

Public Accounts Committee

Oral evidence: Funding Healthcare: making allocations to local areas, HC 676

Monday 20 October 2014

Ordered by the House of Commons to be published on 20 October 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon, Chris Heaton-Harris, Meg Hillier, Mr Stewart Jackson, Austin Mitchell, Anne McGuire, John Pugh

Amyas Morse, Comptroller and Auditor General, Laura Brackwell, Director, National Audit Office, **Sue Higgins**, Executive Leader, Local Services, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses Paul Baumann, Chief Financial Officer, NHS England; Richard Douglas CB, Director General of Finance and NHS, Department of Health; and Simon Stevens, Chief Executive, NHS England, gave evidence.

Q1 Chair: We have two hearings today. Are you all staying for both? Just you? Right. I don't think the first one will be hugely long, although the subject is ridiculously complex. May I start? I don't know whether to ask you this, Richard, or you, Simon. What is the point of labouring for ever on hugely complex funding formulae, which I can't get my head around, having tried over the weekend, when you say you can't apply them without destabilising the health economy?

Simon Stevens: The point is that having a funding formula goes to the heart of what the NHS does, which is allocating care on the basis of ability to benefit according to need, so what we try to do through the formula is establish what is equal access to equal need, together with some element for unmet need, and then establish a pace of change at which we can get there. We can usually make more progress when there is more money to distribute so we don't end up having to rob Peter to pay Paul.

Q2 Chair: Yes, but you're not making progress. Somewhere in this Report it says it might take 80 years or so to get there. I can't remember the— I might be exaggerating. How much is it?

Laura Brackwell: It is 80 years if you are looking at bringing—

Chair: Eighty years?

Laura Brackwell: But that's just for the local authorities that are over target. It is much smaller for moving those who are underfunded—it is six years and 10 years, we have calculated, at current rate.

Chair: Anyway, it is for ever, however you want to look at it. We will come to how you got to your conclusion, but you have spent all this energy creating a formula—with the best of intentions, which you have just expressed—and then you don't go about implementing it.

Simon Stevens: As somebody who arrived in April and looked at the work that was done here, and having previously been involved in this process in the late '90s and early 2000s, I can say that in my judgment this is the most transparent and most accurate application of a funding formula since 1976, when the health service first started at it.

Q3 Chair: I am not asking about the formula. You are not answering my question. You spent all this energy devising the formula—I want to come back to whether it is the most accurate and best—and then you don't implement. That is the heart of my question. Can you just come to that? That is really what this Report is telling us—you have done it and you are being at your slowest in implementing it. Do you want to have a go—is it you, Simon, or you, Richard?

Simon Stevens: I'll have one more go and then let's see what Richard has to say, as well. There are trade-offs here. Obviously, when there is more money to go around it is easier to apply more of the extra to the places that need it most. When you look at the obligations on all of the National Health Service, whatever your position relative to target, there are pressures around extra activity, waiting times targets, pay rates and various other things that apply in each part of the country. The consequence of going faster would be that we would have to make real reductions per person in some parts of the country. That has not been the case up until now, except in one case. Pace of change policy was designed to ensure no real terms cut in total resources. As figure 6 in the Report shows very clearly: you can see in figure 6 that the bars are much wider—in other words, redistribution happens much faster—when there is more extra money coming into the health service.

Q4 Mr Jackson: But you institutionalise unfairness on those not receiving the funding. We can come on to discussing the efficacy of the formula later; I think there are issues about whether it is right to look at ONS figures and GP lists, but that is a separate issue. It is all very well saying, effectively, people are over-provisioned so you can't alter the health care economy too quickly, but equally the trade-off is that you are unfairly resourcing those many other people at the other end of the spectrum.

Simon Stevens: That's right.

Q5 Mr Jackson: So it is incumbent upon you to sort that out as soon as possible.

Simon Stevens: We definitely would like to go further and faster, but, to make it very practical, if you look out the position for 2015-16 on the formula as we've got it, Barking and Dagenham would be £3.1 million over—getting too much—and South Norfolk would be £3.1 million under.

Q6 Chair: What's our deficit—£40 million, £50 million?

Simon Stevens: That is my point. The deficit demonstrates that going very fast can be a struggle. The question is, if we were to go faster, how much of the £3.1 million should we take from Mrs Hodge to give to Mr Bacon next year?

Q7 Chair: That's what I said to you before the hearing. It is not good enough. I think there are mistakes—we will come on to that, and I think Stewart shares that with me; it's about how you have come to the formula. With the greatest of respect to you, because I know that you have a difficult job, you cannot sit there saying, "This is the most brilliant formula and the best attempt we have had at trying to distribute money fairly"—some might quarrel with that, but that is what you assert—and then tell us that two fifths of CCGs and three quarters of local authorities are more than 5% above or below the target. Basically, what you are also telling us this afternoon is you are not going to do anything about it because it is going to get tougher next year and you daren't take away money from Barking and Dagenham and give it to whichever bit of Norfolk Richard represents.

Richard Douglas: Shall I come in at this point? On both of these—there are two different formulas for distribution here, one CCG one and one local authority one—I will talk about the general position of the NHS one first and then maybe say a bit about the particular position on local government and public health, as the person who was doing this for about 13 years before Simon came back. There is always a balance to be struck on how fast you move people. What NHS England have proven they have done this year is make some movement towards target. We would all like to make faster movement on that. Our ability to do that is always constrained by the money and the demands we put on the system, but also by the fact that any time we restructure the system in some way or change the number of bodies, we get a very rapid divergence from target—look at figure 4. Every time we restructured PCTs, we would get a shift away and then have to drag it back in again. This time, we have not only had a restructuring, but have split the money up in different ways. You always start in a position where you have quite wide distances from target.

On the local authority one, where some of the numbers are even bigger than the NHS distances from target, the main issue for us was that it was the first time we had ring-fenced public health money. It was the first time we had identified public health money and allocated it in any way. We took a decision that, at the point we ring-fenced the money and handed the responsibilities to local government, we would not ask local government to cut the amount of funding previously spent by the NHS. We started off constrained by saying, "No one, on taking on a new responsibility, should get less money than the person who spent it before." Because of that, and because this had been run a totally different way, you get very wide differences. I think we would all aim to move as quickly as we can over the next spending review period to narrow that gap.

Q8 Mr Jackson: I do not really think that washes, not least because the Department for Communities and Local Government imposed a freeze or real-terms reduction in a lot of local authority budgets. It did that knowing that that may impact on front-line services. It is not as if this came out of the blue; you knew that you would have a new governance culture and structure in NHS provision, public health and CCGs from April 2013. You could have refreshed your funding formula at some stage to make it more robust and demonstrably accurate—in other words, not inflated GP lists or historical ONS figures—and said to all these bodies, "This is the new, fairer formula." But you did not do that; you seem to have just rolled over the funding that went before. The Report also says

that you ignored the advice from the Advisory Committee on Resource Allocation, which was not fully involved in the situation either. I do not think you can say, “Well, it just sort of happened.”

Richard Douglas: ACRA was fully involved in everything. In terms of the time we had to prepare for this, the restructuring occurred after the 2010 election. We needed to get the policy work done to decide how we would split the different pots of money. We needed to get the legislation through and then identify what people spent. There was not, frankly, a lot of time. We went out to identify the amount of money that was currently spent on public health—I think that was at the back end of 2012, which was the earliest we could have done it. For about a year, we then went through a process of testing out that spend, using both the NHS and local government. There was not a lot of opportunity to do much more in the time we had, and I think we generally did a pretty thorough job of identifying spend and determining an appropriate formula. The pace at which you move towards that new formula is a different issue.

Q9 Mr Jackson: What mechanism have you put in place to encourage commissioners to alter their spending behaviour? There does not seem to be any proper mechanism. What is the incentive for them to get closer to the target?

Simon Stevens: The incentive, I think, is that they can see what their position is relative to the target and therefore have a clear sense of what they are likely to be facing in two, three or five years’ time—whether it is a relatively higher or lower rate of growth. For example, if you look at Cambridgeshire and Peterborough this year, there is a 2.9% increase in CCG funding versus 2.14% in City and Hackney.

Chair: Those are theoretical figures.

Q10 Mr Burrowes: The problem is that, while trying to be fairer, you have ended up with something that is neither fair nor secure for areas such as Enfield, which has historically been a victim of an unfair formula that does not recognise our rapidly changing needs and issues of inequality. A local area with a rapid increase in population is not stable. The formula is still based on an historical legacy of unfairness and it does not wash with local commissioners that this is in any way supporting stability when they are having to deal with a huge increase in population. There are 4,000 unregistered patients and there may well be a lot more. How does saying it is truly fair and stable square with local commissioners?

Simon Stevens: I think Enfield has a strong case for wanting a fast rate of change. When you look at London as a whole, actually it is not that far off its fair shares. There should be, according to the formula at least, a rapid movement of money from inner London to outer London. For example, the formula suggests moving £28 million, I think, out of Hammersmith and Fulham in your direction. So those are the kinds of real-world transitions that we are talking about here.

Q11 Mr Burrowes: In terms of the judgment here, obviously there is an intention to move to fairness as quickly as possible, and I know that when the process was published there was a delay regarding the timing. I want to see how much the political judgment in terms of the impact on the losers—you mentioned Hammersmith and Fulham, but you could have mentioned other inner-city boroughs that will be losers—was a factor in moving towards a fairer system, which is what the purists would want.

Simon Stevens: Again, I think that, given that such judgments are now made transparently and are consulted on and made in public, and so on, actually they are not subject to the kind of political trade-offs behind the bike sheds that you describe. There is more openness than there ever has been.

Chair: Openness does not mean no political trade-offs, with respect. Meg.

Q12 Meg Hillier: The PCT in the borough of Hackney always balances budgets, so that just highlights that even in a poor area we have got it right. Some data are emerging for us in Hackney, showing that efficiencies, mostly through pathways from GPs to the hospital and so on, are saving patients time and the NHS money. That raises a couple of questions.

First, are you actually learning from efficiencies? We always felt sore in Hackney, where we could balance the budgets, about other parts of the country that were richer and overspending, including in London. We would have to send people over to teach them how to balance a budget. That was not fair. So what are you doing about learning?

Secondly, it is early days yet, but local government is now looking at the public health budget for the first time and there is apparently a bit of a culture clash between how the NHS runs it and how local government run it. So what detailed conversations are you having to shape this agenda for the future? I suspect that local government might get more bang for its buck out of the money, because some of them are very good at running tight budgets.

Simon Stevens: On the second point, we are testing the proposition about budget pooling—particularly now through the Better Care Fund, the extra £1.9 billion that is going to be pooled from 1 April—so the extent to which that changes spending patterns and changes the outcomes that we get will be seen at scale during the course of 2015-16.

Meg Hillier: Is this the fund that makes GPs open more often? I lose track, because there are a lot of different funds.

Simon Stevens: No, this is a pooled health and social care fund called the Better Care Fund.

Chair: We will come back to that. Can we stick to the formula, Meg? I promise you we will come to every issue, including the Better Care Fund.

Meg Hillier: Will he be able to answer the questions I asked? He was in the middle of answering them.

Simon Stevens: The first question was about the efficiencies that Hackney has been able to bring about and how those get absorbed or learnt about by other parts of the country, and how we stop bail-outs to other places at the expense of what would otherwise have been money in your area. I think that is the heart of the question.

It is fair to say that prior to 2013—Richard would have to comment more on this—there was not much transparency as to the soft bail-outs that were going on in different parts of the NHS. I think that we now have more transparency about that. However, clearly, parts of the country need to make significant changes in the way care is being provided and they need double running costs, in effect, to enable that to come about. We now have more transparency about what that money is and how it is being used. Richard, do you want to add to that?

Richard Douglas: I agree.

Simon Stevens: That was not a top-slice on the CCG allocation.

Q13 Chair: Can I get back to the targets, where Stewart and I were?

According to the report, two fifths of CCGs are above or below 5% of the target. When, Mr Stevens, will they be in target?

Simon Stevens: The allocations set were two-year allocations for 2014-15 and 2015-16, so I do not think anybody in the NHS wants all those cards thrown up in the air again this close to the start of the next financial year. But clearly, from 2016-17 we definitely want to make much faster progress against target allocations.

Q14 Chair: When will the targets be met?

Simon Stevens: That will depend a bit on the quantum of the settlement that we have to distribute the extra, because part of what is going on here—and I do think that it is important that Richard's points are not lost—is that when you increase the number of commissioning units, by definition, you statistically increase the spread of allocations; so when you go from 152 primary care trusts to 211 CCGs, you will see more of that exposed. I think just one concrete example of that is the Corby example that was quoted in the NAO report. I think the figure was £137 per person under target. Prior to the advent of Corby CCG, Corby was bundled in with Northamptonshire primary care trust, and it comprised, then, just 11% of Northamptonshire's expenditure, and Northamptonshire overall was only 0.9% off its target. So statistically what you have seen is an issue that had always been there with Corby, but, by drawing back the veil and by getting more specific about the fair shares for Corby, as against Northamptonshire, you have this statistical effect.

Q15 Chair: I recognise and understand that problem—we had a very similar thing with Havering. But you still have not answered my question. I would be grateful, Mr Stevens, if you would just answer one question directly. You have these targets. You stand by them. You think they are good. I think Stewart and I want to challenge the basis on which you do that. But when?

Simon Stevens: We would certainly like to get to a position within a year or two where we have dealt with those CCGs that are more than 5% off their allocation.

Q16 Mr Jackson: Let's take you at your own word about the robustness of the methodology you use, because I worry that the bucket is leaking, so to speak. In the NAO Report, paragraphs 3.4 to 3.6, it specifically says, "Population size is the factor that has the most significant effect on each commissioner's target funding allocation", which is fair enough. "NHS England uses data from GP lists to calculate population estimates for clinical commissioning groups and area teams." All well and good, except that it goes on to say, "NHS England's area teams are expected to work with GP practices to manage lists" but that it "centrally does not routinely assure itself that the guidance is being followed but collected evidence for us of the work that most area teams have done." In other

words, that list data is inflating, and it is not actually that robust and demonstrably accurate, yet you are now using that much more as the basis of allocation. Are you convinced about the efficacy of that?

Simon Stevens: It is inflated, and the extent of the inflation has been coming down quite substantially—it is a third less now than five years ago¹. What we inherited as NHS England was a situation where each primary care trust and predecessor health authority did its own thing when it came to list validation. So we have a situation where there are 38 different offices around the country that we have inherited that are each doing their own list validation, using a computer system that is 25 years old. Our intention, from next spring, is to procure a new primary care services back office that will bring national consistency to this right across the country.

Mr Jackson: Don't get Mr Bacon on NHS IT.

Simon Stevens: I look forward to Mr Bacon's advice before we do it.

Mr Jackson: He has written books on that, Mr Stevens.

Mr Bacon: In which you feature.

Q17 Mr Jackson: You are dicing with death.

The other thing about governance is that it is less than satisfactory. The NAO Report goes on to say that the funding allocation is “heavily based on the relevant component of the previous” PCT, which is fair enough, but that NHS England “did not seek the Advisory Committee on Resource Allocation's views”—this is the point I raised earlier—“until three months before the primary care allocations were announced.” The question is, what is the point of having this body if you effectively do not take any notice of it? The data is not that robust, and you do not even take any notice of the pointy-heads in charge of overseeing and scrutinising what you are doing with the data anyway. You can have a million IT schemes in future—surprise, surprise—after the general election, but how will you deliver fairness now when the bucket is leaking?

Simon Stevens: Actually, the NAO said, to quote from page 7: “The new funding arrangements are more transparent and continue to use expert, independent advice.” So when the Advisory Committee on Resource Allocation has given us advice, we have taken it. On the specific point you raised, I don't know whether Paul wants to come in.

Q18 Mr Jackson: It actually says the current approach is regarded as interim, and that NHS England intends to refine how it assesses need in future years.

Simon Stevens: That's right. We do regard the primary care funding formula as interim.

Q19 Mr Jackson: You have had 18 months. How interim is interim?

¹ The witness, Simon Stevens has requested that it be made clear that he intended to say: “It is inflated, and the extent of the inflation has been coming down quite substantially – it is a third less than the figure quoted in the NAO's report.

Simon Stevens: The reason it is interim is that, in the case of general medical services, it is linked to something called the Carr-Hill formula, which was used to set the GP contract back in 2004. All kinds of issues have arisen with the Carr-Hill formula, including the phase-out of a temporary subsidy—

Mr Jackson: Don't get on to the GP contract, because that is another one of the NHS greatest hits.

Simon Stevens: But that is the formula, and that is why we think it needs a look.

Chair: Do you want to get Mr Baumann's answer?

Q20 Mr Jackson: Yes. Can you specifically answer the questions about the GP inflation—how interim it is and how robust you think it is—and about the involvement of the Advisory Committee on Resource Allocation?

Paul Baumann: On inflation, Simon has talked at considerable length about how, over the next while, we are going to systematise what we are doing. In addition to what Simon said, during the course of this year, we are going to be mandating that—

Chair: Sorry, can you say that louder? You are going to be mandating what?

Paul Baumann: Before the end of this financial year, that every area team does what most area teams have already been doing, which is implementing the very detailed procedures and guidelines that we put out in the publication back in 2013.

Q21 Chair: To check GPs to see whether they are inflating?

Paul Baumann: To validate the list, which is a perfectly normal—

Q22 Chair: So your area teams will validate?

Paul Baumann: The area teams are responsible for it. They will use the primary care support services that Simon mentioned to do it, but it is their accountability, because they are the people who commission primary care, to ensure that it is done. Two thirds of them, as we have looked at it, have done substantial amounts of list validation this year; it is true that a third of them have not. Therefore, it is our intention not just to wait for the new primary care support services to do that but to ensure they are getting on with that job this year.

Q23 Mr Jackson: That's all well and good, but it is a quantitative and qualitative issue. If the ones who are doing the work are in leafy Surrey, Devon and Hampshire, cumulatively, it is not going to have that much effect. It is inner London, Liverpool, Manchester and hot spots like Peterborough that have the biggest impact on GP list inflation.

Paul Baumann: Yes. London, for example, is one of the area teams that have been doing a lot of work on that, and you are right that they have the biggest issue around the list differences you talk about, but they are one of the more active area or regional teams in doing that.

It is worth saying that the key formula for the CCGs where this is relevant has a number of offsetting mitigations which mean that even if there is list inflation beyond what is normal and explicable, there are facets which mean that the money does not go with it in quite that way. For example, one of the key variables in the CCG formula is claimant rates, which are clearly an indicator of the nature of the population. Clearly, if the number of population members is inflated, the claimant rate will decrease, so the rate per head of that particular factor will be smaller. There are quite a number of offsetting factors that mean that while we need to take very seriously the list validation points you are making—we are doing so—it is not a simple translation, in that if you have more population—

Q24 Mr Jackson: No, but with the Chair's indulgence, can I give you a very simple example? In Peterborough between 2004 and 2011, we had 34,500 new national insurance numbers issued to EU migrants who came to the city. Many of them do not come from a health culture that recognises primary care, so when they or their children get sick, they go directly to accident and emergency, hence the very significant pressures on the former Peterborough District hospital and now the Peterborough City hospital, with which this Committee is familiar because it has the largest PFI structural debt in the UK, at £40 million.

The point is that that is the sort of issue which the formula skirts around. Those people will not necessarily register, because they do not think they have to. Mr Burrowes has alluded to that as well.

Mr Burrowes: There are 4,000 in Enfield.

Mr Jackson: In a very circuitous way, my question is how you are capturing the likely or estimated numbers for non-registration. Within the wider health care economy, that is going to be a big issue for the allocation of resources.

Paul Baumann: You are right. We cannot do that formulaically in advance, because you cannot capture what you do not know, but we do capture in retrospect the some of the unregistered population and the way in which they consume the services, particularly in hospitals, and there is a process by which that is then, as it were, redistributed around the system on a retrospective basis. At the moment it is not an enormous number compared to the total allocation, but clearly that is one we will watch.

Q25 Chair: Meg wants to raise the other issues, but I have two final questions on this bit. In the old days, the Audit Commission validated the GP data, so they would go around and see whether it was inflated or inaccurate. They do not do it any more. Are you telling us that area teams do it now? That is question one.

Paul Baumann: The area teams are accountable for it. The primary care support service teams who work for the area teams do the work.

Q26 Chair: But who validates it? In the old days, the Audit Commission would have done that. Do you know who does it now, Mr Douglas?

Simon Stevens: The Audit Commission was the external auditor, and our external auditor is obviously Sir Amyas.

Q27 Chair: Do you validate the data?

Amyas Morse: No.

Q28 Mrs McGuire: Who audits the lists to say this is a correct, or near as damn it correct, list?

Paul Baumann: Let me try again. On the area teams and the primary care support services, the auditors check that they are following the appropriate processes, as they look at every other process that we run. What the auditors do not do of course is to go around every single GP surgery in the country and check the lists.

Q29 Chair: I do not believe the Audit Commission did that. I am merely saying that in the old days they did a matching exercise, as I recall it.

Q30 Mrs McGuire: Can we be clear here? I am using the word “auditor” with a small a. I just want to know not who verifies the process, but who actually spot-checks in a particular area that those lists, or a sample of those lists, are correct. Does anybody know?

Mr Bacon: You are all looking at each other blankly.

Simon Stevens: The clarification about little a and capital A helps. The answer is little a: NHS England. It is our responsibility.

Q31 Chair: And big A?

Simon Stevens: Big A, our external auditor, is the NAO.

Q32 Chair: But he does not do it.

Simon Stevens: He has. He has raised it in this helpful Report.

Q33 Mr Jackson: But, given that the Report says the funding is capitation based on lists, if you do not systematically and robustly scrutinise the lists on a timely basis, you are really potentially looking at—let us put it charitably—a misallocation of resources.

Simon Stevens: Absolutely. Let us be clear: this is an important thing to get right. We have inherited a pretty fragmented system. The extent of list inflation has been coming down. It is now lower than it was when the prior arrangements were in place, and we will continue to do more, aided by the ability to run a national validation process. But, in the case of 2013-14, we did take 362,016 patients off inflated lists, and then there was a process whereby individual practices were able to come back and say that some of those people who appeared to be inflated actually were not, and that was under 5% of them. So there is work that happens, and we need to do more of it.

Q34 Chair: Not very systematic.

I have one other thing to ask Richard Douglas before I go to Meg. We talked about two fifths of CCGs being more than 5% above or below and three quarters of local authorities being above or below. What is your date?

Richard Douglas: It is the same answer that Simon would give—it will depend on the outcome of the spending review.

Q35 Chair: To be honest, we all know to within a billion or so, from even our party conferences, about where that spending review will be. We all know that there is a billion and a half in it between the two main parties—or probably all political parties—so just shoving it into the long grass without giving us a clear answer is not good enough.

Richard Douglas: It is not shoving it into the long grass, and it is not a matter of there being an election and different parties' views. Until we have a spending review settlement—

Q36 Chair: You know vaguely where it will be, Mr Douglas. You cannot wait.

Richard Douglas: Clearly, we have ideas of where you might expect to land.

Q37 Chair: Given your ideas, when would you expect it to work? You think this is a great formula. Let me also make the point that some authorities are regularly in surplus. Given the financial constraints that you are in, it does not seem a bad idea to get the money out of those in surplus to redistribute it.

Chris Heaton-Harris: If funding for the NHS just goes up with inflation, when would the formula work?

Simon Stevens: Within two years from now—2015-16 and the following year—we would like the CCGs that are more than 5% off of their target to be within that range, recognising that there will always be some volatility given changes to the data flow, adjustments to the formula based on ACRA and so on. To say that everybody will be bang on, which in the case of Hackney would mean taking £26.5 million off City and Hackney CCG in one fell swoop, is not realistic.

Q38 Chair: And you, Mr Douglas, on your bit of it?

Richard Douglas: It is a policy decision for the Government of the day. Difference to public health does not sit with NHS England as an arm's length body. It sits with the Department and the

Government of the day. I hope we could do a similar thing and get to within 5% relatively quickly, but it would be wrong for me to commit when that would be on behalf of a future Government.

Q39 Chair: If you assume the existing policy and take Chris's helpful suggestion of assuming it goes up with inflation, when?

Richard Douglas: But there is not an existing policy on how quickly the Government would want to move that public health—

Q40 Chair: No, there is an existing policy on what is a fair distribution, and three quarters of local authorities are more than 5% off of that.

Richard Douglas: I cannot give a time. It would be wrong for me to do so because that is a matter for the Government of the day.

Chair: I think that's a cop out. I really do.

Q41 Meg Hillier: Perhaps I can pursue the issue a bit more. Paragraph 3.23 of the NAO Report says, "The evidence is unclear on the extent to which increasing funding can help to reduce health inequalities." The Report goes on to say a bit more, but perhaps we could just look briefly at Blaydon, and Hackney South and Shoreditch. I have chosen those constituencies because they are in different parts of the country; one is mine, of course.

My constituency has a young population—around a third of people are under 25. When we had issues around high levels of incapacity benefit, the claimants were mostly people in their 50s. In fact, quite a large percentage were younger than 50. We do not have that many older people. If you are old, you get great services in Hackney because there are not many people to get them. We have high instances of mental health issues, and high maternity, which saves our local hospital. Children are born into deprived backgrounds—47% are in poverty. In Blaydon, there are challenges in that they strongly feel that the new formula is not really paying regard to their health inequalities, probably at a slightly different age range. How robust do you believe the age-related approach is in tackling inequalities?

If you are not familiar with it, I point you to some work by Dr Kambiz Boomla of Queen Mary university, although I cannot give you that much more right now. He is a GP in Hackney and has produced some analysis about the issue, which concludes that illness and the need for health care depends on not how far you are from birth, but how near you are to death. There is a lower life expectancy in Hackney than in parts of west London and, similarly, in Blaydon than in smarter parts of north Northumberland. A 52-year-old Turkish farmer in Hackney who has arrived in the UK will be less likely to live as long as a rich banker in west London, but this formula does not seem to take any of that into account. I am really concerned about the robustness of that and the impact on my population.

Simon Stevens: It does, in that it attempts to do two things at once in different proportions: one is meet equal need with equal funding, and the other is deal with unmet need where the situation as you describe it is such that if people die young, they will not be there to need health services later on. We rely on the advice we get from ACRA on the best way of making those kinds of

judgments and this is one of the things that it is continuing to look at. We have ensured that, in the funding formula that we are using for this year and next, we have explicitly built in an additional health inequalities component, over and above what would be explained by equal access for equal need.

Q42 Chair: What proportion of the general need formula is it?

Simon Stevens: We have built an additional 10% into the CCG-commissioned allocation process, over and above what the pure statistics would suggest, and an additional 15% into the primary care formula.

Q43 Meg Hillier: All of that is fine on one level, as a statistic, but on the ground it does not feel like it is working. As we were preparing for this hearing, I was saying that, if you look at the Booth poverty map of London now, it will tell you pretty much what you need to know about Hackney today. I am not laying that all at your door as you have only been in position for a few months—I might do it in a year's time—but in all seriousness, isn't that a real scandal for our health system?

We are the Ellis Island of the UK—we get a lot of people coming through—but we should be learning from that about how to resource appropriately to tackle the inequalities. We have some pretty smart health practitioners who do work smart, rather than always ask for more money, and I am concerned that even though the formula takes into account the health inequalities a bit—10% of it—it is not taking all of them into account. Can you say anything more to convince me and health workers on that?

Simon Stevens: In addition to the research that you mentioned, some other research was done, looking at the impact of the resource redistribution that occurred during the 2000s: it was published in the *British Medical Journal* recently by Ben Barr and colleagues. The point about that was that it did suggest that having the inequalities focus in the NHS allocation formula was associated with closing the class inequality in death rates and life expectancy.

So I think we know that it can have an impact. The question is, given that a lot of public health experts will tell you that what the NHS does is only a bit of the impact on overall health inequalities, which are the things that the NHS does that will have the biggest impact? Our judgment is that proactive primary care will probably have more impact than access to some of the high-end specialist services, which is why we gave a much greater weighting to the inequalities component in the primary care piece of the formula than the hospital piece.

Q44 Meg Hillier: So—the NAO Report touches on this in paragraph 9—you are trying to incentivise use of primary care over tertiary care?

Simon Stevens: We think there is a particularly strong case for boosting the access to high-quality primary care in parts of the country that have got poor health inequalities, because that is where a lot of the contribution that the NHS can make to cutting inequalities will occur, recognising

that there are lots of other questions around health that need to change as well, around other health questions.

Q45 Meg Hillier: My final question on this point. With local authorities now responsible for public health—I mentioned the Booth maps, which show what some of the key public health indicators are in my borough—if successful public health interventions reduce inequalities and those are proven and mapped, would you see a shift of funding from primary care to public health, or indeed vice versa?

Simon Stevens: I would like to get to a position where we have more of the total NHS spending available for local judgment about how to use it, so bringing together the budgets for CCG-commissioned services with those for primary care services. As part of that, CCGs and local authorities are free, under the section 75 arrangements of the 2006 Act, to move money around between headings to where they think it will have the biggest impact.

Q46 Meg Hillier: Sorry, I did say that that was my final question, but given that answer, isn't there a danger in this world where a thousand flowers bloom that each of our constituencies could have a completely different approach to health care and how they decide to spend their money? How do you stop them spending it in a way that might be popular locally but perhaps not as effective?

The NHS currently provides certain services that are not about tackling health. What about bariatric surgery, for instance, which a colleague has raised with me? We know that exercise and eating sensibly are the best approaches to obesity, yet the NHS has rules about providing gastric band surgery. If, say, that suddenly got popular in Hackney but not in Peterborough, how do you from the centre ensure that we would not be wasting money in Hackney on that—dare I say it—rather than spending it on more public health interventions? How do we ensure that we are not spending valuable NHS resources inappropriately? For the record—in case anyone is watching this—I am not saying that every gastric band surgery is inappropriate, but there might be times when it is not the most appropriate option.

Simon Stevens: The point that you make is an absolutely fantastic example, because we are now spending more on bariatric surgery than on some evidence-based obesity reduction and diabetes prevention programmes. I do not think that NICE were wrong to argue that bariatric surgery could be cost-effective under certain circumstances, but in effect we have had a misallocation of resources across the NHS. One of the things that we are going to be advocating in a document that we are going to publish this week called the NHS Five Year Forward View is precisely on that point—that we invest more in upstream obesity prevention services than we do on downstream bariatric surgery.

Chair: Chris has a quick question on that and then I am going to John and Anne.

Q47 Chris Heaton-Harris: It is on the same point really. You are trying to rule out inefficiencies and overcome health inequalities, but can you give me some confidence that you are not actually building a reward for failure into this formula? If people start getting healthier in an area, then in two, three or four years time, that area's health budget gets cut.

Simon Stevens: Hopefully, their budget won't be cut, but this is one of the reasons why there is a policy choice to be made as to whether to allocate based on outcomes or on likely health care usage. If you just do it on outcomes then you run the risk that you describe, which is one of the reasons why we don't do that.

Q48 Chair: I want to ask a question arising out of what Meg said. If you feel that primary care is so important in dealing with health inequalities, why have you cut that as a proportion of your total NHS expenditure this year and next? Why was it cut?

Simon Stevens: Primary care spending is higher now than it was before NHS England—

Q49 Chair: Why was it cut? Do you think it is important for tackling inequalities? In 2014-15 and 2015-16 it is a lower proportion—

Laura Brackwell: That is public health. If you look at the proportion of the NHS budget that has gone to primary care, it has fallen over recent years compared with the proportion that is going into hospital care.

Chair: Fallen?

Laura Brackwell: That is in paragraph 1.14.

Chair: What Simon said was that primary care was an important element on the health inequalities.

Simon Stevens: Yes. I am—

Chair: So why has it fallen as a proportion if that is your belief?

Simon Stevens: In 2003-4 we were spending 29% of PCT budgets on primary care—

Q50 Chair: Please answer the question. Why has it fallen?

Simon Stevens: I am just explaining that it has been falling for a decade from 29% down to 23.5%. That is because we have been spending a lot more proportionately in hospitals doing things such as more waiting list surgery, cutting the orthopaedic waiting times, expanding services, more on new medicines and so on. Looking back over the course of the last decade or so, was that the right decision to have made? I am not sure it was. Looking forward, would I like to see a far greater increase in primary care spending? Yes, I would.

Chair: Okay, that is clear.

Q51 John Pugh: This question comes with a bit of a preamble because I am developing some sympathy for you.

Simon Stevens: Perhaps we could stop proceedings at this point? It's downhill from now on.

Q52 John Pugh: What you are trying to do—and what we want you to do—is get the right health mix for an area so it is adequate to their needs and fair to everybody else. However, you are actually dealing with a number of financial streams. One is the social care fund, which is controlled by local authorities and not by you. Then there is primary care, which we just talked about; public health funds, which are fixed by you; secondary care; and commissioned services by the CCG. Then, overlaying that, there is specialist commissioning as well. All of those are separate and distinct funds. I have written down here your range of policy initiatives—the Lansley imperative to pay greater recognition to more public health in deprived areas, the desire to shift care from the secondary care setting to the community, the mandate in the legislation to address inequalities—and you also have to integrate health and social care. We are arguing about targets—how far you meet them and so on—but just running over that, is it not an impossible task for you to do centrally?

Simon Stevens: Well, that is one of the reasons why it is good that we can now harness the clinical energy of the CCGs. Two thirds of the NHS budget is making local decisions through CCGs, but you are right that there are a large number of imperatives that we are set and it is not always straightforward juxtaposing them.

Q53 John Pugh: But the problem is that you do not really have a clear picture of the total area effect of all these various funding streams. In paragraph 2.25 the Report says, “To balance fairness and financial stability, the Department and NHS England need to consider the aggregate funding position of local areas, rather than making allocations in isolation.” Later on, it is described as “more challenging”, and later the Report says, “The Department did not provide us with any evidence that it has considered the wider funding position when deciding its public health allocations.” Unless you have that picture, you are working in the dark to some extent, aren’t you?

Simon Stevens: I certainly agree, and I also agree with the NAO finding. We want to move to a position where we have place-based formulae for as much of the NHS, and possibly the public health spend, as we can.

Q54 Chair: Public health spend or all spend?

Simon Stevens: NHS and potentially public health spend as well. We want a place-based view of fair shares for health services.

Q55 John Pugh: And that means looking at all the streams of funding?

Simon Stevens: It means primary care, specialised services and so on. For next year, we are enabling the CCGs that want to do it to take on the responsibility, either jointly or by themselves, for primary care spending. Our aim is to give the CCGs more ability to influence the specialised service spending that their people are getting, even if it is done on a collaborative basis across a broader area.

Q56 John Pugh: Can you explain why that matters? For the local authority in my constituency, the commissioning area is £18 over, which in one respect seems generous, compared with some of the other stats on the page. However, it happens to be an area in which the adult

social care budget is under very severe pressure. Unless you take that into account, one budget will simply put pressure on another budget, won't it?

Simon Stevens: Yes.

John Pugh: Therefore, you must look at things on an overall area basis.

Simon Stevens: That is the clear direction of travel in which we want to head.

Q57 John Pugh: Right. What is the smallest commissioning group in the country at the moment?

Paul Baumann: It is Corby.

John Pugh: How big is that?

Chris Heaton-Harris: About 75,000.

Q58 John Pugh: I was assuming that these organisations were all equally big, but they are not, are they?

Simon Stevens: No.

Q59 John Pugh: Finally, following through the integration point—you can give me those data separately—I have seen local authority statistics provided by DCLG that represent funding that is clearly Department of Health funding to show that the local authority reduction in funding is rather less than it might seem. I also see the same funding in Department of Health stats, which show that the reduction in health funding is less than it seems. That is double counting, isn't it?

Richard Douglas: The Better Care Fund—

John Pugh: Yes, the Better Care Fund.

Richard Douglas: The Better Care Fund money comes through the Department's budget; it goes through NHS England, and Simon is the accounting officer for it.

Q60 John Pugh: But it does feature in DCLG and Department of Health budgets, doesn't it?

Richard Douglas: I am not responsible for DCLG.

Chair: Yes, it does. I think if we asked the Comptroller and Auditor General, he would say that it does. We established that at a prior hearing.

Simon Stevens: I think you are having a separate hearing.

John Pugh: That is wholly undesirable, in terms of getting the broad picture, isn't it?

Chair: It does double feature.

Q61 Mrs McGuire: In the 2010-11 Session, the Committee's report on health inequalities identified that some of the elements that would reduce health inequality—smoking cessation, lowering cholesterol and lowering blood pressure—were not used at the scale required. That was the criticism at the time. Will the allocation adjustment of 10% to 15% that you have identified allow some of the issues that were identified at the hearing four years ago to be tackled more realistically?

Richard Douglas: I will let Simon come in in a minute, but one of the ways of addressing those issues is separating the public health budget from the main NHS allocation. For that hearing, we were dealing with the old system, in which the PCTs had all the money. What generally happened was that at times of stress in a PCT, the health improvement element of the budget, which addressed those types of issues, tended to get squeezed, because the money would go to keeping the hospital going. Separating out that money and putting it into local government gives it a degree of visibility and protection that we did not have before. Simon, I don't know whether you want to add anything from the NHS side.

Simon Stevens: You are certainly right about smoking. There is considerable expert opinion to suggest that the different smoking rates between social classes explains more than half of the health inequalities in the country, so it is huge. When you look at the formula that we have used for health inequalities, particularly the standardised mortality ratios for those under 75, one of the advantages over the prior arrangements is that we can look at quite small geographical areas within a borough, city or town. That then enables you more precisely to target the effort that will you make to cut inequalities. To take, say, north Manchester, the SRs² for people under-75, if 100 people is the normal death rate—

Mrs McGuire: Did you say "SRs"?

Simon Stevens: Standardised mortality ratios. If 100 people in England die before 75, in parts of north Manchester it will be 145 and in other parts of Manchester it will be 86. So you really want to know what the geographical difference is. Even in some apparently affluent parts of the country, you also get those big differences between micro-areas, so this targeting effort at different sub-populations will actually be very important. The formula does now help with that.

Q62 Mrs McGuire: Can I take you back to my question? Does your 10% to 15% adjustment actually allow you to look at tackling some of the major causes of health inequality?

Simon Stevens: I do not think that it has smoking as a variable, but it certainly picks up the consequence of smoking in terms of what then shows up as the health inequalities that flow from it.

Q63 Mrs McGuire: Right. Where did you get the 10% to 15% figure from? Was it just plucked out of the air? Did it sound like a nice round number? Page 39 of the Report states:

² The witness, Simon Stevens has requested that it be made clear that he intended to say "SMRS (standardised mortality ratios)", not SRs.

“The Advisory Committee on Resource Allocation also does not consider there is any evidence about the appropriate weight to give to any health inequalities adjustment.”

Simon Stevens: We could have said that we would not do one, which would have been a purist reasoning of what came from ACRA. We decided that in principle it was important to have a health inequalities adjustment, picking up some of what had happened in the legacy formulae, but one of the tasks that they have been set is to do further work in that area. We made an in-principle decision that the health inequalities adjustment was important.

Q64 Mrs McGuire: How long do you think it will take for us to move from an interim position on tackling health inequalities to one that gives us a far more strategic approach to delivering on health inequalities? As Meg Hillier has pointed out, the evidence out there is not exactly new. It might be more analytical, but I am beginning to think that we are analysing so much that we are not taking the action that is necessary. How many more advisory committees will there be on health inequalities?

Simon Stevens: Our decision was to act while they do whatever they are doing, as against doing nothing until they come up with something.

Q65 Mrs McGuire: Can you tell us what they are doing? “Doing whatever it is they are doing”—that is not particularly focused.

Paul Baumann: I think the question was about—

Simon Stevens: When will ACRA come up with their next view on the health inequalities element of the allocation formula? It needs to be in time to influence 2016-17 allocations. So working back from the conclusion to the premise.

Paul Baumann: I think you have answered the question for me. There is work going on. ACRA will do that. It will be factored into our 2016-17 work. I would just say that work on unmet needs has been going on for decades and decades. I totally agree with your point.

Q66 Mrs McGuire: You have actually made my point. It has been going on for decades. When will we actually see some end to the decades of work and actually see some real targeting and focusing of resources to tackle health inequalities? We are probably one of the most unequal societies in terms of health inequalities in Europe—certainly western Europe—and there is an element of frustration about how long we can go on analysing the problem without coming to some sort of decision about how to tackle it.

Simon Stevens: With respect—

Mrs McGuire: That means that you are about to insult me, usually.

Simon Stevens: We have come to a decision. The NHS has been tackling health inequalities for at least 15 years now. If you look at what happened during the 2000s, the research study that I mentioned shows that the pro-inequalities resource allocation in deprived areas apparently cut the gap between poor and rich areas in male mortality amenable to health and saved 35 lives per

100,000 people. We have been at it and are continuing to be at it. In the meantime, however, we are also getting such expert advice as we can on further refinements to the formula.

Q67 Meg Hillier: Can I just chip in on this? What has driven me crazy over the years is things such as good housing, which has a big impact on people's lives, mental and physical health and so on, yet twice in my own manor I have seen NHS land go. The Royal Northern hospital was sold off, and most of it was not for social housing. If we had had that it would have had the best health impact locally—to have decent, good-quality, affordable housing for the poorest people. Similarly, we saw St Leonard's hospital in Hackney, the old workhouse, sold and handed over to PropCo, this mysterious national body that nobody knows how to access. Perhaps that is another challenge you could take on.

If we could have sorted out the St Leonard's site and kept it locally, we could almost certainly have made sure that there was a good proportion of good-quality affordable housing. That would have had a big impact on the hundreds of people who queue at my surgery week in, week out and live in hugely overcrowded and inappropriate conditions, even after some of the major improvements we have seen in housing.

Perhaps we get naively impatient yet, as Anne says, we have this big, endless erudite discussion about figures and analysis. But it is quite a basic thing, isn't it? A good home has better health outcomes. Yet, the NHS grabs the property, the Treasury takes the money, and that is another 100, 200, 300 or 400 people in each area.

Chair: To be fair to the NHS on that, it is Treasury that is the greedy one. It takes the money from them.

Meg Hillier: I am hoping that Mr Stevens might say that, Madam Chairman, without your having to prompt him, and then we can use it.

Chair: I was going to push it at the Treasury; why the Treasury does not allow it to be reinvested.

Meg Hillier: Maybe Mr Stevens agrees with us and we can continue to push the Treasury on this.

Richard Douglas: Could I say something quickly on that? The issue of housing is important, and that is one reason why we put the public health allocation to local government and gave local government responsibility around public health issues. Housing is one of the biggest factors.

Meg Hillier: They don't have the money.

Richard Douglas: We have given them the money that we have. If you want to write to me or come and see me about PropCo I will talk to you about it, if you particularly find it mysterious finding your way into it. I am happy to have a long discussion about PropCo.

Q68 Mr Bacon: We did look at NHS Estates a while ago. Is PropCo an emanation of NHS Estates or is it separate?

Richard Douglas: No.

Amyas Morse: We are doing a Report on that.

Mr Bacon: You are doing a Report on PropCo. How encouraging.

Richard Douglas: Very basically, when we did the reforms and restructuring of the NHS, there was a lot of property held by strategic health authorities and primary care trusts. In future, NHS England and CCGs as commissioning bodies were not going to hold property, so we created a property vehicle that put all of that together.

Q69 Chair: Who gets the benefits of sale?

Richard Douglas: Any rationalisation benefit comes back into the Department and recirculates within the NHS.

Chair: So it is within the NHS.

Richard Douglas: We make savings on it. There is a combination of trying to release money through sale of assets and also bring down the cost of the estate. I worry about doing things at national level, but it is one of those things where bringing together something that was previously run by every different PCT across the country with very different approaches to facilities management and the like meant that there was a big opportunity to save money, and we are seeing quite big savings.

Mr Bacon: We will obviously return to this when the NAO's Report on PropCo comes out.

Q70 Mrs McGuire: Could I bring us back to the Advisory Committee on Resource Allocation? I just want to pin you down a bit on this advisory committee. I understand that it is currently doing work for the next spending review. Is that right, Mr Baumann?

Paul Baumann: There is ongoing work. I do not want the thought to be there that we are waiting until that happens and that there is not something in the formula that deals with it. There is something explicitly in the formula that deals with deprivation, with the best quantification we can put on it. If we can add to that through the research work we do over the coming year, we will do, of course. I come back to the point you made yourself—there have been decades of review. We are not waiting for another review; we are getting on with doing it.

Q71 Mrs McGuire: So we are sticking at the 10% just now. Is that what you are saying?

Paul Baumann: That is what we are doing for 2014-15 and 2015-16.

Q72 Mrs McGuire: Right. I thought I had picked up from either Mr Stevens or Mr Douglas that the advisory committee was doing work just now that would inform the next round. Is that correct?

Paul Baumann: They will do. We anticipate the next round as 2016-17. We have given two year allocations.

Q73 Mrs McGuire: Right. Have they given any indication of their thoughts at the moment? For instance, is your 10% or 15% accurate, or should it be less or more? Have you started to think of the political implications, dare I say it, of removing money from one area to give more to an area that is designated more unequal in health? Have you started the process, or are we going to be here in 2017, though I won't be?

Mr Bacon: Shame.

Mrs McGuire: Thank you, Richard. Will new members of the PAC or a health committee be coming back and swimming through the same shark-infested waters?

Paul Baumann: Yes, of course, we have been thinking about how to deal with that, but no, I haven't got a view on the answer yet, because we are just starting the work now. It is a piece of work that we are going to get external help with, because it is clearly something that needs expertise that we do not necessarily have in-house. It is something that ACRA will get involved in as well—it is not actually an ACRA piece of research at this stage. But I keep coming back to it: I do not think that this is going to be the silver bullet that suddenly solves a problem which has eluded us for decades. We will get more insight, potentially, from that work. For the moment, there is a deprivation adjustment and it means that allocations per head very much reflect the deprivation that is in the communities that they serve.

Q74 Mrs McGuire: One final question on this subject. Given the fact that complex issues are involved in health inequalities, including—we have alluded to some of them—housing, education, income, and all of those things, as the guardians of the nation's health, have you had conversations with the Departments that can influence income, education and child welfare, and said, "Hey, there is problem here. We can't solve it all. You have a role to play"? What sort of conversations do you have with those other Government Departments about these issues?

Richard Douglas: We have regular conversations, particularly with DCLG, about housing and local government. We speak with DWP, particularly about the benefits system and the interplay with the benefits system. They are probably the two—and to some extent, the Department for Education as well. We see part of the Department's role as working on health across Government, not just within the NHS.

Q75 Mrs McGuire: So are you a critical friend of DCLG and DWP, in terms of the impact of their policies on health education and the impact, therefore, that that has on your resource allocation?

Richard Douglas: I think "critical friend" is probably a decent phrase, and we will work with them particularly on the next spending review. Sorry to refer again to the next spending review, but frankly, in Government we haven't been very good at talking and working across Departments, and that will be a big focus of the work we are now doing for the next spending review.

Q76 Chair: Are you suggesting that you use the same criteria—the same formula—instead of having one formula for social health care and another formula for something else? You have four formulas in your lot, and then we have the fifth formula with the DCLG.

Richard Douglas: I don't think that it would necessarily be a situation where we have the same formula for everything, because they are trying to meet different objectives. The public health formula is largely, although this is a crude caricature, trying to improve the population's health for the future. To a large extent, Simon's formula for CCGs is trying to care for people today. Inevitably, because of the different purposes, you will end up with slightly different formulas. What you need to do is understand the differential impact of each of those and how they then play out into what the total spend across a particular part of the country is, but I would not necessarily say that you plug straight into the same formula. I just don't think it would work.

Q77 Mrs McGuire: This is the final bit. Do you see yourselves as a passive deliverer of health services, or—

Richard Douglas: No.

Mrs McGuire: Fine, well let me get the next bit out—or do you see yourselves reflecting back into Government the impact of a range of other indicators and what impact they have in terms of social inequality? I just want to be clear that that conversation—we do not need to know what that discussion is; we accept that that might be confidential—is happening in Government.

Richard Douglas: We absolutely don't see ourselves as a passive deliverer of health. We see ourselves as the people who are responsible for trying to improve the health of the population, and improving the health of the population means taking action not just within the NHS, but within other areas of Government.

Simon Stevens: Just to add to that, from an NHS Forward view, and in my role as chief executive of NHS England, I very strongly believe that the NHS has to become more socially activist on some of these broader questions about the health of the population. In the NHS forward view, which we will be publishing on Thursday, we are going to stray quite wide on to some of these other topics and the impact that they have on health, and we will make the argument that we have been far too passive as a country in dealing with the upstream causes of ill health that the NHS is then on the receiving end of, having to try and pick up the pieces.

Mrs McGuire: I look forward to the report—

Simon Stevens: If I am still here on Friday, I will let you know.

Q78 Mr Bacon: Isn't "stray" a rather tendentious word? It suggests you are going where you shouldn't.

Simon Stevens: No, I'm just expanding the conversation beyond the narrow confines of treating patients who need care right now—although of course, they do.

Q79 Mr Jackson: It is pretty evident from various hearings we have had that the No. 1 challenge for the health service over the next 25 years is accepted as being the number of older people, particularly over-80s. A survey by the Healthcare Financial Management Association in June 2014—this is on page 29, paragraph 2.29—found that “nearly a third of clinical commissioning group chief finance officers considered that cost pressures in social care were causing cost pressures in their clinical commissioning group.” I think you would accept that that is probably to be expected, except that the next paragraph specifically states that, in making decisions about health funding allocations in the current financial year, “neither the Department of Health nor NHS England took account of local authority spending on social care or the Department for Communities and Local Government’s plans for funding local authorities. In June 2014, NHS England calculated total levels of local funding, covering both health and social care.” That is a problem in itself, except that, again, it is a movable feast. The Report actually says: “More work is needed to understand the extent of, and causation in, this relationship”—the relationship between spending on social care and spending on mainstream health. This is an imperative, so why isn’t it taken more seriously in the funding allocation decisions that you make?

Simon Stevens: It clearly is taken seriously. When you have a hearing on the Better Care Fund, we will have a chance to talk a bit about how those local conversations are going. In every part of the country, including in Peterborough, CCGs, local authorities and acute hospitals are now having a conversation about where to spend money sensibly within the pooled budget so as to deal with the kinds of pressures that the HFMA reports. People absolutely get the fact that this is important at a local level, but equally, as I said perhaps a little controversially on my first day in post, simply putting together two leaky buckets does not produce a watertight funding solution for health and social care.

Q80 Mr Jackson: No, but the Report specifically states, and I will read it again: “In local areas where aggregate health funding is below the target allocations, local authorities tend to spend more than expected...on adult social care. More work is needed to understand the extent of, and causation in, this relationship.” That is the NAO saying in a very polite, diplomatic and gentle way that you actually do not know what you are doing with respect to adult social care spending and health spending and their causal relationship.

Simon Stevens: I don’t know if you want to comment on that, Richard.

Richard Douglas: I don’t think we are absolutely clear on causal relationships there—I think you are absolutely right. We know there is an impact on both sides. If there is inadequate social care, people basically end up going into hospital more often and getting out of hospital a lot more slowly. We know that if there is inadequate health care, people may not be treated properly by the NHS, which costs money to social care. We know that. How you actually quantify that precisely and get a figure on the causal relationship is a lot more difficult. The whole idea of working through the Better Care Fund was to try to deal with that by looking at the two funding streams together and at how we can get more bang for our buck by looking at the two systems as one, rather than separately.

Q81 Mr Jackson: Okay. Do you have a template for what is done in the best health care economies to do what we all want to do, which is keep older people out of the health care system and in their home by, for instance, promoting extra-care housing, by having a named individual health care worker for older people or, as we have in Peterborough, by having a city care centre as

an intermediate health care facility for people who have had orthopaedic surgery and who do not want to have to go back into hospital? Are you sharing good practice in that way?

Richard Douglas: Yes, we try to share good practice. As we have said to the Committee many times before, just because we share good practice does not always mean that people do it. We will hopefully get—we are going through the final knockings of an assurance process on the better care plans—a better view from the new better care plans that are coming through.

Simon Stevens: Just to add to that, on the earlier question about joint work with the Department for Communities and Local Government, Bob Kerslake and I met this morning to review the local Better Care Fund plans that have come up from every part of the country. One of the components of that assurance process has been identifying good practice that we think should be deployed across all the geographies of the country. That intense process of understanding exactly the kind of things that you described in Peterborough is going on as we speak.

Q82 Mr Jackson: It is an issue that will get more acute through the years. It is very acute now in such places as Bournemouth, Eastbourne, Worthing and east Lincolnshire, where there are more old people. They are more likely to fall and their families are a lot further away. I suppose I am asking whether you will use the best experience in those places to inform the policy decisions that you will take for the rest of the country, which inevitably will have this issue over the next number of years.

Simon Stevens: I think we are. What we have not been terribly good at, it is fair to say, up to now is quantifying benchmarks by asking what the avoidable admission rates are per 100,000 people, standardised for age and need and then asking what the active ingredients are that enable the folks in Bournemouth to do this and not those in Worthing, or vice versa. That is the kind of exercise we are engaged in.

Mr Jackson: As long as you are capturing that—

Chair: We need to go and vote. Can you all come back, please? Ten minutes is usually enough, so we will resume at 4.51 pm. We have the Tamiflu session as well.

Sitting suspended for a Division in the House.

On resuming—

Q83 Chris Heaton-Harris: I want to start where we finished off. On the Better Care Fund, I know that you are the accounting officer and you talked about the meeting you had earlier today. Although there are obviously examples of good practice, I just wondered whether there were any areas where there are some significant issues, such as Northamptonshire, perhaps?

Simon Stevens: We are in the process of reviewing the plans that have been put together. There has obviously been a major job of work since July, when a more precise set of expectations was set out for how the money would be used. Our aim is to have come to a conclusion on what those look like across the country by the end of the month, and then make announcements shortly after that on how each place appears to be doing.

Q84 Chris Heaton-Harris: Okay. So the next significant milestone is the end of this month?

Simon Stevens: Yes.

Q85 Chris Heaton-Harris: I will look forward to that. We all talk about how we can predict the future for the NHS. Not that I should be arguing for more private money to pile into the NHS, but you add in Government policies on localism, you look at local areas' growth agendas, and you look at where population is building. There is pressure on GPs' surgeries. In my constituency, I have now got four examples—one is crucial and time critical—where, as part of getting planning permission, the section 106 deal states that a local developer has to build a new GP surgery. One example is in a village called Brixworth, where everybody has agreed to everything apart from NHS England, whose issue with it is that although the business case initially does not say that there is going to be any extra expenditure, it does not say that that will be the case for ever. I just cannot work out, for the life of me, how getting a gift for the taxpayer—it might even be rent free for the initial five-year period—can cause such angst among the people doing the back-office work.

Simon Stevens: I would certainly be more than happy to take a look at that specific instance that you raise. The overall context for GP premises, as you know, is that we are spending about £800 million a year on them. Of that, about half of the premises are owned by GPs themselves and about half are leased. There are cost consequences from the development of new premises, because in effect there is a mortgage payment that has to be paid off over the life of the project. It is right that having better premises costs more, otherwise all premises would be fantastic if they were free. But in areas of growth and where we need big changes in services, one of the things we want to do is to see whether we can create, as it were, the new model NHS in high-growth places that are not constrained by previous ways of doing things. I would be more than happy to get together and look at this specific instance.

Q86 Chris Heaton-Harris: I have four of these instances, when you have got everybody lined up: developers, planners, local people who were against the housing scheme in the first place but now realise that they could get something good from it, and local GPs who believe that they will be able to recruit more GPs to an area that does not have quite so many. Please note that I haven't moaned about levels of funding, which my CCG chairman, Darin Seiger, will have a go at me about, because we are actually delivering quite innovatively in my area. Darin Seiger's practice is one of those that could easily be moving to a brand new premises built by developers at no cost to the taxpayer but that are being stopped by NHS England, so I really would like to hear more about this.

Simon Stevens: I am happy to get together and look at that.

Q87 Chair: Can I ask a few general questions? First, I want to get this clear in my own mind. Under the formula we are talking about, 10% goes on health inequalities and 90% goes on need. Right?

Simon Stevens: Well, there is an additional 10% over and above what is already captured by the rest of the formula. The 90% for the CCG part of the allocation is already allocating according to need for care, based on a detailed, person-based allocation.

Q88 Chair: Okay. We get into the need. I understand that—it is based on need—but there are additional health inequalities. The definition of need at present is primarily based on age.

Simon Stevens: Age plus usage over and above age.

Q89 Chair: Okay. If you want to be your socially activist intervener in the health and well-being of the nation, why don't you use poverty rather than age?

Simon Stevens: It is a question of using a blend of both. The fact is that, as people get older, all things being equal, they have more health problems. So, if the health service is going to properly look after people, we are going to have to make sure we are able to provide cancer services, cardiac services and other treatments for people whenever they need them, and as you get older, you need them more. A health service based on need will tend to spend more on iller people, including older people.

Q90 Chair: In my area, a third of the population is under 18 or 25—it is absolutely extraordinary. I have not looked at the mortality rates recently, but they are hugely worse than elsewhere in the country, partly because the service people get is so poor. I would love my people to have cancer or heart problems only at the age of 90, but they do not—they are dying much younger. That is why I said to you that I can accept that there is an element of age in this. It is clear that, in the last months of our lives, we are all going to use the health service; whenever that is, most of us will presumably use them. But it just seems to me that age, rather than poverty, being the key determinant is an odd way for a socially activist intervener to improve the quality of health care and equalise it across the country.

Simon Stevens: We are not in favour of age discrimination against older people on the back of that social activism. We have to balance these objectives, haven't we?

Q91 Chair: Of course I am not in favour of age discrimination. I am trying to get a bit more consistency of approach to meet the original obligations that you have in statute around health.

Paul Baumann: It might be helpful to add just a couple of things. First, in the formula itself, even before we do the additional inequalities adjustment, there are several factors—I mentioned the claimant rate already—which deal with the demographics and poverty.

Q92 Chair: I notice a bit, but the main component is age. That is what all my local people tell me; that is what I think we are all hearing. That is why GP clinics in Hackney are having to close—because the formula is changing.

Paul Baumann: I want to reassure you, though, that, in the end result, when I take together the formula and the inequalities adjustment, there is almost exactly the same impact of inequalities, poverty and those factors as there is of age. If you look at the spread of pounds per head that we give to populations, the difference from the oldest to the youngest is roughly 30% when you strip

out the market forces factor and other distortions. From the least deprived to the most deprived is 30%, similarly, when you are looking at comparable ages. So the weighting given to the two in the end result of the formula is more or less equivalent.

Q93 Chair: Okay, I hear that. Let me move on to an issue for NHS England to address. Figure 1, on which I reflected earlier, shows how the money gets divvied up. You give one lot to the CCGs, keep another lot for yourselves for commissioning services and give a third lot to your area teams. Why do you need some in the area teams and some at a national level? That complicates things. Why are you determining funding formulae in three places?

Simon Stevens: Because the two buckets that we control directly are doing different things. The optics are probably more impressive than the reality on this. The two buckets are: the area teams have the spending for the GP services, primary care services, dentists, opticians and pharmacists, which is done locally, because by definition it is a pretty local conversation about allocation; the other bucket is the specialised commissioning—or direct commissioning here—for when we are buying super-specialist neurosurgery, bone marrow transplants, heart or lung transplants and so on, which tends to be for a much bigger population than the area team. That is what those two buckets are and why they are organised at different levels.

I come back to the point I made earlier: we want to try to converge to a single place-based allocation formula, even if the contracting with different hospitals is being done on a shared basis for a bigger population.

Q94 Chair: Having looked at figure 1 and the accompanying notes, I can understand that you want to do things such as child heart surgery nationally, but I cannot for the life of me understand why immunisation has to be determined nationally. All that you have to do is make that a KPI or something—make sure that they all do it—but the idea that it has to be a national formula seems a bit odd to me.

Simon Stevens: Various things were put into the national bucket on 1 April 2013 that, frankly, should be distributed more locally, one of which would be the responsibility for funding bariatric surgery versus obesity prevention. There are other things as well, such as some wheelchair services and neurology out-patients. We are proposing to make some changes from next April and will consult on further changes in subsequent periods.

Q95 Chair: So you agree that there are some anomalies that you would like to iron out.

Simon Stevens: Yes. They were understandable for year 1 of the CCGs so as not to overburden them, but since they have found their feet, it makes more sense to adjust.

Q96 Chair: Littered throughout the Report and any other work that we were able to look at before this sitting, you constantly see this correlation between the poor financial position of a CCG or a trust and their fair share of funding. It comes up all over the place. For example, of the CCGs that are currently presumably in deficit, 19 out of 20 receive less than their fair share of funding. Although you have said that you want to do it within two or three years, that is a pretty stark correlation that suggests to me that you ought to be tackling this rather more quickly.

Simon Stevens: Well, there is a correlation and we do want to tackle it, but the two key facts in paragraphs 2.22 and 2.23 are that, even if you look at the accumulated financial positions of CCGs, their distance from target explains less than a quarter of where they stand. If you look at how they actually did last year, it explains only 8%.

Q97 Chair: I don't know how you get to that.

Simon Stevens: Paragraph 2.23 says: "Distance from target explained 8% of the variation in financial position."

Laura Brackwell: I think that the 8% might refer to the PCT position.

Simon Stevens: At 2013, yes.

Q98 Chair: Okay. I was quite interested in the fact that the Report mentions Treasury controls around how you use this money. What are they? Perhaps our Treasury official can answer: what controls do you exercise over this formula funding?

Marius Gallaher: I think that the Department has to operate within the departmental expenditure limit in the first place.

Q99 Chair: No, this is on page 16, paragraph 1.13. It is one of those NAO-style things that makes you think there is something behind it: "In practice, the degree of flexibility that the Department and NHS England have in making funding decisions is constrained by a number of factors, such as financial controls imposed by...Treasury".

Richard Douglas: I don't think they are ones that are specific to us. I don't know what the thinking was behind it, but I guess it's partly the administration controls, separate from the programme—

Q100 Chair: Well, you obviously have to stay within the limit, but—

Richard Douglas: Yes, but I think it's probably the breakdown of the limits between administration and programme to some extent, between the ring-fenced and non-ring-fenced—

Laura Brackwell: I think there were also a couple of things that the Treasury, in giving approval to NHS England's budget or to the Department's divisional budget—there were some areas they wanted protected.

Q101 Chair: What?

Laura Brackwell: One of which was public health.

Richard Douglas: I don't think that's the Treasury. I might be wrong on this. We have to share all this with the Treasury, but the only direct controls are split between administration and programme and a sort of technical thing about ring-fenced and non-ring-fenced money.

Q102 Meg Hillier: This is just a small point, Chair. We have raised before the issue of locums in hospitals, but I just wondered whether both the Department and NHS England keep track of the number of locums recruited. With the way the funding works at the moment, you can bid to run a service, not actually have the doctors to deliver it, and back-recruit, backfill with locums at great expense, which seems to me to be not the most effective way of doing it. I just wondered whether you are doing any work to watch and monitor the cost of locums.

Simon Stevens: Indirectly, in that obviously the allocations to Hackney versus Norfolk are adjusted for the different costs of hiring people and providing buildings in Hackney—the so-called market forces factor. One element of what the market forces factor tracks in the labour costs piece of that is the relative pay rates to get full-time people in—relative to what they could get earning elsewhere in Hackney or in comparable occupations. There is some sort of indirect measure of that through the labour cost component of the market forces factor, which feeds into the overall formula, but it is not, I don't think, a specific measure of locum costs per se.

Richard Douglas: In the hospital costs, we will track what is happening in total with agency and locum spend—

Q103 Meg Hillier: It's just that sometimes it is unacceptable. Sometimes, you don't need that many locums. The Chair has seen particular issues, I think, in her local hospital—that high number of locums. That must be a systemic or a more structural problem for an area. Do you watch that? Does a little flag go up if you have too many locums?

Richard Douglas: A big flag goes up first of all on the locum agency spend, because it costs a shedload of money compared to your own people, so the financial flag goes up. It is something that would be picked up by the CQC on its inspections as well. It would pick it up most from a quality perspective.

Q104 Meg Hillier: But you don't have a “bad guy, good guy” league table on this, do you, NHS England?

Simon Stevens: I think Monitor tracks this spending, and I think I remember that its Q1 report on foundation trusts talked about the rising agency spend, for example, so I think there is some—

Q105 Austin Mitchell: I've been very quiet, because I can't raise my usual point about Grimsby and Yorkshire being underfunded compared with everybody else, so that has stunned me into silence! But we have a letter from East Berkshire CCGs, which says: “We believe the current level of variation between CCGs simply cannot be justified. There are wide differences in funding between CCGs in the south of England. For example, just a few miles away from us is Surrey Heath CCG, which is £95 per head over target. They have a very similar level of needs and population characteristics, yet receive almost £200 a head more than Windsor, Ascot and Maidenhead.” Why is

that, and why is the underfunding concentrated here—this is figure 8—in the midlands and the home counties, while the north tends to do better? What in the population of that area causes it to be underfunded?

Simon Stevens: I will defer to Paul on your second question. On the first question, in terms of those CCGs that have written, they obviously received a higher rate of increase for 2014-15 and 2015-16 than did the others, including ones they refer to; but obviously, it goes back to the overall point we have been talking about: the balancing act between providing a core level of services versus making the redistribution. We did ensure that everybody got an increase based on their population movement, so that high-growth areas would see that reflected in their allocations for this year.

Paul, do you want to talk about the geographical aspects and the middle of the country?

Paul Baumann: Two big factors to explain why they ended up in that position. One is that they have a faster-growing population, and that comes back to the earlier discussion we had about population changes. The second one, I think, is that the way in which the new formula with the new inequalities adjustment works tends to have a different impact, I guess. Any change in formula will have that. On the whole, that has led to places like that—it picks up pockets of deprivation, which Simon talked about earlier. Previously, in the sorts of places that we are discussing at the moment, those pockets of deprivation would have been invisible. They are now picked up in the formula, which will have attracted some targets to them. That is why we have developed the target formula, showing a higher value, potentially, than it did before.

Clearly, going back to all of the earlier discussion about how quickly we can move from A to B—because fundamentally the letter was saying, “Why don’t you move us more quickly to target?” That is the discussion we have had a number of times. The answer to that is the one we have discussed, which is that we have balances to strike as we go forward with that.

Q106 Chair: Can I ask a final question? We are more than halfway through the year, so what proportion of the foundation trusts is in financial difficulties, what proportion of the NHS trusts and what proportion of the CCGs?

Richard Douglas: On the foundation trusts, I believe it is probably around a third at the moment. On NHS trusts, it is broadly the same number as we started the year with, but if you will bear with me a minute while I find that number. I can ask Paul to do the CCGs in the meantime.

Paul Baumann: For the CCGs, it is the same number in the report that is valid at the mid-year—

Q107 Chair: Twenty.

Paul Baumann: Twenty of them are in cumulative deficit.

Q108 Chair: No new ones then.

Paul Baumann: None in addition to the 20 in the report.

Q109 Chair: So that is about 10%.

Paul Baumann: Yes.

Q110 Chair: And the other trusts?

Richard Douglas: For NHS trusts, at the moment I have the number of deficits at around 33.

Q111 Chair: Thirty-three out of about 100 and something.

Richard Douglas: I don't want to give you a number that is wrong.

Q112 Chair: Okay. And you have not got a figure of potential projected overspend?

Richard Douglas: The system will not overspend.

Q113 Chair: Pardon?

Richard Douglas: In the system as a whole, we will not overspend the parliamentary vote on our spending limit, because we are not allowed to. The overall position on providers at the moment—their projections would be around £400 million or £500 million mark, but we are halfway through the year and there are still not actually people concerned.

Q114 Chair: £450 million or £500 million?

Richard Douglas: It is actually about £500 million to £550 million.

Q115 Chair: Okay. Of course, you are not, but NHS England could be in deficit, couldn't it?

Richard Douglas: NHS England can't be in deficit, no.

Q116 Chair: Can't?

Richard Douglas: No, they have a spending limit they have to live within and that includes—

Q117 Chair: Yes, but it means they have to get that £550 million from somewhere.

Richard Douglas: No, no. That £550 million does not hit them; it hits my books.

Q118 Chair: So where does it hit you on your budget?

Richard Douglas: Effectively, it scores against the Department's overall spending limit. So if there is a surplus in the provider's side, it is a benefit to the spending limit; if there is a deficit, it is a loss to the spending limit. So if it ends up with a deficit, in the Department we have to make sure that we have other savings that can cover that off.

Q119 Chair: So you can square it off against the balances that other—can you?

Richard Douglas: We have to square off the overall spending limit. In the overall spending limit in figure 2, it gives you the number for the Department as a whole. The Department has to make sure that whatever Simon spends, whatever the deficit or surplus is in the providers, and whatever the central Department's spending is, it all comes within that total.

Q120 Chair: Sorry, but I am interested in this.

Finally, for a foundation trust that is independent and could be in surplus, can you have regard to those surpluses in your squaring off?

Richard Douglas: Those surpluses count in my squaring off.

Q121 Chair: They do, even though they are not yours.

Richard Douglas: Absolutely, just the same as their deficits count.

Q122 Chair: It's really a paper exercise, in an odd way.

Richard Douglas: It doesn't feel like a paper exercise.

Chair: Thank you very much.