commissioners in a usable form so that they can drive service improvement. Secondly, it is about commissioning itself, and NHS England and Sir David may want to say more about this as they are doing a lot of work through the Commissioning Assembly and the academic networks to be able to improve the quality of local commissioning for mental health services. Thirdly, it is about standards themselves, and we now have a proper outcomes framework for challenging localities for progress on mental health. Finally, and I suppose it is a bit more philosophical, probably the model of provision for mental health over many years has become over-clinicised and we have to get a better balance between social and clinical. There is a big role for social work within that.

Q243 Dr Wollaston: Can I come back on one very serious issue, which is section 136 and detentions? In the Devon and Cornwall police area, 25 children so far this year have been detained in cells instead of in an appropriate place of safety. Some of those children were as young as 12 and 13. That is an example of a gross situation where there is no parity of esteem. It would be unthinkable for a child with a broken leg to be waiting in a police cell for an assessment. Can the panel reassure us that that will not be happening next year?

Jon Rouse: It is certainly unacceptable; that is the first thing to say. The good news is that there has been a reduction overall in the numbers of people who are having to be detained in police cells, and clearly we want to have as many people as possible in clinical settings when they are being assessed. One of the things we have been working on over the autumn is the development of a crisis care concordat, which has brought together a whole range of organisations, including NHS England, the police, the ambulance service and the courts service, to review from first principles how crisis care should work from pre-crisis—because often with people who have long-standing mental health conditions you can plan for crisis—right through to recovery from crisis. We are probably about a month away from being in a position to publish that document, and that will hold the whole system mutually to account for progress.

Finally, and again Sir David may want to say more about this, Bruce Keogh's review of urgent care is crucial here to make sure that the pathways that are defined work for people with mental health conditions as well as physical health conditions—and, of course, where they have both physical and mental health issues.

Q244 Andrew George: Can I ask how you think the "any qualified provider" system is going to help you achieve efficiency gains? CCGs have inherited the decisions of their predecessor PCTs, who were forced, or required, to commit themselves to a number of contracts under AQP. Across the country, not just in my own area, this has resulted in, for example, a high-street optician—a well-known name—providing hearing aids, and I am sure you know of that particular system. It has left the CCG with an impossible-to-manage budget, which has no upper limit, so long as patients can be driven in through the front door of this particular high-street provider and the provider will follow human nature or the commercial rationale of doing everything they can to attract them in, in the proper manner and within the rules, of course.

How does that system help the Government achieve their efficiency gain, what monitoring are you undertaking, and, if you are monitoring it, what decisions are you making with regard to how you are going to roll it out or, indeed, not roll it out any further because it is not providing you with a means by which you can achieve the efficiency gains you need?

Mr Hunt: Shall I start on that? It is clear that the intention of the Health and Social Care Act is that CCGs should be able to commission the services that they believe are in the interests of patients locally, so I would be concerned if any CCG felt that they were not able, in the case that you mentioned, to commission services that were in the interests of patients. The "interests of patients" also includes having a budget that they are able to control at sensible levels, because, if they cannot do that, that impacts on services available to them.

Q245 Andrew George: They cannot under AQP. They tell me—they confirmed with me—that they have no control; they inherit this. It is not just in NHS Kernow but across the country. Where they have inherited the AQP arrangement, my understanding is that they cannot control the upper limit of what patients demand from those services.

Mr Hunt: They may have inherited a contract from the previous PCT and the contract will not be for ever, but in many NHS contracts there are measures in place to control demand. I do not know the individual details of that case.

Q246 Andrew George: No, but I am sure that Sir David must be aware of these arrangements.

Sir David Nicholson: The most obvious place where we use "any qualified provider" is in elective care in the sense that people can choose to go to any provider that they wish to, to have elective care, and we do not put a ceiling on all that. We think that is a perfectly reasonable thing to do, driven by patients and their choices. But as to the particular example that you give on hearing aids, if the CCG feel that it is inappropriate, given the contractual framework that they operate in, they can withdraw from it.

Q247 Andrew George: They can at any time?

Sir David Nicholson: Yes, they can.

Andrew George: Thank you.

Q248 David Tredinnick: Secretary of State, I want to ask about available money and pay. Your Department has argued in a submission to the NHS pay review bodies that there should be no general 1% salary increase in 2014, contrary to what had been previously indicated, and that progression pay should also be ended as part of a move to pay "with stronger links to performance, quality and productivity." Do you believe that there needs to be continued pay restraint in order to make the NHS funding settlement viable?

Mr Hunt: Yes, I do. I hope the Committee will forgive me if I do not elaborate too much on this answer because we are in the middle of negotiations now over this. I will make two points. First, I dearly want to give NHS employees the 1% rise that we want to give across the public sector. If money was no object, I would like to give them more because I think they are working extremely hard under very challenging circumstances, but budgetary constraints exist.

The commitment that the Government made was not 1% regardless of any other increments that you may be getting in your pay package; it was that everyone in the public sector should get at least a 1% rise, and we want to honour that, but we do need to negotiate on the increments that are a part of many NHS contracts, which means that pay in certain contracts can go up by as much as 6% or 7% automatically. My concern is that, if we do not do that and we agreed to the 1%, essentially an unaffordable 1% increase in the pay bill equates to about 10,000 front-line posts. The thing that makes the NHS different from other parts of the public sector is that we are expanding in terms of the number of people we employ at the front line, and we want to employ more people, particularly in the wake of the Francis report. Hospitals want to employ another 4,000 nurses compared with a year ago, and I want them to employ those extra nurses. It is something we need to do to meet our commitments under Francis. I want to make sure that trusts end up with a financial position that enables them to do that.

Q249 David Tredinnick: Do you think it is a fair accusation to say that there is an over-reliance on pay restraint to enable the NHS to meet its efficiency targets?

Mr Hunt: We recognise that the pay freeze that we started this Parliament with is not sustainable and that is why we have moved to 1%. We also recognise—and Sir David, I am sure, would want to comment on this—that that means we have to be even more imaginative in finding other ways to make efficiency savings because we cannot constantly rely on the kind of pay restraint that we have had to date.

Q250 David Tredinnick: So you are not considering maintaining pay restraint beyond 2014?

Mr Hunt: No, we are; that is precisely what we are negotiating at the moment. We do believe there needs to be pay restraint and it is very important that we are successful in that ambition.

Q251 David Tredinnick: So there will be pay restraint over the whole of the next spending review period. We can take that as read?

Mr Hunt: The spending review period we have agreed is until the end of March 2016, so I cannot comment on anything beyond that, but certainly until that period, yes, indeed, there needs to be pay restraint.

David Tredinnick: Thank you.

Q252 Barbara Keeley: This follows up, Sir David, the points that we put to you at our last meeting. The broad question I want to ask—I have some other points to make as well—is whether you think you have enough information available about the way the NHS operates, including on issues such as staffing and redundancy, so that you can identify and address issues of concern.

You may remember at our last meeting that my colleague Valerie Vaz asked you about the figure for people being made redundant and then rehired, and we went through a question and answer where in fact you said you did not have that information. But we have been sent the information in a table since and we have that here. The figures are quite interesting in the table that the Department sent us. They state that 19,126 members of staff were made

redundant, 3,261 of whom have been rehired to the NHS after redundancy, including 2,534 within one year, and, fascinatingly, 403 within 28 days of being made redundant.

At the same meeting you were asked a question about Ruth Carnall, and you initially told us that she was not doing paid work for the NHS after she had taken what turns out to be retirement, but not redundancy, and a pension, but we learned during the meeting via social media—and in fact you told us too—that that was not the case and she was being paid for the work she is doing at the NHS in Manchester.

Now, I understand the policy. You told us that there was a policy that people who were made redundant would not then move into paid employment—you said—for a period of six months, but I understand there is also a policy around re-employment of people who have taken early retirement and pensions that "Offers of re-employment, or payments for consultancy work, are not expected to be made to former Scheme members who have taken early retirement from the NHS at public expense…"

So here we have a policy around rehiring people after redundancy and rehiring people who have taken early retirement that just does not seem to work. We seem to have a practice of getting rid of posts for people via redundancy or early retirement, with sometimes very costly pay-offs, and then rehiring them. In some cases you are straightforwardly rehiring them as staff again, and that is shown in the table you have sent us, or they have been taken on in other parts of the NHS as consultants and you are effectively paying them twice. This is really of concern. We thought it was a concern at the last meeting but we did not have much information from you. Can you explain how you have a policy that you are just not upholding?

Sir David Nicholson: I am sure Una will want to talk about the broader issue, but I can deal with it from the perspective of NHS England and what we have done.

Yes, it is an absolutely legitimate thing to raise this whole issue about rehiring. We went through the process of the transition, and we tried to reduce the amount of redundancy to the absolute limits of what we could do. As you know, we originally thought we would spend about £1.5 billion on redundancy, and in fact we only spent £600 million or £700 million on it. So we managed to do that, although I have to say I have also been criticised for transferring too many people from the old system into the new one as well. But, nevertheless, we have reduced the redundancy bill significantly based on what we thought beforehand. Of course, we have delivered—we will have done by the end of the Parliament—£5.5 billion-worth of savings that we can reinvest in front-line services, which I think is not to be ignored at all; it is very important.

In terms of the people, you are absolutely right that we have a position where, legally, if someone is made redundant they can be re-employed within 28 days. I wrote to all the senior people in the SHAs as part of the transition arrangement saying that I understood that was the case, but I wanted them voluntarily to agree either not to be rehired or work as a consultant for at least six months.

Q253 Barbara Keeley: That is not happening.

Sir David Nicholson: I have no legal basis on which to do that. I have no power to make it happen. I just asked them not to do that. I can confirm, in terms of the very senior

managers, that NHS England has not either funded or employed any of those people over the period. That is NHS England.

Q254 Barbara Keeley: Over which period, sorry?

Sir David Nicholson: Over the six months since the beginning of NHS England's existence.

Q255 Barbara Keeley: Do you mean as employees or consultants?

Sir David Nicholson: Either.

Q256 Barbara Keeley: So what about Ruth Carnall?

Sir David Nicholson: NHS England have not employed Ruth Carnall in any capacity.

Q257 Barbara Keeley: She worked in Manchester

Sir David Nicholson: The point I am trying to make is for NHS England. The issue, of course, as you know, is that the NHS is not a single organisation. It is made up of almost 500 different employers, all of which have their own arrangements and it is—

Q258 Barbara Keeley: Let me stop you at that point. You have a policy that is impossible for you to enforce because now it is so fragmented that you do not have control over those parts of it. You can write and ask them not to do this, and they can just ignore it. That is what has happened, is it not? Ruth Carnall is one example, and heaven knows how many others there are. I am not in any way doubting that she is a talented staff member, that she has skills and something to offer, but this is the use of public money. This is the use of public money—pay-offs and redundancies and people taking pensions from the public purse and then being re-employed in another capacity and being paid for consultancy. Effectively, what we are seeing is people being paid twice from the same purse.

Sir David Nicholson: I completely understand that and I think you are absolutely right. That was why I wrote the letter out saying that I wanted people voluntarily to do it. But you are absolutely right—I do not have the power at the moment to enforce that—

Q259 Barbara Keeley: And no one does.

Sir David Nicholson: —in CCGs, foundation trusts or NHS trusts overall, so that power does not exist in the system as we operate at the moment.

Q260 Barbara Keeley: That policy that I quoted parts of is effectively meaningless, because you cannot stop people being rehired and you certainly cannot stop people coming back and being paid as consultants at all.

Sir David Nicholson: I cannot, no, in the job that I do.

Q261 Barbara Keeley: So the policy that I quoted from is meaningless. They are being paid twice. I do not know if the Secretary of State wants to say how we come to have a policy that we cannot enforce.

Mr Sharma: Is there anyone who can control that?

Mr Hunt: The first point I would make is that the NHS is 1.7 million people strong, and successive Governments, not just this Government, have concluded that it does not work to try and run it as a single structure with everyone reporting up directly to the Secretary of State at the top of the pyramid. So successive Governments—for example, the last Government—introduced the policy on foundation trusts that operate as independent bodies. We do not have the power—Sir David is absolutely right—to stop someone leaving one foundation trust and rejoining another, even though you are absolutely right to say that, ultimately, both salaries or consultancy figures are paid for by the taxpayer. We took that decision because we recognised that we needed to have a system that is—

Q262 Barbara Keeley: I do not think it is a question of people moving, Secretary of State. I think it is a question of the reorganisation that your Bill forced through and people being made redundant—in some cases, their structures going. I think that is the case with Ruth Carnall. Her structure disappeared, so there was a redundancy pay-off; there is an early retirement. These are very substantially highly paid people, who are getting that amount of money and then just coming back in through the revolving door as consultants, just popping up somewhere else in the country. It is not people moving. The real issue is people being paid twice.

Mr Hunt: Okay. So if we come to reorganisations, which happened a number of times under the last Government as well as under this Government—

Barbara Keeley: Not as expensively as this one, I have to say.

Mr Hunt: This one is also saving a lot more money.

Q263 Barbara Keeley: Point to one that has cost £3 billion.

Mr Hunt: It is saving £5.5 billion, but that is a different discussion. As a result of what we have learned from this reorganisation—and indeed practised under previous reorganisations—we have now changed the rules. When national arm's length bodies are re-employing someone who has been working for another arm's length body or in a previous structure, if they are re-employed within a year, that person pays back their redundancy on a pro-rata basis. That is a change in the rules to deal with that issue.

Q264 Barbara Keeley: Does that apply to any of these people who have been rehired?

Mr Hunt: We cannot apply it retrospectively because people are entitled to their own contractual entitlements, but it is a rule that we have introduced. I do not know whether the Permanent Secretary wants to answer that.

Q265 Barbara Keeley: You have rehired 17% of the people who were made redundant in the last three years, according to the figures the Department sent us, and that is a very substantial proportion; 17% have been taken back on again, a number of them within 28 days, ridiculously enough, and most of them within one year. That smacks of appallingly bad planning—that they were not able to be redeployed from the role you were moving them out of into another one. It smacks of carelessness with public money. I am sure that people outside here will not be impressed that you have policies that you cannot enforce, and, now that you have thought of a way of enforcing them, you cannot do anything about the costs that have already been incurred.

Mr Hunt: Let me ask the Permanent Secretary to come in and I will come back on that.

Una O'Brien: The first thing to say is that very significant efforts were made to restrain the total amount of money spent on redundancy. That was a significant effort, and it meant that a significant number of people who were entitled to redundancy payments under the rules set in 2006 did not get those payments but got jobs in the new system. The facts bear out what David has said—that a significant proportion of people employed in the new system are in different jobs, many of them, and some of them have much bigger jobs. But the truth is that we did not spend a lot of money on redundancy that we would otherwise have spent. That was our focus and we were very, very determined to keep that redundancy bill as low as possible.

If I could come on to the next point—

Q266 Barbara Keeley: I think 19,000 staff have been made redundant. With a good proportion of those coming back, it does not follow through with what you are saying.

Una O'Brien: Currently, the 2006 rule is that, if someone is re-employed within 28 days, they have to pay back their redundancy. I think that rule is too lax and we now need to change it. We need to change it so that, as the Secretary State has said, if you are re-employed within a year in another NHS organisation and you are in receipt of redundancy payment, you pay it back pro rata. I would point out that it is absolutely true that you have identified for people who have very long service and who are on high salaries that their redundancy payments are significant, but it is most usually the case that people's redundancy payments are relatively modest. So there can be a junior administrator made redundant on £15,000 or £20,000, who, six months later, finds a job in another organisation, a job that was not available or vacant at the point at which they were made redundant. This is an industry and I do think that point needs to be made.

Q267 Barbara Keeley: I have given an example of one of your most highly paid staff, who has now been effectively paid twice.

Una O'Brien: I want to come on to that, if may. The third point is that it is well known, for example, in the civil service that we have the Advisory Committee on Business Appointments where there are arrangements, if you are made redundant or you leave for other reasons, particularly in a senior position, that you are restrained in the work that you do, particularly that you should obtain no commercial advantage from your experience. I now want all the arm's length bodies of the Department to follow the example that David has set in NHS England by beginning as he means to go on, which is to set business rules equivalent to the civil service rules for NHS England. I now expect all the arm's length bodies for the Department of Health to do that so that people's expectations are the same as those for civil servants when they leave office, particularly people who have been in a job where they gain knowledge or contacts. Before they move on to their next role or at the point at which they take up their next role, they will have to get an agreement about whether they have to have a waiting period or step back for an appropriate amount of time so that we do not get the sort of situation that you have described.

Barbara Keeley: It sounds as if you needed to have done that before, because, clearly, with the reorganisation, a very large number of managers—you have not supplied us with the figures, but we have had other figures in the House of Commons—who have been made

redundant and rehired as well, and there are examples of people who are very highly paid, who have taken packages and are now coming back as consultants. You have given us the response, but I think that there will be a view outside here that this is not satisfactory; this should have been dealt with earlier; if you have policies now that you cannot make retrospective, you have used money from the public purse that you should not have done; and this is not a satisfactory situation.

Chair: There are several members of the Committee who want to come in on this, but if we are going to spend all afternoon on it we are not going to get—

Q268 Andrew George: While we are on pay, I want to ask a question about where the Government currently lie in respect of the risk, as I see it—and perhaps, Secretary State, you may take a different view—about the possibility that foundation trusts, NHS trusts, may introduce regional pay. You are aware that your predecessor took the view that, while he was not going to direct the south-west consortium of 20 or so trusts to discontinue their activity of exploring the possibility, at the time that the Agenda for Change national negotiations concluded, each of the trusts wrote to me and confirmed that they would abide by the national pay, terms and conditions, providing they remained, as they put it, fit for purpose, which of course gave them the let-out of reintroducing this concept at a later stage.

I want to be clear about whether, if NHS organisations suggested they might introduce the concept of lower pay—that is critical—in certain areas, that is something which, as a Department, you would take action against, that you would discourage. What is the view of your Department on that issue?

> ***Mr Hunt***: As a Department, we subscribe to the principles behind autonomy and independence for foundation trusts. That is the Government policy and we want all hospitals over time to become foundation trusts. We really think it is a matter for them, but, as I understand it, most FTs, if not all, prefer to have national pay scales. They find it easier to negotiate with their staff on the basis of them, providing those national pay scales are competitive and fair, both in terms of the employees and what the FTs want to deliver to their patients. The example you cite was an example where the south-west consortium felt that the national terms and conditions were not fair. Negotiations then proceeded. There was some flexibility on the union side and they were able to live with the result. I think everyone has ended up happy and I think the Government are happy as well.

Chair: Charlotte Leslie wants to talk about the integration fund, but before that she wants to ask a very quick question on this subject and then we will move on.

Q269 Charlotte Leslie: Very quickly to round off the discussion that Barbara led, it seems that a very large and expensive loophole was left in the implementation of the reforms whereby people were able to get redundancy payments and pensions from the health service and then go off into consultancy. It is commendable to write advice asking that these people do not take up any positions within the NHS for six months after they have left, but it is kind of after the horse has bolted. Secretary of State, are you happy with the way the reforms were implemented in leaving that large loophole open?

> ***Mr Hunt***: Always, when you do something on that scale, of course you learn lessons afterwards. I do not think it is possible in a huge system like the health service to prevent people from leaving the health service and then becoming consultants. Indeed, it may be in

the interests of the health service and patients that we are able to tap into the expertise of people on a time-limited basis through a consultancy contract. But what we do not want is abuse of that system and we do not want the public to be paying twice. We have tried to learn the lessons from this reorganisation and other reorganisations by making some changes, as the Permanent Secretary outlined.

But the overall point I would make about these changes—and I do think it is important to take the overall context—is that, by removing 23,000 administrative posts, including 8,000 managers, we are able to employ 6,500 more doctors. The NHS is able to do 800,000 more operations every year on broadly the same budget, and that is because we have moved a lot of money from back-office functions to the front line. I think that that, overall, represents a massive increase in value for money for every taxpayer's pound that goes into the NHS.

Q270 Charlotte Leslie: In terms of the performance being good overall, this is an expensive loophole that, with hindsight, it would have been very good to close before we had this problem arise rather than have to write letters after the event asking people not to take up lucrative posts.

Mr Hunt: I don't think it would have been right not to do—Some of these things are quite complex and it is not as easy as just wishing the problem would go away or making a simple change, because people have rights under employment law. Where there are loopholes that are easy to deal with, we have done that. One of those is the new 12-month rule that we are implementing across the system. It is not possible to implement those kinds of rules on a very localised level, but, obviously where we can, we do everything possible to make sure we get best value for money.

Chair: Let us turn to integration transformation.

Q271 Charlotte Leslie: Absolutely; that is what I am burning to ask about. What will the impact of the integration transformation fund of £3.8 billion be and can you clarify whether this is new money or not?

Mr Hunt: It is not new money in that it comes from the NHS budget, and it is now called, incidentally, a much improved name—the "better care fund"—which I hope will make it much less of a mouthful for the Committee and indeed all of us. It represents an additional £2 billion going from the annual NHS budget into integrated support through the health and social care system. The intention is to improve out-of-hospital services for some of the most frail and vulnerable older people who use the social care system by giving them a joined-up service and by being a catalyst. In order to access that money, CCGs and local authorities will have to jointly commission services. There is a list of things that have been on the chairman's list of requirements for any integrated care package for many years now that will have to be done in order to access this money. It is deliberately designed to be a sufficiently large sum of money so that no one will feel that they cannot be bothered with accessing it. They will feel they have to access it. Things like record sharing will be part of it, and having a named accountable clinician responsible for each and every one of those vulnerable older people will also be a part of it. But it comes from the NHS budget.

The other point about it is that we expect there will be significant savings both to the NHS and the social care sector in terms of, particularly, omission avoidance by proactively looking after people better in the community.

Charlotte Leslie: Thank you.

Q272 Barbara Keeley: There are real concerns about whether the planning for the integration fund is going well. In fact, we have had concerns that it is not going well at all. A witness from the Nuffield Trust said: "My anxiety is that planning is happening too late for this and it is happening too late to co-ordinate with the acute sector." In the next panel that day we had witnesses from the LGA, who did not talk about planning for the integration fund but talked about talking and developing relationships. So it seemed that the LGA representative evidence bore out what we had heard from the Nuffield Trust.

It seems that planning for integration is not robust enough. I think there are two things related to that. First, there is a fear that the money will not be spent as effectively, and, secondly, that you will not make the savings that you just talked about. The real fear is that there could be problems in 2015-16 and that we will not see effective integrated working established. What we will see is just money going in to soak up pressures, of which there are plenty—obviously pressures in A and E and very substantial pressures around social care. That is what we have heard and we are concerned. Are you concerned and what can be done?

Mr Hunt: It is absolutely right to express that concern because it is very important that this is a real transformation, not just either a cosmetic transformation or a continuation of what we had before, which was much more limited in its ambition. But we have tried to mitigate the risk of that happening through a very aggressive timetable. The fund is for the financial year 2015-16, so it starts in April 2015, and we have said that we require all CCGs and local authorities to have put together their plans by April 2014, a whole year in advance. That gives us time to go through those plans in detail to check they are robust, but also, importantly, for the plans that are good, we believe that many local authorities and CCGs will not want to wait. Even though they are not going to get access to the fund till 2015, they will probably want to start a lot of the integration well before April 2015 and indeed make it part of their 2014-15 cycle because of the prospect of significant savings being made. But I think you are absolutely right to say that, with a plan of this scale, it is all about the implementation and we need to monitor that very carefully.

Q273 Barbara Keeley: We did not hear anything that gave us a lot of confidence that it was happening because the LGA representative talked about relationship building and that is the stage they were at. If you are expecting to see plans in four or five months, the people we have heard from do not suggest that is happening. One of the things—and I do not want to rehearse everything that happened in the debate yesterday—is that my own local authority, which is suffering from cuts, has had very substantial management resource cuts. It has lost a chief executive—that post has been cut—and the previous chief executive's job is now shared between three former deputies. There just is not the resource there. You cannot take 20%, for instance, out of social care and not lose managers and people who will do that planning. From what I see locally in my area, there are not the people on the ground in local government to do that planning. They have just spent all their time and had the auditor in, and been talking about how they are going to make £75 million more cuts. They have to get that budget right because, if not, your colleague in DCLG will come in and do it for them. Where

is the resource that is going to do this planning? What we have heard over the last number of weeks is that it is not happening yet.

Mr Hunt: We have said that we require those plans by April, so that is a pretty important deadline for all local authorities and CCGs because those are the rules of the fund. We will be following up very closely. But we recognise the kind of challenges that you are talking about. It is very tough, particularly for local authorities, but actually tough for CCGs as well because they have huge pressures on their budgets. This is something that is overwhelmingly in everybody's interests. I think the north-west has made some of the best progress towards integrated care of anywhere in the country actually.

Q274 Barbara Keeley: You have not mentioned Torbay.

Mr Hunt: And indeed Torbay—Torbay and the north-west.

Dr Wollaston: Stand by.

Jon Rouse: Can I add one point? It is a counter-balance in terms of what could give us confidence. In the summer, we asked for applications to be pioneers for integration, and I remember at the time that we had a bit of a sweepstake in the office in terms of how many bids we would get. I chose the highest number and said 35. We actually got 99 and some of those had more than one local authority in them, so we had well over 100 of the 152 upper tier authorities bidding to be integration pioneers and putting all the work with their CCGs and their providers into those applications. I think there is a real momentum out there. I travel pretty extensively around the country visiting localities. Most places are planning pretty transformational integration models and I have high hopes that that will be reflected in the plans.

Barbara Keeley: It might be that people were more optimistic in the summer than they are when they are facing winter pressures, but I have reflected to you what we have heard over the last few weeks from the Nuffield Trust and from the LGA. We can only tell you what we hear.

Q275 Dr Wollaston: Now on to Torbay, and I am very glad that they are an integration pioneer. Can I touch on the impact of the Care Bill, because the Care Bill is going to impose many new statutory responsibilities on councils? If I look, say, at an area like Torbay, they are going to have a crunch year in 2015 when their projected funding will fall to below 90% of their projected expenditure, and that is not including all the new commitments they will have. Unfortunately, the impact of that, it seems to me, is that there is a risk that, because everything will have to go on their statutory responsibilities, there will be nothing left to fund the kind of projects around the voluntary sector that provide all the wellbeing that was the stated aim of the Bill.

How concerned are you, Secretary of State, that we may not be able to put in place a lot of the good intention around wellbeing in the Care Bill because of that funding pressure? In Torbay's case, just in the next two years, they will have to take out between £22 million and £27 million; the elastic can only stretch so far. As you will know, there is no fat on the bone left. They have already done the bulk of the integration that other areas have not even started.

Mr Hunt: I would not want to underestimate the financial challenges facing local authorities. I think it is very tough and it is very tough in the NHS, as you know, as well, but that is why we are seeing such imagination and energy going into thinking about new ways of working. Sometimes it is at those times of financial pressure that people are at their most imaginative, and I think that is one of the reasons why Jon Rouse found such enthusiasm for the integration pioneers and one of the reasons why people will really take seriously the plans that we put forward for the better care fund.

I know Torbay has also been one of the pioneers when it comes to integration, but I think there are a lot of things where, even in Torbay, we can do a lot better than we are currently doing. For example, as to the use of technology, the new GP contract includes agreement from GPs that has not existed before surrounding the use of the GP record, which, with patients' consent, will now be able to be used throughout the system electronically. So some very exciting things can happen, but the truth is—and I think this relates to the very earliest discussion—we absolutely need them to happen at pace because we need to make the productivity improvements deliver within the budgets.

Q276 Dr Wollaston: Can I come back to that, because within Torbay, as you know, they have already done a huge amount of the work that other areas have not even started? They have already cut their acute beds and have the lowest, if you like, hospital admissions in the south-west; they are doing incredibly well nationally on scales for early discharge; they already have in place all those mechanisms for rapid equipment and a single care co-ordinator—all these kinds of things. I wonder whether they are going to be able, even with the measures you have outlined, to make sufficient savings and where it is all going to come from. Do you feel that we are going to have to see an increase in overall funding for the NHS in social care—new money coming into the system—for it to work?

Mr Hunt: I think everyone is going to have to live within their budgets—budgets that were agreed in the 2015-16 spending settlement. Indeed, I know that the Labour party have said if they win the next election they will stick to those spending limits in the first year of a new Parliament as well. We are in a very invidious position nationally of having to deal with the deficit and that means we are going to have to live within those spending limits. I would say that the kind of vision that you have had in Torbay bodes extremely well because you have shown imagination, and the ability of different parts of Government to work together has been tried and tested there, which should mean that you are more than up to meeting that challenge, but I do not want to pretend it is going to be easy.

Q277 Chair: I think part of the scepticism of the Committee about the pace and scale of necessary change going on in the system might derive from the relative absence of major proposals for service change affecting disinvestment from traditional models of care. Given the point you were just making about the resource constraints being here for the medium term, the proposition that there is something beyond imaginative thinking—i.e. imaginative action—would be more credible, would it not, if we were seeing significant resource transfers out of the acute sector into the community service, whereas what we are actually seeing is resources increasingly drifting into the acute sector and out of community and primary care?

Mr Hunt: That is a fair point to make, but I would say that I think the better care fund is a very good example of the reverse happening because that is money that, by and large, is

not going to be spent in the acute sector at all. I think that is the first really significant step. As a result of the better care fund, the QIPP —

Q278 Chair: Do we not have to establish in the policy community's mind the principle that the better care fund, if it is to be real, means more community-based services, which means, in a cash-limited budget, disinvestment from acute services, which, the NAO says, are meeting need that never ought to have arisen?

Mr Hunt: I would say "less money" rather than "disinvestment". Less money means more efficient use of resources, but it does mean less money in the acute sector. As a result of the better care fund, which is going to be real, we have to increase the QIPP savings that we will be requiring from around £4.5 billion a year currently to around £5.5 billion in 2015-16, and we will have to find that extra money. I am very happy to talk to you about how we can do that, but, yes, we will have to make savings because it will mean less cash spent in the acute sector.

Q279 Chair: I do not want to hog it, but I guess I would be more comfortable that it was more than "early stage discussions" if we were seeing some dust being thrown up by these proposals for "less money", to use your phrase, rather than disinvestment. I, like you, prefer that formulation; it is easier to understand.

Mr Hunt: Perhaps I can reassure you by saying that we do intend, before the end of March, to publish how we will get to the necessary QIPP savings for 2015-16, and that will show how we think we can deliver that for that period of time. But there is a lot of work happening right now in order to firm up the realistic possibilities for saving money. We can go into those now if you like, but that is—

Chair: We do not have time to do that because I know Andrew wants to go into the implications of this competition policy—some of the points that Sir David was making when he was last here.

Q280 Andrew George: In fact I will start with a quote from you, Sir David, on 5 November when you were before the Committee where you described that we have a problem that may need legislative change. If I may quote: "...competition was a tool to improve quality, to be used when commissioners felt it was the right thing to do, not something that would be brought in externally…For whatever reason, legislatively and in practice, that is not what is happening. What is happening at the moment…we are in my view getting bogged down in a morass of competition law, which is causing significant cost in the system."

My question to you, Secretary of State, is, do you agree with Sir David? Do you think that competition law is resulting in this morass and indeed is costing more than it is saving?

Mr Hunt: I believe that what is happening on the ground is not what the Act intended as much as we want. We intended with the Act that local commissioners—GPs—would have the power to commission services in the way that they believed was right for patients. They are operating under the same procurement rules as the PCTs did, but they are new teams of people and they are finding that quite onerous. My own view is that we need to look at why that is and, in particular, whether there is advice and support we can give them so that they do not feel they are getting bogged down in that competition law. I do not think that it is a case of the competition law that, as I say, the PCTs themselves were

operating under necessarily being wrong, but we need to make sure that CCGs feel they have the autonomy and the ability to commission in the way that is in the interests of patients.

Q281 Andrew George: It is the CCGs that need tutoring and support, as it were, through this process? You would not agree with Sir David that there is a prospect for legislative change to achieve the clarity that is needed in order to get the efficiencies that are clearly not being delivered.

Mr Hunt: I think the efficiencies are being delivered by a lot of CCGs—by the way, I do not think this is a problem that affects all CCGs—and, you know, all the legislation that we pass as a Government we keep under review to make sure that the practical way it is being implemented on the ground is in accordance with our intentions when we passed the legislation; and that is what we will continue to do.

Andrew George: Unless anyone else wants to come in on that, I want to ask a question—

Q282 Chair: Can I ask a brief question? If NHS England comes to you with a proposal to change the legislation to ensure that the competition law is not an inhibition to necessary change, that is something that in principle you are prepared to promote?

Mr Hunt: Of course I would listen to them very carefully because I want the commissioning process to work and it is really important that it should work. So I want to make sure that the intentions of the Act are reflected in what happens on the ground. I do not think we are at that stage yet. As I say, CCGs are new organisations and they are operating under the same procurement framework as their PCT predecessors, but, of course, PCTs were long established and had lots of people who were used to dealing with procurement. EU procurement rules are a nightmare at the best of times. Having run my own private company, I experienced them on a number of occasions, so I can well understand the frustrations, but it is very much my job to listen to what NHS England say, to make sure that CCGs are able to do what the Act intended.

Q283 Andrew George: I will then move on to a related issue, which is the relationship between tariff funding and the risk or the potential perverse consequences of cherry-picking that might happen in the system, which I have raised before with you and we have corresponded on it, and indeed with Sir David and Richard Douglas a year ago when we first raised this issue. We were told at that stage—a year ago, that is—that there was a concern about the potential risk of perverse consequences; that certain providers would, in effect, cream off the easier work and therefore profit from the tariff arrangements and not undertake the more complex work because the tariff system enabled them to do that; and that you, or at least the NHS commissioning board, were undertaking a review. You were very specific last year—and indeed, Mr Douglas, you were clear—that it was the commissioning board's responsibility to undertake a review and to redesign the tariff system to ensure that such unintended consequences did not occur. We sought clarity on that particular point and wanted to be absolutely clear that it was not Monitor's role. You were clear that it was not Monitor's role; they were there purely to inject the prices into the system, but the design itself was for the commissioning board. Is that right, and what progress have you made in the last year towards achieving this outcome?

Richard Douglas: In terms of the basic approach, you are absolutely right. In broad terms, the commissioning board sets the structure of what the tariff should deliver and Monitor attaches a price to that. There are some elements around the edges, but that is the broad structure. The position for next year for the tariff is, broadly speaking, that it is steady state. There has not been and will not be a fundamental change to the tariff for next year. It is now a matter again for NHS England and Monitor to work through what the next stage is, but there has been a deliberate decision for next year that we will keep it broadly as it is. I do not know whether David wants to add anything on that.

Sir David Nicholson: No, only to say that the tariff is being published I think today or tomorrow by Monitor. We have had our input into all that. We think that, with the tariff, we have taken the right balance between changes and continuity to enable trusts to have as much certainty as they can about the future. But in terms of the particular point that you make, if an individual commissioner or trust believes that a provider is acting in the way that you describe—i.e. for other reasons, selecting their patients on the basis of that—that is a matter for Monitor. That would be a complaint that could be made to Monitor and Monitor would investigate and take the action that was required.

Q284 Andrew George: On what basis?

Sir David Nicholson: Monitor has a responsibility—the tariff has a responsibility—both to improve services to patients and also to enhance integration. If in those circumstances they find a provider is acting against that interest—i.e. against the interests of patients in those circumstances—it can take action.

Q285 Andrew George: But you know that this is going on all the time. You know this is going on all the time because you know that a lot of providers are not taking the more complex patients, and they have been set up to provide a system, particularly in the area of elective care, where they cannot. So that is going on anyway.

Sir David Nicholson: I am sorry—you were suggesting that people were doing it. You are absolutely right that there are hip and knee providers and people who provide heart surgery, but that is part of the segmentation of the way in which the service is delivered, is it not?

Q286 Andrew George: It is, and, therefore, for any patient who comes to them with a set of co-morbidities, or who represents an anaesthetic risk that they are not prepared to take on, clearly they have designed a service that is cherry-picking the easier patients, for which they are then being paid a decent tariff to provide a service only to those patients and not to others.

Sir David Nicholson: There are two separate issues here. You are absolutely right that in some circumstances, in some stand-alone elective units, it is not safe for them to treat people with a lot of co-morbidities, but that seems to me the right thing. You would expect them not to do it.

Q287 Andrew George: No, you are twisting the tables on me—

Sir David Nicholson: Sorry.

Andrew George: —which is a fair point. The issue is that, in those circumstances, the providers that are providing those elective services in limited circumstances are being paid at

a rate that does not properly reflect the relatively low risk of patients that they take on. That is not reflected in other settings where they take on significantly more complex patients, and the tariff does not properly reflect that for them.

Sir David Nicholson: If you could give me examples that would be great, and I will investigate them.

Q288 Andrew George: You do not accept that this is a theme that has been raised with you?

Sir David Nicholson: No, it has absolutely been raised with me, but on almost every occasion where we have dealt with it in detail, we have found it either to be not the case or people have put in action to change it straight away.

Q289 Andrew George: Last time we discussed this, you said that you would be road-testing your proposed redesigned tariff system. Where did you road-test it and what were the outcomes? Can we read the report on your road-testing, please?

Sir David Nicholson: I can do you a note on all that.

Q290 Valerie Vaz: I want to go back to some of the answers you gave my two colleagues, Barbara Keeley and Charlotte Leslie. The point they were trying to make, to which we did not quite get an answer, is that it is as a result of the reorganisation that took place that this issue arose about the rehiring. God bless Norman St John-Stevas for having a Select Committee structure, otherwise you would not have come back to us with information and perhaps you would not have discovered this loophole. Is that correct?

Mr Hunt: "God bless Norman St John-Stevas" was not a phrase I was expecting to hear this afternoon. Listen, I recognise that when you do any reorganisation you learn lessons, and the NHS has probably had more than its fair share of reorganisations over recent decades. That is why we have decided to make this very profound and significant change after this one, which was to say that, if people rejoined the NHS within 12 months of leaving the NHS as part of a reorganisation, they should repay any redundancy money they were given on a pro-rata basis. So we have learned that.

All I would say is that in terms of value for money—and I am sorry to repeat myself—the only reason that we are able now to be doing 600,000 more elective operations, and seeing 1.2 million more people every year in A and E, is because we have more people at the front line, and that was made possible by this reorganisation. Overall, I think it was a very big improvement in value for money because it did allow more resources to be invested in the front line, which is what we needed to do.

Q291 Valerie Vaz: I congratulate you on your selective memory, but there was a transition and then a pause, and a number of people raised issues—professionals and we as a Select Committee did—about the Health and Social Care Act and what was going to happen. It is clear from the letter that you sent me—and, obviously, I am a bit upset really—that in one of the sentences you say, "The Department holds information relating to NHS managers who have been made redundant, but does not hold information on numbers re-hired as management consultants." Are you saying that money is being paid out of the Department of Health and you have no idea who it is being paid to?

Mr Hunt: We make very significant multi-million and multi-billion-pound grants to other organisations. We have the second biggest budget in Government. Then we assure how the money is spent with all those organisations, which is a very important part of the role.

Q292 Valerie Vaz: Do you know that answer? Does someone know the answer?

Mr Hunt: We do not know exactly how much money is spent by consultants in every single NHS organisation, and the question we have to ask when we are asked questions like that by members of the Select Committee is about the value for money, because there are a lot of organisations throughout the NHS and it is an expensive business to do that. I do not know if you want to add anything, Richard.

Richard Douglas: We do not collect the data from every NHS organisation on precisely who they trade with day on day.

Q293 Valerie Vaz: But setting that aside, we are just talking about the Department of Health because you do not seem to know—

Richard Douglas: For the Department of Health itself—

Valerie Vaz: You do know the answer?

Richard Douglas: —as opposed to NHS organisations, we will have the information on every single individual organisation that we have paid out of our budget. If the question is, "Could we say for the Department of Health if there is any?", yes, we could. I could go back and do that.

Q294 Valerie Vaz: Good. So let us go back to where this letter arose from. I suppose we are a public expenditure hearing or inquiry at the minute, are we not? But there is no mention of any money anywhere—no figures. Could we have another letter with some figures in?

Mr Hunt: I am not quite sure which of the figures you are saying are missing.

Valerie Vaz: On the answers that you have given me; you very carefully set it out.

Mr Hunt: Okay; I will look over that letter. If you could let me know the exact bits where you would like—

Q295 Valerie Vaz: For all the answers to my questions here, you have numbers of people, but I think it is quite helpful—

Chair: It is the letter you wrote to me.

Valerie Vaz: It is dated 9 December or stamped 9 December.

Mr Hunt: We will take that letter and have a look, and where we have numbers available—

Q296 Valerie Vaz: Great; we need figures. Obviously, you have 84,838 temporary staff, and so we would like to know, roughly, what sort of money is going out of the accounts. You say it is in the accounts, but I think it would have been helpful to have the figures here for us.

Just on the other point, to clarify, because obviously Sir David was there and there were lots of "I don't know" answers, this letter has been written by you. So, ultimately, are you the person responsible for all this information? If we want information, do we ask you? You are not going to say, "Please ask Sir David."

Mr Hunt: I will either provide you with the information myself or direct you to somewhere where you can get the information.

Q297 Valerie Vaz: So you do not feel that you have a responsibility to the public that you should be answering for NHS England or anyone else. Is that as a result of what has happened under the Health and Social Care Act?

Mr Hunt: I am absolutely responsible for every penny of taxpayers' money that goes into the NHS, but I believe—and, in fact, I think this is a cross-party view—that giving NHS organisations some autonomy in a huge ecosystem like the NHS is a better way to get value for money than managing it as a sort of centralised monolith. There are occasions when you ask me for information where I would go to an arm's length body and ask them to provide that information or direct you to the arm's length body.

Q298 Valerie Vaz: I am glad you gave me that answer because it comes on to the next part, which is the role of the CCGs, and they are statutory bodies, but now I understand they are going to be asked for a quarterly assessment of their effectiveness. Is that right?

Mr Hunt: I will ask Sir David to respond to that.

Sir David Nicholson: Yes. We have set up an assurance system, so quarterly—

Q299 Valerie Vaz: Why is that?

Sir David Nicholson: We think it is the best way of assuring ourselves that they are delivering what they said they would deliver.

Q300 Valerie Vaz: Why are you doing that now?

Sir David Nicholson: Because we think it is part of our responsibilities to do that.

Q301 Valerie Vaz: You did not think about it before? You did not think it was part of your responsibilities to find out what the CCGs were doing before?

Sir David Nicholson: This is on a relatively limited set of numbers around outcomes that we are agreeing with them as part of their planning.

Q302 Valerie Vaz: Tell us what they are. Tell us what you are going to ask for.

Sir David Nicholson: There are the five elements of the outcomes framework, so stuff around mortality, the quality of services for people with long-term conditions, their delivery against a whole series of safety issues and their patient experience issues. Let me get the three. There is the stuff around the way they govern themselves and organise themselves, because, as you know, they all went through an authorisation process and we have been working through with them. Some CCGs have had conditions attached to them, and we have been working with them to take them on. Then there is the quality of the leadership of their organisation. They are the sorts of things you would expect us to do.

Q303 Valerie Vaz: So they are not independent. You would be a kind of "Monitor" of CCGs?

Sir David Nicholson: I would not describe us as a "Monitor" of CCGs, but we are assuring ourselves that they are delivering on what they said they would deliver.

Q304 Valerie Vaz: Do you feel you have enough tools for that or do you think you might need some more?

Sir David Nicholson: The tools are those that are set out in the Act, and, like other organisations now, we have to have a very clear protocol as to the way we deal with organisations that do not deliver. We think we have the tools available to us to ensure that CCGs are either delivering great outcomes for their patients or are taking the action that they need to put themselves in place to do so.

Q305 Valerie Vaz: What is the sanction if they do not?

Sir David Nicholson: We have a whole variety of sanctions, if you like, such as literally withholding resource from them. We can withhold their quality premium. As you know, there is £0.25 billion available to CCGs—an incentive fund—to deliver against those sorts of things; so we can either give them that or withhold it. I have the power—how can I put it in the right way?—or one of the things that I do is approve the accountable officer of the organisation, so I can withdraw the powers of the accountable officer. We can put people into the organisation, so we can insist that they have people to intervene to make things happen. We have a variety of things that we can do if we can sustain and justify the point that we are not just taking action as a matter of our will but it is based on some real measurable alterations to the services that they are commissioning.

Q306 Valerie Vaz: So they are set up as local organisations making local decisions, but NHS England is going to be the spider in the middle, presumably, with the tentacles that control all of them?

Sir David Nicholson: Monitor as a spider with tentacles. I think—

Valerie Vaz: Well, you think of something else then.

Sir David Nicholson: I cannot think of a better one than you have. We are certainly there on behalf of patients and the taxpayer to ensure that they are doing the best that they can for their local populations.

Q307 Valerie Vaz: Will you be taking a strategic view? A local CCG may make a decision, say, about reconfiguration and they take a strategic view that both of you like, but what happens in the situation where you do not like it? Do you take a strategic view? Who is going to take the strategic view?

Sir David Nicholson: We have said in the planning guidance that we published today that CCGs have to come up with their own plans for their own localities for the next five years—two years operational, five years strategic. But for some services they have to come together in larger groups, because, obviously, the population size on which some of the services are planned is greater than an individual CCG. The process we would take is a process of assurance. They would set out their plans, organise their locality to make them

happen, and we would assure ourselves that they were using the four tests, for example, and make sure that they are properly consulting their public around them to enable us to make a judgment about whether they should go ahead.

Q308 Valerie Vaz: I think I get what you are saying, but I am trying to work out why, then, if they are local and you have the strategic view, you need clause 118, Secretary of State.

Mr Hunt: Clause 118 is for the very particular situation where you have a trust that is in extreme difficulty and we need to find a solution because, for example, patient safety may be at risk. It is incredibly important in the wake of Francis that we have a structure in place that is able to sort out those problems quickly and decisively. As part of the trust special administrator's remit, when a trust goes into administration, they are required to consult CCGs and the four tests do apply, but the four tests were never meant to give any individual CCG in a situation that involved multiple CCGs an absolute veto on change. We did not believe we needed clause 118 until the High Court ruled that I was not able to do what I did over Lewisham hospital. We realised that, in fact, the intention of the Act was not reflected in how the courts interpreted it; so that is why we need to make the change in clause 118.

Q309 Valerie Vaz: Right. So it goes wider than just failing trusts, does it not? You have a very wide power there. Have you taken advice on that?

Mr Hunt: It applies to situations where trusts are in administration. That is why it is really important.

Q310 Valerie Vaz: Is that right, Secretary of State—just trusts in administration?

Mr Hunt: I believe so.

Q311 Valerie Vaz: All right, okay. Does anybody else want to comment? I understood it was much wider than that. Is it not?

Mr Hunt: As I understand it, it is to deal with the situation that I have to—

Q312 Valerie Vaz: So if you lose in the courts, you have a power?

Mr Hunt: No, it is not if I lose in the courts. It is because we believed that I was entitled to do that in the case of Lewisham; the High Court disagreed, so we have to respect the court judgment.

Valerie Vaz: Yes, you do.

Mr Hunt: But we want to change the law now to make it clear that—

Valerie Vaz: Not to respect the court judgment.

Mr Hunt: No. The court was interpreting the law as it stands before, but Parliament is always entitled to change the law, as you well know.

Q313 Valerie Vaz: But you changed the law afterwards because you did not like the judgment. You wanted to give yourself wider powers.

Mr Hunt: No, we changed the law afterwards because we believed that we were entitled to do something under the previous law that the court disagreed with and we think it is incredibly important for patient safety reasons. I am happy to write to you with chapter and verse as to how we intend clause 118 to be applied.

Q314 Valerie Vaz: That would be great, because I think the understanding is that it is not just failing trusts, but that you can take over anything that you want to. Clarification would be really helpful.

Can I go back to a question that I asked you in the Chamber—and the Chair has been very kind and is allowing me to ask this again? I did not quite get an answer from you, apart from a political one.

Chair: I am kind—or just recognising reality.

Valerie Vaz: Kind, I hope, Chair.

The question is on the underspend. There is some underspend from the previous year, £2 billion, and the year before that, and £600 million this year. You know that the College of Emergency Medicine—

Mr Hunt: £600 million this year?

Valerie Vaz: Yes. If you dispute the figures, please write to us; that would be great.

Richard Douglas: We do not have the underspend for this year until we reach the end of the year.

Q315 Valerie Vaz: Up until the end, but it is £600 million so far. If you dispute any of these figures, please write to us and let us know what the underspend is. Why did it go back to the Treasury? Why did it not go to front-line services? The College of Emergency Medicine are desperate for doctors.

Mr Hunt: There are two reasons. It is the practice of all Governments, including the last Labour Government, that they return underspends to the Treasury. The underspend that we have been returning to the Treasury in the NHS is broadly similar to the levels of underspend that were returned to the Treasury under the previous Government. So this is Government accounting practice. The point I would make—and I think it is really important to understand—is that under Government accounting rules the underspend, if it is going to be used for something else, has to be spent within the same financial year. So it is not always the panacea that it seems, because if you have a multi-billion pound underspend you would only be able to give it to somewhere that could actually use that money in that very year, in a matter of a couple of months. That is why, in practice, it is much more difficult to use the underspend in the way that you are suggesting.

Q316 Valerie Vaz: However, you have had Francis saying we need more nurses, and the College of Emergency Medicine saying for the last three years there was a 50% non-fill of emergency doctors and consultants. You said to me in a previous session that it was Stalinist to plan, and I am saying to you that you had this information two years ago, you had the money and you could even use it for a pay rise, which you are desperate to give to the staff of the NHS. Why do you not use that money for that purpose?

Mr Hunt: For the reason that the finance director just explained. This is money that has been committed to NHS budgets in many different parts of the NHS and we did not know that we were going to underspend until it came to the end of the year. So it is not possible to plan in advance to spend an underspend, except with very small margins. We have done that, for example, this year with £150 million of the £400 million that is going to help support hospitals deal with winter A and E pressures and we used some underspend money for that last year. It is possible to do that where you are very certain that you are going to underspend by a certain amount, but it is not possible to plan at the start of the year to fund things like pay rises from underspend because you do not know. This money does not sit in the Department of Health. It gets distributed out to CCGs and they distribute it out to trusts, and so it is sitting in many different parts of the system.

Q317 Valerie Vaz: Now you will know because you are going to be monitoring what the CCGs do. Secretary of State, you went to China. Did you go on a personal basis or on behalf of the Department of Health?

Mr Hunt: I went as a Government representative.

Q318 David Tredinnick: I have a quick question related to what we were discussing and it is about patient choice. It has often been said that patient choice is at the heart of the health service now—a complete change in thinking. Going back to clinical commissioning groups and what Sir David was saying just now, do you have a mechanism for how clinical commissioning groups are taking note of the changes in patient requests—how patient choice is actually working on the ground? We had your Minister of State recently in front of the Committee and I asked him whether patient choice had priority over doctor choice. I think the answer was that patient choice came first. If this is actually happening, are we recording them now? In this new paradigm are we trying to draw any information, if there is any new information—and maybe there is not—from the clinical commissioning groups on how patients are exercising patient choice? If they have patient choice, presumably they are doing something with it.

Mr Hunt: Patient choice is a right under the NHS constitution, so nothing should change with respect to the new powers being given to clinical commissioning groups. In terms of choice of provider, the choices that patients had before still exist, and indeed we want to extend them where we can. The challenge is to make a reality of that ability to choose. Sometimes people want to change their GP, for example, but they find the GP they want to get to is not accepting new patients and so their effective choice is not as great as it might be. Sometimes, people do not know about their ability to choose as well. There is much work to do, but it is one of the mechanisms we have for promoting a patient-centred NHS.

Q319 David Tredinnick: I have one follow-up on this. With personal budgets, I understand that there has been a great success in that patients and carers are finding it easier to manage their lives and their budgets, and the treatments the patients choose are very successful. I see Mr Rouse nodding his head, which is a very encouraging start. Surely, if this is the paradigm with the small budget for personal budgets, then this is something we need to roll out a little further. Perhaps we can let Mr Rouse, through you, Chair, respond and then I will say no more.

Jon Rouse: We have made some good progress on personal budgets, and of course this is something that cuts across both social care and health, and social care were the

forerunners. As of this year, we are now up at 55% of people with social care packages with personal budgets. We have a target of 70%, and the Care Bill will take that to 100% because it will become an entitlement for those who want it. Then, of course, with extension into continuing health care, you begin to be able to put personal care and personal health budgets together if you have a long-term condition so that you have a lot more control of your life and can make your own choices. Obviously, we must not do it in a way that undermines the proper operating of the health system, but, where there is the ability to do so, personal health budgets are definitely an expression of control and choice.

Q320 Dr Wollaston: I have a quick question for Mr Douglas about the underspend—whether there is any mechanism at all towards the end of the year, or once it becomes clear what level of underspend there is, whereby some of that could be used to repay PFI debt. I ask because it seems that PFI payments are just an ongoing drag on the whole system.

Richard Douglas: There are two things there. One is—and I think the Secretary of State said—that the underspend is the sum of 473 organisations, so trying to pick that up organisation by organisation and then potentially moving it around would be difficult. Then, for any trust or foundation trust we allow them to keep the cash, so I cannot just go back and take the cash from them. They can keep the cash and spend it in future years. It is not—

Q321 Dr Wollaston: So they can spend it in future years?

Richard Douglas: They can spend the cash. It is clear with foundation trusts that the cash goes into their bank accounts as part of their surplus. It is there and it does not get taken back from them. The issue I think we discussed last year is that, at the point at which they spend it, it scores against the spending limit of the Department, but it is there for them to spend. I have looked at what we could do around PFI debt and whether there would be opportunities to use some capital underspends for that purpose. The difficulty is that every time we have looked at this—the value for money of trying to re-open one of those deals—it does not stack up financially. So it is not a simple thing, such as we pay down a bit of debt. They are quite complicated financial arrangements that we have in most of the deals. I have not yet found a way that we can use money in a value-for-money sense that could buy out some of the PFIs. It is something that we will keep looking at because, if there is an underspend on the capital side, it is something potentially we could do.

Chair: Mr Douglas has given us enough evidence to offer an opinion again about the absurdity of end-year inflexibility as it exists for NHS trusts.

Q322 Grahame M. Morris: Secretary of State, you are aware that we have invited you here as part of our inquiry into public expenditure in the NHS. In the second of our terms of reference that we are looking at is the effectiveness of the mechanisms by which resources are distributed geographically in the NHS. I am sure you can recall from our debate yesterday that some concerns were expressed about NHS England's current remit to review the formula by which resources are allocated to clinical commissioning groups. To begin with, Secretary of State, how satisfied are you that the mechanisms for deciding on geographical allocations of funding—to CCGs for primary care and specialised services—are both effective and fair in providing sufficient resources on the basis of need?

Mr Hunt: The first point to make is that this is such an important issue—

Grahame M. Morris: It is very important.

Mr Hunt: —that it is really important that it is put beyond party politics. That is why my predecessor decided that that should be a decision that was made at arm's length from serving Secretaries of State, and that is what we have done.

In terms of how good the mechanisms are—and I will ask Sir David to comment because it is the responsibility of NHS England—as they have been explained to me, I am very happy with the principles that are used. The challenge that we have is that, where overall the NHS budget is not increasing by any significant margin, where you have people who are a long way off what their target allocation would be under any funding formula, it is incredibly difficult to move more closely to that target funding without other people having to lose out. That is the real challenge that we have. I do not know if Sir David wants to add anything about the principles.

Sir David Nicholson: Yes. This morning NHS England have considered an extensive paper on allocation. It is all in the public domain. We did it openly and transparently for everyone to see and that document is available for everybody. You can, if you want, go home tonight and watch the live stream—not live obviously but the whole of the debate we had at NHS England. This is the first time in my experience that allocations have been done in such a transparent and open way with the workings of how you got there also being set out to the public in a way they have never been done before. Inevitably, in the circumstances, there is a kind of technocratic argument, a technical argument, around it all, but there is one of principle as well. I do not know whether you want me to go on to the principle bit yet or—

Q323 Grahame M. Morris: I have a number of questions. I have stayed very quiet because I think this is really very important, both to me and a number of other Committee members, and it has been a focus of a number of debates, but I wonder if I can pick up a couple of points that both you and the Secretary of State have made. We are aware on the Committee that there has been a written statement produced today, which is very brief. I must say that I am rather disappointed that it does say—although you have said it is already available—that the final documents will be published by NHS England on the website by Friday 20 December, which is the day we go into recess; so we will not have any opportunity to hold the Ministers to account. Is that not right?

Sir David Nicholson: It says that. You have probably picked up that the meeting itself took place this morning. There were a number of options available to NHS England about which one it chose, and my guess is that turning that document into something pristine will take a bit of time. But to short-circuit that, we can circulate that document and it was option 4 that we agreed.

Q324 Barbara Keeley: Could we have that before Friday?

Sir David Nicholson: Yes; you can have it straight away.

Chair: It is on the website, as I understand it.

Q325 Grahame M. Morris: Not in its final form. I think the kind of online consultation—I have forgotten what it is called—is there, but I do not think the final version is there, and,

according to the written statement, it is not available until Friday. But I want to ask you a couple of questions just on this subject.

I have been lobbied heavily, as have other Members of Parliament, by our clinical commissioning groups, the BMA, local government and the directors of public health, who are all very concerned about the possible consequences for particularly more deprived and poorer areas of any change in the funding formula where there is a greater emphasis placed on areas that have more ageing populations, which presumably, by definition, must have better health outcomes because people live longer.

I want to seek some clarification on where we go and on what evidence NHS England have come to their conclusions, because I am rather concerned, having had discussions with people who know about these things, in terms of populations, as to whether there has been any assessment of the numbers of disabled people in populations. That is relevant, for example, in my area because it was a coal-mining area, with shipbuilding and steel on the doorstep. The physical manifestation of that in later life is that many people suffer from pneumoconiosis, COPD and forms of mesothelioma, and that must have an impact on the call on health resources, although, perversely, if it is going to be on age, those people die prematurely so that would not be reflected in the allocation. That is a huge concern and I hope, when NHS England are considering the formula, there is a proper equalities impact study, or whatever it is called, to weight that. What are the implications of using the ONS population data rather than GP list sizes?

I want to ask the Secretary of State because you very niftily said, "Sir David Nicholson, this is one of the areas of responsibility that is devolved to you." Whatever it says in the Acts, I can assure you that people in my area hold me to account for resource allocations and I intend to hold you to account for them as well. Do you share my concern that it is your responsibility to ensure that CCGs have the necessary resources to be able to provide funding to provide the treatment that people require?

> ***Mr Hunt***: I completely agree with that and I want to stress that I am completely accountable for the decisions that NHS England make. I have subcontracted that decision, or the Act—I should say more accurately—subcontracts that decision to them because we think it is better if it is decided at arm's length from Ministers, but I am completely accountable for the decision to make that decision at arm's length and, indeed, for whatever it is that they actually decide. As I understand it—Sir David will correct me if I am wrong—the decision that NHS England took this morning, option 4, does include a weighting for social deprivation so that it does take account of some of the factors that you have talked about.

Q326 Grahame M. Morris: There was already weighting there for social deprivation. Is there any change in it?

> ***Mr Hunt***: As I understand it, no, but I will allow Sir David to come in. I could just add that I think it is also a matter of social justice. I agree with you that in the end it is about need, and that means that we do need to respect the needs of older people because they have greater health needs than younger people and it is important that we have a formula that adequately reflects their needs. It is also important that it is a formula that reflects the needs of people who live in pockets of deprivation and not just people who live in areas

where deprivation is more widespread, because people who live in pockets of deprivation also have the kind of needs that you talked about.

Q327 Grahame M. Morris: I have one more supplementary. Just before the meeting started, my colleague Andrew George and I were having an argument about CCGs—or a discussion—about allocations about the areas that were furthest away from target, and I can remember being part of the lobbying effort. This is when we had relatively small PCTs and we had one for Easington lobbying John Reid, who was the Health Minister at the time, because Easington was the furthest away in the country. I do not know whether that is lost or has been subsumed into a larger PCT and then a CCG, but, as to the ability to target pockets of deprivation, I do not know whether you have thought about how that might be achieved. I know in local government we use super output areas to tackle particular pockets, but it might be something that needs some further work.

Mr Hunt: I think we have put that in.

Sir David Nicholson: I am not quite sure at what level to deal with this, but as to the issues that we are faced with, let us think about 12 months ago, when we originally looked at this as NHS England for the allocations for this financial year and we were faced with the work that ACRA had been asked to do by the Government, which essentially said that older people were the big driver in the way that you should allocate resources. The issue for us, when we looked at that as an issue to change the formula, was that we did not think it necessarily dealt with the issue that you describe, which is unmet need, because very often most of the allocation form in the past was driven by utilisation of resource. If you use a lot of resource you tend to get it, but how do you deal with unmet need? This whole issue about deprivation and unmet need was an important thing, and we have been working with ACRA over the last 12 months to get that in the right kind of place.

As far as the allocation to CCGs is concerned, we have put a 10% weighting on deprivation for CCGs and a 15% weighting for primary care, because we think that primary care is a much more targeted way of delivering more equal services for patients.

The second area was how you measure that deprivation, and we are using the standardised mortality ratio for under-75s. The experts tell us that that is the best way because it captures the "early die-ers", if you like, that you have described there and does give you a better case for it. It also has the benefit of being able to pinpoint relatively small populations. The example in the paper for one of the issues we were tackling is Ipswich. Ipswich in Suffolk, if you look at the totality of the population, does relatively well in terms of the health of its population and has a relatively low growth rate in terms of its allocation. But there are particular points in Ipswich, particular localities, which are among the most deprived in the country. By using the SMR <75, you can pinpoint very small localities in your allocation process and so identify them and give the benefit to the CCGs for that. So that is one thing.

The second thing was population. There has been significant population shift over the last few years that we thought had to be taken account of in what we did, and that is what we have done in the allocation process.

Q328 Grahame M. Morris: They are very full answers, but I think they generate some more thoughts and questions. Can you tell us where we are going in terms of option 4? What does that mean for the next few years?

Sir David Nicholson: With the allocation arrangements that we have put into place, first, the most deprived populations get the most money. That is the first and most obvious thing. If you are thinking about somewhere like Knowsley at the one end, it will get, I think, £1,500 per head, and Oxford CCG at the other end will get £850. The money goes, on a per-head basis, to the most deprived population. That is the first thing.

Secondly, there is a shift around the country in terms of population. You can see that in the way the population has moved, and that is recognised in the way we have allocated the resource.

Thirdly, we wanted to ensure—it was one of the things that was put in the mandate from the Department—that we kept as much stability as we could in the NHS, so that everyone is getting flat real terms no matter where they are in the system. Everybody gets that basic thing. But we have been able to invest about £250 million in bringing some of the people furthest away from target closer to target, and what we are saying to people in terms of the five-year strategy is that they should assume that over the next five years we are going to work to bring people closer to target.

Q329 Grahame M. Morris: Andrew says Cornwall is the furthest away. What is the biggest percentage increase from areas that are furthest away from target?

Andrew George: Below target I did say.

Grahame M. Morris: Is he right?

Sir David Nicholson: I would not want to comment. I think you should look at the whole thing. One of the things we tried to do all along is not to go through this process and identify where everyone is, but to focus really hard on the arrangements so that we are absolutely fair and transparent in what we do.

Q330 Andrew George: It would be very easy for the whole Select Committee to get into special pleading to manipulate the formula to suit our own areas, and certainly with my area—it would not be easy because the Chair would stop us—I would endorse the view that deprivation, age, and, I think Sarah and I would add, rurality and so on need to be there.

One element is the market forces factor. I would be interested to hear where that sits, because that is cause for significant concern in those areas where wage levels, indeed, outside the NHS are rather lower and, therefore, those areas get lower investment in spite of the fact that employees are on national pay scales. I would be interested in that and you may wish to comment on it, but I want really to come back to the point where you arrived at, Sir David, that this is not actually resource allocation but target allocation. There is frustration that the pace of change, as I understand it, over the last decade, has been incredibly slow. You can set the targets, but it is almost a pointless exercise, because those areas that are significantly below target remain, and particularly those that are below target seem not to move very rapidly towards their target over a period of a decade, let us say. One of the reasons for that is because the previous and the present Government take the view that those who are above

their target should not experience the shock wave of being moved closer to target by reducing their budget.

Providing you continue to take that approach—while you say you think that people will be closer to target within a five-year period, I am not sure on the basis of the evidence I have seen that you are going to achieve that—how realistic is it that you believe that you are going to achieve these target allocations within a five-year period?

Sir David Nicholson: I absolutely understand what you are saying and I have seen all those things in operation myself. In a sense, this was the dilemma for us because it is said, of course, that at a time when you have very little growth it is the last time you should actually start thinking about moving this around. But, in a sense, that is why we have taken 12 months over getting this, we think, into the right kind of place. Part of our statutory responsibilities as an organisation is to tackle inequalities. It is not a statutory responsibility that we can put aside. We have to do something about it, and over the next two years, because of the spending review, we can give everyone flat real terms—we can give everyone the uplift—but we can invest on making people closer to the target. How quickly we can do that for the three years after that will clearly depend on the spending review afterwards. One of the options we looked at was, in a sense, not giving organisations that were above target any increase at all, but we judge that that would be too destabilising for the service as a whole, particularly in those areas.

I should say, on the other side, which is quite interesting, that, of the 37 CCGs that we are worried about who are showing the most pressure financially at the moment, 31 are gainers from these arrangements.

Q331 Andrew George: In those areas that have been consistently well above target—and most of them have been in the south-east, the leafy suburbs and the metropolitan boroughs of London—it seems to me that some of them have been 10%, 12% or an even larger per cent above target. Are you saying that they will be brought closer to target over the next five years? In reality, unless the target changes, that clearly is not going to happen because you are not going to be reducing their budgets.

Sir David Nicholson: The targets have changed because we have changed the allocation formula. You have to look at the totality of all of that.

Q332 Andrew George: We have to look at it afresh. But, even so, let us say it is a new set of CCGs and health economies that are getting a target that is significantly below where their actual settlement is and no doubt will continue to be therefore. Are they going to be brought closer to target over a period of time?

Sir David Nicholson: Yes, they are. It is part of our statutory responsibility to make that happen. The fact that we can make it happen at the moment by giving flat real terms to everybody is a benefit, but, if in the future we are unable to do that, we will still have to look at the way in which we are going to deal with those as health inequalities.

Q333 Andrew George: But you said that you would not be giving flat real terms settlements to—

Sir David Nicholson: No. I said we would give it so that everyone has flat real terms, yes.

Q334 Dr Wollaston: I have to say I am rather appalled that there are going to be flat real terms and I was not clear whether there was going to be any extra weighting for age, but that matters in an area like mine where they are 31 years ahead of the curve in terms of the changes in age structure. By the end of 2021 they are going to have 4.9% of their population over 85 as opposed to 2.9% nationally. In addition to that, they have pockets of very serious deprivation, and in other parts of the CCG they have real issues about rurality and sparsity and the extra costs that go with that. What comfort is there for CCGs like that, which, if you like, have all of those very challenging issues?

Sir David Nicholson: The formula takes account of all of that and you will see that, in the target allocations, that is taken into account. But can I say that I did not mean that everybody got flat real terms and nobody got any more? We have about £250 million now, and the allocation paper sets out how—I will get it absolutely right—either 70 or 71 CCGs can make more rapid progress and get more than flat real terms for the two years 2014-15 and 2015-16. When you look at the allocation you will see that in it.

Q335 Dr Wollaston: Can I ask about the age issue? Because of the link between being over 85 and real challenges in terms of extra need, is there going to be a change in the weighting for age or sparsity?

Sir David Nicholson: Certainly age but not for sparsity.

Q336 Dr Wollaston: Is that something you would consider for the future?

Sir David Nicholson: Yes. When I last came to the Committee you raised the issue with Paul Baumann, and we said we would take it back to ACRA for them to have another look. They have looked at it before and concluded about three years ago that there was not sufficient evidence to support a weighting for that. Given that things have moved on, there is more information about what happens and we can now do this very much more identified small population work, we are going to ask them to look again at sparsity.

Chair: Barbara is next and then we are going to move on. Leicestershire is going to take a self-denying ordinance from the Chair and Mr Tredinnick, but we are not going to have pleadings from every authority.

Q337 Barbara Keeley: This is a kind of a pleading, but, as we were talking about age, it is a plea on behalf of carers. When we were talking earlier about the integration fund, you said you would be getting in and examining the plans. A real concern I have is that the carers' breaks funding, which is in this pooled large amount of money, might just get swallowed up. This is a plea not to do that, because I think some of the changes that have been made in the way that we fund care, and it could be in integration, mean that carers lose out. I had a case that I talked about yesterday of an elderly couple who were getting eight weeks' respite care when it was organised by the local authority and it gets lost within a personal budget so that, effectively, all they have now is three weeks and it is not enough. They are older people looking after an adult son, and that is quite a hard task that they have taken on. With this undermining of respite care, it is a real worry, when you start pooling funding, that something like that just gets lost. It got lost a bit in local authorities—and I know that this Government are not very keen on ring-fencing—but, if you do not do something to tie it to some outcomes or to something, it will just vanish, and that would be a real concern.

Mr Hunt: I think that is a very fair concern and we will certainly take that away. Jon, I do not know if you want to add anything to that in terms of the process.

Jon Rouse: There are two things. One, you have to put this in the overall context of the Care Bill as well and new rights for carers that will come in at the same time in April 2015.

Q338 Barbara Keeley: But it does not have funding attached to the rights.

Jon Rouse: No, but there is that right to assessment and to access to certain services. Then, in terms of the fund itself, we have put a number of things into it: the carers' money, reablement money, the DFG—

Barbara Keeley: Adaptations.

Jon Rouse: That was done for a clear purpose, which was to send a strong signal: if we are going to have an integrated approach to care, then it has to embrace the needs of carers. If we are wrapping care around the individual, their carer and family, then it has to take those carers' needs into account; also, in terms of the DFG, you have to look at the broader environmental factors, and particularly the role of accommodation and housing providers and what happens in that accommodation as well. When the plans come in, we are going to be looking for all of those things and how they tie in to the condition we have set around co-ordinated care. Of course, Ministers have the final ability to sign off those plans once NHS England and local authority colleagues have had a chance to review them.

Barbara Keeley: Hence the plea not to forget the carer role.

Chair: I am afraid there are some questions that members of the Committee wish to pursue, so could we vote and come back in 10 minutes? Thank you.

Sitting suspended for a Division in the House.

On resuming—

Chair: The Committee is quorate. I understand that both the Secretary of State and Sir David have meetings elsewhere. I wrote to you, Secretary of State, on the question of NHS Property Services, and Charlotte wants to follow up your reply on that.

Q339 Charlotte Leslie: Thank you. First, thank you very much, everyone concerned, for your replies. My questions are pertinent to public expenditure obviously because of the amount of money that NHS Property Services represents in the portfolio, and they are pertinent to Property Services because it regards key individuals and the set-up around Property Services. From the answers you have given me, it seems like it was quite a tall order that NHS Property Services had to perform, and, on a layman's view, it looks like there were some significant teething difficulties that people have worked hard to overcome. It is that set-up I would like to probe a bit further, if that is all right.

I would like to thank the Secretary of State for the correspondence that I requested, which I have also requested through FOI. I was quite disappointed that I had put in Freedom of Information requests for this correspondence and was told it was only available at disproportionate cost, which I was surprised at, because it was two named pieces of correspondence with named authorship and sender. But I was able to get it quite easily,

thanks to the Secretary of State, who was very helpful in providing it. This is a request—in that I was slightly confused as to why the FOI should be so difficult to answer, but then I was able to get the correspondence through other means. Perhaps you will be able to take back to officials that it is not a very intuitive way of answering FOIs in that case. Unfortunately, the Committee was not given copies of the correspondence I have, so apologies to the Chair and the Committee that I am referring to material that they have not been given.

I am directing my questions to Richard Douglas, as I think you are the official to whom the individual concerned, Peter Coates, reported. In the piece of correspondence that the Department very kindly provided for me regarding some correspondence between Peter Coates and Deloitte at the beginning of 2010, the correspondence refers to Peter Coates's note of 19 January 2010 attaching further commentary.

There are two things. As the Department kindly provided this correspondence, would it be able to provide the note of 19 January 2010 from Peter Coates to Mike Turley of Deloitte so that we can see what that further commentary and the contents of it are? Since you were the chief officer at that time, would you be able to enlighten us as to what this event was? They referred to "normalising relationships" between Deloitte and the Department, "the matter which we have been dealing with here", and "further evidence" that they require. Could you let us know what that further evidence might be, what the relationships were that were required to be normalised, how they have been disruptive and the background to the letter?

> ***Richard Douglas***: Could I say first of all that none of that is linked to NHS Property Services Limited at all? This discussion with Deloitte was pre the general election and pre any idea that we would set up something like Property Services Limited. Those two things are not connected.

Q340 Charlotte Leslie: Except for the connection that I drew between whether there were concerns over an individual, which is what I suppose we are questioning here, and the appropriateness of that individual then setting up NHS Property Services with this question hanging over them, which I note was not resolved until 28 May, which is after the general election. That is why I suppose I am asking these questions. It relates to the appropriateness of the individual concerned. Then, if—and I am not saying it is—it was found the individual concerned was not appropriate because events were going on surrounding them in some way, of course that impacts the set-up and the wisdom of those to whom they reported and those who authorised his set-up as a director in terms of him being the person to set up a property company of £5 billion. Although it is not directly to do with Property Services—I do understand that—it is very pertinent to it and that is what I am trying to gain from you.

> ***Richard Douglas***: Okay; we will go straight to the point that there was nothing in any discussions with Deloitte or anything that I have ever seen that would have me question in any way the personal integrity of Peter Coates.

Q341 Charlotte Leslie: Could you give an illustration of—

> ***Richard Douglas***: The issue with Deloitte at the time was concern expressed to us about whether Deloitte were getting work at the same time as other consultancy firms were getting work.

Q342 Charlotte Leslie: In what sense—that they were getting more or less work?

Richard Douglas: No; a view about whether they were getting sufficient work relative to other organisations. That was something that was fully investigated and there were no issues about that at all.

Q343 Charlotte Leslie: Why was there any reason to suppose they would not be getting as much work? Was there any suggestion or events that led up to Deloitte raising these concerns? Who raised the concern that they were not getting enough work?

Richard Douglas: Concerns were raised separately in an anonymous letter to us and that was fully investigated.

Q344 Charlotte Leslie: The anonymous letter was sent to you saying, "We do not think we are getting enough work."

Richard Douglas: It was sent to the Permanent Secretary of the Department at the time.

Q345 Charlotte Leslie: Who was that?

Richard Douglas: It was Sir Hugh Taylor at the time and that was fully investigated at the time.

Q346 Charlotte Leslie: An anonymous letter was sent to Sir Hugh Taylor raising concerns that Deloitte were not receiving enough work.

Richard Douglas: Yes.

Q347 Charlotte Leslie: Would we be able to access that anonymous letter?

Richard Douglas: I would have to check back on that because that was subject then to an investigation by the department. It was concerning individuals, and I would have to check, from a legal and HR perspective, whether it would be appropriate for to us do that.

Q348 Charlotte Leslie: Of course. Was it concerning individuals within the Department or individuals within Deloitte?

Richard Douglas: That letter was concerning individuals within the Department, yes.

Q349 Charlotte Leslie: So no individuals in Deloitte were named. I am just struggling to understand. You have not really answered my question—

Richard Douglas: In their letter, no.

Charlotte Leslie: —why Peter would want "further commentary" and to look into the points that were raised in the note. What were those points that Peter raised in the note?

Richard Douglas: Peter had had concerns about the work with Deloitte in relation to a couple of members of Deloitte staff at the time.

Q350 Charlotte Leslie: Were those concerns ever substantiated?

Richard Douglas: They were not issues that were needed to be taken forward because we were having a normal business relationship with Deloitte.

Q351 Charlotte Leslie: I am trying to get a narrative here so that I do not have to keep on asking you boring questions and submit FOIs, which I am sure your officials are very tired of by now. Peter Coates raised concerns about two officials in Deloitte; so it is people in Deloitte.

Richard Douglas: There were issues about working with some individuals in Deloitte at the time.

Q352 Charlotte Leslie: Were those issues ever substantiated? Was there any evidence of that? What was going on?

Richard Douglas: I cannot remember the precise details that far back on that discussion with Deloitte.

Q353 Charlotte Leslie: Was the anonymous note with regard to Deloitte not getting enough work in any way related to Peter Coates raising concerns about two individuals at Deloitte? Is that an odd coincidence? People might be afraid that, say, work was being diverted from Deloitte because an officer had concerns, which obviously turned out not to be substantiated?

Richard Douglas: As part of this, we looked at the contracts that had been let for consultancy services, the basis on which they had been let and whether Deloitte appeared to have been treated any differently from any other organisation. There was no evidence of that.

Q354 Charlotte Leslie: So Peter Coates's concerns were what again?

Richard Douglas: I cannot remember the precise nature of it going back to 2010.

Q355 Charlotte Leslie: Would they be in the note attaching further commentary, would you imagine, that I am sure the Department will be able to provide for me?

Richard Douglas: I am not sure whether they are in that note or not.

Q356 Charlotte Leslie: Okay. You can understand why this is of some concern because I am afraid your Department provides quite a lot of information informally from people who have been concerned about the way things have been conducted. So I feel it is my job as a Select Committee member to ask these questions and I would be most grateful if we were able to get that note of 19 January. Also, it refers to meetings as well. Could I get some assistance with FOIs regarding meetings that went on between key individuals? I have to say I think, and I think the public find, that it is slightly upsetting and difficult to understand when simple requests for meeting dates between individuals and minutes of those meetings come back as only available at disproportionate cost. So, in the interests of my never having to raise issues like this again, I would ask that those requests that I will be putting in are treated as effectively as possible.

My second question is regarding the replacement of the chair of NHS Property Services. An account was given in correspondence about that chair's departure. What process is in place for appointing a new chairman?

Richard Douglas: We have advertised for a new chairman. There will be an appointment panel that I, the Permanent Secretary and one of our non-executives from another arm's

length body will sit on. We will then make recommendations to Ministers on that appointment.

Q357 Charlotte Leslie: Have you any ideas about who this might be?

Richard Douglas: There are people that we would encourage to apply for it, and we will look and see what the market produces as well.

Q358 Charlotte Leslie: The reason I have to ask is this. What correspondence have you had with Mark Boyle from the Shareholder Executive? I have been led to understand that he has already received e-mail correspondence about taking on this position. Could you perhaps enlighten us as to what that correspondence contains?

Richard Douglas: We have encouraged Mark to apply for this.

Q359 Charlotte Leslie: It is still a transparent process, but you have already approached someone for the job.

Richard Douglas: The normal process is to make sure we have credible candidates for positions that we advertise.

Q360 Charlotte Leslie: The reason I have to ask this is that again someone from within the Department is raising concerns about the way the process has been managed, and there is an allegation being made that because of questions I have asked—I will be very candid with you—the appointment had already been made and there was a plan to appoint this person slightly more quickly, shall we say, than otherwise. Would you be able to perhaps put our minds at rest and provide us with the correspondence that has been going on between Mark Boyle and the Department just to prove that these allegations—

Una O'Brien: Can we just knock that on the head? We have placed an advertisement. It is absolutely normal practice to encourage people to apply. Do you know how difficult it is to persuade capable people to come forward to take chairmanships of major organisations? It is extremely difficult to get capable people to step forward. It is absolutely right and legitimate that we should contact people and say, "We are interested in and encourage you to apply." I am chairing the panel, and I can assure you that I will make sure, as will Richard—and we will appoint an external non-executive—that this process will be conducted as we have said it will be.

Q361 Charlotte Leslie: I apologise for always seeming like the awkward squad at these Committees, but I hope you can understand from my perspective as an MP—and it is this Committee's role as a scrutiny body—that, if I receive communications from concerned members of your Department, I feel it would be remiss of me not to raise these in front of the Committee. I appreciate I am probably not the most popular person at all, but I do hope you appreciate that it would be remiss of me not to raise these concerns with you and not to give you the opportunity to put our minds at rest. After all, the people we are all of us serving are the public and, essentially, the patients. The reason that I suppose scrutiny like this should be a welcome thing is so that things like this can be aired in a collaborative and open way. I would like any correspondence and help you can give me with my inquiries so that these issues can be cleared up—obviously people are concerned, otherwise I would not be getting communications about it—and laid to rest. In that way everyone is able to get on with their jobs, at which I am sure everyone is working very hard.

Richard Douglas: Let me be clear. I interviewed Mark for another role. Mark was considered to be someone who was above the line for that role. He had a very good track record. He was not in the end appointed to the role. I recommended Mark then for replacement to Property Services chair when I knew the chair was going. In light of the concerns around the governance of Property Services, I then decided that we really needed to talk with the Minister about having a full competition, for which Mark could apply. But he was someone who had been through an interview process that I saw and I thought fitted the bill at that time.

Q362 Charlotte Leslie: About when would you have recommended him? Can you recall?

Richard Douglas: I cannot remember the precise dates and I am trying to think when the interview was for the other job, but it would have been towards the beginning of autumn, I would think, on this.

Q363 Charlotte Leslie: You will be able to reassure us and any concerned people—and I am sure you can—that the process in appointing the next chairman will be completely transparent and open.

Richard Douglas: Yes.

Chair: I think that is just what the Permanent Secretary said.

Charlotte Leslie: Thank you very much.

Chair: Valerie wants to move on to trust finances, and we will try to get you away on the stroke of five o'clock.

Q364 Valerie Vaz: This is a very important issue. As to trusts and foundation trusts, I think the National Audit Office have said some of them are in difficulty, and with the winter crisis and A and E crisis going on you have allocated some funds to them—£250 million.

Mr Hunt: It is £400 million to help with winter pressures.

Q365 Valerie Vaz: No; £250 million for the foundation trusts and £150 million to the CCGs. Is that not right?

Mr Hunt: It is £400 million to help the whole NHS with winter pressures. The mechanism through which the money is distributed is slightly different with the two funds, but it was about £300 million last year and we have increased it to £400 million this year.

Q366 Valerie Vaz: I suppose that will help us to get to the bottom of it. I was in the Chamber when you made both those announcements, so £250 million was to the foundation trusts. Can we get that correct or not? Just give us the figure then.

Mr Hunt: I am trying to do that. £250 million was decided in August and it was to 53 areas, some of which were foundation trusts and some of which were NHS trusts and not foundation trusts.

Valerie Vaz: Yes.

Mr Hunt: Some of it went to help ambulance services and some to help NHS 111 centres. Basically, we decided to allocate that money where we thought the pressures were going to be greatest for winter and we made that decision in August.

Q367 Valerie Vaz: Could you tell me what you took into account when you made those decisions? Did the trusts or foundation trusts come to you and say they needed the extra money? Were they the failing trusts?

Mr Hunt: No. I asked NHS England, the NHS Trust Development Authority and Monitor to collectively decide where they thought the need was greatest in terms of winter funding pressures. They selected 53 health economies where they thought there were particular needs, and then they negotiated with those health economies as to how the funds should be spent.

Q368 Valerie Vaz: But I suppose those were areas in trouble. What I am getting is that people in the NHS were saying that you were kind of rewarding failure, which is why your second tranche came out.

Mr Hunt: It was a very difficult call, because what happened with the £300 million last year was that essentially it was distributed evenly, including to a lot of areas that were performing extremely well, and of course you have to make a call. I decided that it would be a better use of taxpayers' money and would have more impact for the winter if that money was distributed to the areas where we thought the biggest problems existed. Of course, by definition, those are the areas that are less successful. But because we were then able to identify another £150 million of underspend, as it happens—

Valerie Vaz: I was going to ask you where the money came from.

Mr Hunt: —we were in fact able to give all areas broadly the same as they received. When you tot it up to the £400 million, basically all areas got broadly what they got last year, but areas with particular problems got more.

Q369 Valerie Vaz: Correct me if I am wrong, but I understand that this £150 million was going to 57 CCGs as opposed to the trusts and the foundation trusts, or is that not correct?

Mr Hunt: I do not know if it was 57 CCGs, but it was essentially designed to go out to the people who had not received the £250 million but had got some support last year.

Q370 Valerie Vaz: When you say "people", what do you mean?

Mr Hunt: Organisations.

Q371 Valerie Vaz: Which particular ones?

Mr Hunt: All organisations that have A and E departments receive some help from the £400 million.

Q372 Valerie Vaz: Can anybody help? We had understood that it was going in two different directions and we just wanted to find out why.

Sir David Nicholson: At the end of the day, £400 million has gone out. £300 million of that has essentially gone out on the basis of fair shares in the same way that it would have

done and £100 million has been targeted at those areas. That is the net result of what we have done.

Q373 Valerie Vaz: Is all that money underspend money or has it come from different areas?

Mr Hunt: No. The £150 million of it is.

Q374 Valerie Vaz: That is underspend, and the other lot?

Mr Hunt: That is additional.

Valerie Vaz: Okay.

Chair: I think, on that note, three minutes ahead of schedule, we will say a quick thank you—

Mr Hunt: Thank you very much.

Chair: —and good wishes, on my part, to the Prime Minister.