

Public Accounts Committee

Oral evidence: Planning for the Better Care Fund, HC 807

Monday 01 December 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon; Mr David Burrowes; Chris Heaton-Harris; Meg Hillier; Mr Stewart Jackson; Austin Mitchell; Stephen Phillips; John Pugh; Nick Smith.

Sir Amyas Morse, Comptroller and Auditor General; Sue Higgins, Executive Leader, Local Services, National Audit Office; Ashley McDougall, Director, National Audit Office; and Richard Brown, Treasury Officer of Accounts, were in attendance.

Witnesses: Carolyn Downs, Chief Executive, Local Government Association; Helen Edwards, Director General for Localism, Department for Communities and Local Government (DCLG); Sir Bob Kerslake, Permanent Secretary, DCLG; Una O'Brien, Permanent Secretary, Department of Health; Andrew Ridley, Better Care Fund Programme Director; Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, Department of Health; and Simon Stevens, Chief Executive, NHS England, gave evidence

Q1 Chair: Welcome. You may like this room, but I don't; you're too far away, so please speak up. The reason why we had to come here is that there are seven of you. Every time I tried to knock somebody off the panel, I was told they were absolutely central to this hearing. I will start with a sentence answer from each of you about what you are accountable for today in relation to this hearing, starting with Andrew Ridley.

Andrew Ridley: I am the programme director for the Better Care Fund, and I have been accountable for running it since 7 July this year.

Chair: I hear you have already been promoted out of it.

Andrew Ridley: I also started a new job for NHS England today.

Q2 Chair: So how many months have you been in this absolutely crucial job?

Andrew Ridley: Five months, but I am continuing the BCF role as well as taking on additional responsibilities.

Q3 Chair: So it is so important that it can become a subsidiary responsibility to your other responsibilities? We hate that here; I have got to say that to you, Mr Stevens. If there is a new £3.8 billion programme, to have a senior responsible officer for four months—five months?

Andrew Ridley: Five.

Q4 Mr Bacon: What is your new job?

Andrew Ridley: I am regional director for the south of England.

Q5 Mr Bacon: How many people live in the south of England within your region?

Andrew Ridley: About 13.5 million.

Q6 Mr Bacon: So you have a job where you are responsible for the NHS England function for 13.5 million people in the south of England. That is the job; that is what being regional director means, does it?

Andrew Ridley: It does.

Q7 Mr Bacon: Okay. So you were going to be doing your other job—your now part-time job of Better Care Fund programme director—as well?

Andrew Ridley: Yes. There are three things. I have appointed a deputy to support me in the Better Care Fund role and a deputy in the region. Presumably we will hear something about it this afternoon, but it is our intention to increasingly mainstream the Better Care Fund into—

Q8 Chair: Who is going to be the SRO for the Better Care Fund, you or your deputy?

Andrew Ridley: The SRO is actually Barbara Hakin.

Q9 Chair: Who is she?

Simon Stevens: The SRO is Barbara Hakin, who was appointed the SRO of NHS England on the same date that I hired Andrew Ridley to do this; 7 July was when Barbara took over. Barbara

continues as the SRO of this programme. We offered for Barbara to be here today, but I guess it was decided that an eighth seat was probably not feasible.

Chair: Well, I don't understand. It is not very satisfactory.

Q10 Mr Bacon: Isn't she the deputy chief executive as well?

Simon Stevens: She is the director of commissioning operations, so she is one of my national directors. So the accountability goes from me, Barbara, Andrew. And so you have got the sandwich, if you like—

Q11 Mr Bacon: To Andrew's deputy, because he is now doing the south of England.

Simon Stevens: Andrew will have ongoing responsibilities here, but I obviously have overall responsibility in NHS England. Barbara is the SRO since 7 July, and that will continue.

Mr Bacon: Clear as mud.

Stephen Phillips: We just don't have the SRO here, for a hearing on the Better Care Fund. It seems extraordinary.

Carolyn Downs: I am Carolyn Downs and I'm chief executive of the Local Government Association. Our role in relation to the Better Care Fund has been that I sit on the advisory board, with colleagues here. We have put two full members of staff into the taskforce to help—

Q12 Chair: What is your accountability here? Sorry—I just want a really quick sentence on why you are accountable. Why are you before us?

Carolyn Downs: We have staffed and indeed supported the whole assurance process from the local government perspective.

Q13 Mr Bacon: Did you say two quarter-members of staff?

Carolyn Downs: We have put two members of staff into the taskforce.

Mr Bacon: I may have misheard you—forgive me. I thought I heard you say two quarter-members of staff.

Carolyn Downs: No, no. Sorry—

Mr Bacon: So, there are two full-timers? Okay. Thank you.

Helen Edwards: I am the director general for localism at the Department for Communities and Local Government, and I am the joint chair of the Better Care Fund programme board. The SRO, Barbara Hakin, and the programme director, Andrew Ridley, report into that board.

Sir Bob Kerslake: Yes. I am permanent secretary at DCLG and therefore accounting officer for the Department, which, with the Department of Health, is responsible for overseeing the policy and the overall implementation of the Better Care Fund.

Una O'Brien: I am Una O'Brien. I am the permanent secretary and the accounting officer at the Department of Health, and I have the mirror image of Bob's responsibility and I am overall responsible for everything that is done with and through the Department of Health.

Simon Stevens: I am Simon Stephens, chief executive of NHS England. Since the bulk of the Better Care Fund revenues are flowing through the NHS England budget, I am the accounting officer for the £3.46 billion that will flow through CCG allocations from 1 April.

Q14 Chair: So what are you accounting officer for, Una, on that?

Una O'Brien: The way it works, as set out in my accounting officer system statement, is that the Department of Health is the initial receiver of all the funds that are granted through Parliament, and then—in relation to all of NHS England's responsibilities—we set out a mandate for the money that we hand over. But because, self-evidently, the scale of the responsibility is that each of our a or b chief executives becomes an accounting officer for the utilisation of those funds.

Q15 Chair: So if this goes wrong, who do we hold to account out of you two?

Simon Stevens: You will no doubt have us both back.

Q16 Mr Bacon: Who is the accounting officer for the rest of the £3.8 billion? That is Sir Bob at DCLG, is it?

Una O'Brien: Yes.

Q17 Mr Bacon: And the other £340 million?

Sir Bob Kerslake: The difference between the £3.46 billion and the £3.8 billion¹ is money that is routed directly into local government, and therefore it is part of my accounting officer responsibilities.

Q18 Chair: Finally, Jon Rouse.

¹ Note from witness: Una O'Brien is ultimately the accounting officer for all of the £3.8bn. Of this, £354m is routed through local government including £220m in Disabled Facilities Grant that is paid out by DCLG with the balance being paid by DH.

Jon Rouse: I am director general of social care, local government and care partnerships at the Department of Health, and I am the other co-chair of the programme board with Helen, which therefore joins up DCLG and DOH.

Q19 Chair: How do you fit in with the other person? We were told she should be here, but she isn't here. And she is the number two to—how do you fit in?

Jon Rouse: So, Barbara Hakin works for NHS England, and she is the SRO. Barbara, as SRO, reports into the programme board, which is co-chaired between myself and Helen Edwards.

Chair: All right. Is everybody clear around the table?

Mr Bacon: What could possibly go wrong?

Q20 Chair: Can I ask another question? I don't know who will choose to answer it: who signs the cheques on this?

Simon Stevens: I sign the cheques for £3.46 billion.

Sir Bob Kerslake: Obviously, the balance comes through DCLG, so that's for me.

Q21 Chair: At Barking and Dagenham level, who signs the cheques?

Simon Stevens: Principally the CCG, and the CCG through its normal line of accountability to NHS England has to account for the use of the money that has been earmarked from its allocation for 2015-16. In doing that, it obviously works closely with Barking and Havering council through the health and wellbeing board that agrees the use of the funds.

Q22 Chair: Is this money ring-fenced?

Simon Stevens: Yes.

Chair: So they have to use it on the plan that is approved by Ministers.

Simon Stevens: That is correct, but they can add more to it which, interestingly of course, many parts of the country have chosen to do, such that the pooled amount will be £5.3 billion, £1.5 billion more than the minimum that Ministers expected.

Q23 Chair: My next question is clearing the deck a bit. I don't know whether Simon or Una will take it, but there are probably two matters arising from the £2 billion that was announced over the weekend. First, can you explain where the £700 million from within the NHS budget is coming from? Secondly, what is the impact of the £2 billion? It is one-year money isn't it? It is only for 2015-16 and I am worried about that.

Simon Stevens: No, it will be recurring, and built into the NHS baseline.

Chair: So it is into the base.

Simon Stevens: Yes.

Chair: Good, £2 billion is into the base, or £1.3 billion.

Simon Stevens: Well, I can give you the breakdown, but I don't want to pre-empt the Secretary of State who I believe will make an oral statement in half an hour or 25 minutes on this very point.

Q24 Chair: Okay. Secondly, will any of the money be used to further the Better Care Fund initiative?

Simon Stevens: No. The Better Care Funds are separate from this and the announcements by the Chancellor do not affect what we are talking about to you here today.

Q25 Chair: Okay, so out of the £2 billion, £1.3 billion additional is added into the base. Where is the £700 million coming from?

Simon Stevens: I think Una will take that, but I just want to say that from the point of view of the NHS in England it will be £1.95 billion of extra funding available through the NHS England mandate for 2015-16 over and above what we already had available to us.

Chair: Of which £700 million comes from the Department of Health.

Simon Stevens: But that is additional to the funds that are available to the NHS through the resources that will be routed to the NHS front line. In terms of how that will be used, as the Secretary of State will set out, we will use about £1.5 billion for front-line health services, £200 million to support health economies in transition on the back of the five-year forward view and then another £250 million, which will be repeated for each of the next four years, to boost investment in GP services, and out-of-hospital infrastructure, again to relieve some of the pressure on hospitals and to expand the supply of our primary care and some of the models we were talking about in the forward view.

Q26 Chair: That distribution will be up for grabs in 2016-17 presumably.

Simon Stevens: For the £250 million for the primary care piece? We are getting £250 million for each of the next four years, so we have £1 billion that we can plan against over the next four years specifically for primary care, infrastructure, community services, out of hospital—

Chair: So this is capital.

Simon Stevens: It will be flexibly deployed between revenue and capital. That is the understanding we have.

Q27 Chair: Okay, but that's your decision. Of the, in effect, £2 billion, £250 million will be to create some GP infrastructure.

Simon Stevens: GP and primary care more widely and community health services, but there is clearly a backlog of requests from GPs, rightly, for premises and infrastructure improvement to allow them to take on more and they will have the first call on this resource.

Q28 Chair: And the other £1.75 billion—this is slightly peripheral to our hearing.

Simon Stevens: The other £1.7 billion. It is £250 million for that, and of the £1.7 billion, £1.5 billion will go to support front-line health services through CCG allocations and specialised commissioning and we will make decisions on exactly what that allocation looks like later this month. The £200 million on top of the £1.5 million will be used particularly for challenged health economies and challenged geographies around the health service where they can see they need support to change their service configurations to get on the new path of sustainability that we set out in the five-year forward view.

Q29 Chair: And that is recurring for four years.

Simon Stevens: Obviously, everything is subject to decisions that the next Government make for the 2016-17 spending review, but that is not a one-time increase; that is an assumption that is in the baseline.

Q30 Chair: And the £700 million?

Una O'Brien: The £700 million is made up of a number of programmes, including some that come to a natural end in 2014-15. In addition: back-office savings, contingency funding that is no longer needed, and spreading the delivery of some infrastructure programmes over a longer time frame. It also includes running cost reductions on national arm's length bodies. These savings have been found without impacting on existing front-line NHS services, so the funding does provide a genuine additional boost to the NHS.

Q31 John Pugh: You cannot build contingency funding into the base budget.

Una O'Brien: The initial planning for 2015-16—

John Pugh: It is all going to the base budget, and some of it is made up of the big element of contingency funding that you found from somewhere for this year. It is not in the base budget, is it?

Una O'Brien: All I can tell you is that we have looked at the figures for 2015-16 and scrutinised them thoroughly. Again, over the last few weeks, we have been able to identify up to £700 million of additional savings.

Q32 Chair: How much of that is underspend?

Una O'Brien: I cannot give a detailed breakdown, but I would be happy to write to you about it once we are able to.

Q33 Chair: Why can you not give it to us?

Una O'Brien: I have not got the detailed breakdown of the £700 million with me.

Q34 Chair: You must know vaguely in your head how much of that is really what John is getting at, which is underspend, rather than a real saving that can then be redistributed into NHS England's baseline.

Una O'Brien: As I say, I am happy to write to you with those further details.

Chair: I hate things coming after the hearing. I love to see things out in the public domain. That is really what I would like.

Una O'Brien: All this will come into the public domain in the coming days. The Secretary of State is making a statement this afternoon, and the Chancellor is making the autumn statement on Wednesday.

Q35 Chair: I know. Is it because he is making a statement that you feel constrained and not able to say it?

Una O'Brien: I am happy to write to the Committee with more details, as I have said. I do not have that level of detail with me.

Q36 Chair: Maybe somebody sitting behind you—there are a load of people behind you—can get those details so that I can ask the question again at the end of the session. I cannot believe they are that difficult to identify. Does the Treasury know them?

Marius Gallaher: No.

Q37 Chair: I will ask that question again at the end of the session. Right, let us move on to the £1 billion. Sir Bob and Una, when you were in charge of this, was the £1 billion saving an expectation or a requirement?

Sir Bob Kerslake: What we were always clear about was the expectation that there would be significant benefit from the funds that would flow both to the NHS and to local government, and that would happen in 2015-16 and in subsequent years. So we always expected significant benefit. It was not, as has been recorded in the Report, a formal outcome of the spending round process. So what we did do was to build into the guidance an expectation that savings would be identified through either the national conditions or the metrics, and that is what happened through the process.

Q38 Chair: Do you agree, Una, that it was an expectation, not a requirement?

Una O'Brien: I do. I think there was always an understanding that there would be a combination of savings and investment that would arise. I have just gone back and checked the original guidance that was put out, and I would agree with what Bob has just said.

Q39 Chair: Carolyn Downs, you were around at that time. Was it an expectation or a requirement?

Carolyn Downs: It was an expectation, as has been stated by the two permanent secretaries.

Q40 Chair: So when, Mr Stevens, did it become a requirement?

Simon Stevens: Shortly after I arrived.

Mr Bacon: I bet it did.

Q41 Austin Mitchell: Since it was a planning assumption, why were the local authorities not told?

Simon Stevens: The local authorities were told.

Q42 Austin Mitchell: When were they told? All the plans were taken back and revised to bring forward the £1 billion saving. It was a planning assumption in the original thing, so why were they not told right at the start?

Simon Stevens: I think the guidance went out on 25 July. That is the date that you are referring to, Mr Mitchell.

Q43 Chair: No, we are not. You approved them in April. Your second guidance went out—

Simon Stevens: The guidance on the £1 billion, and the expectations around emergency provisions, was 25 July.

Q44 Mr Burrowes: I am trying to understand what is the difference between an expectation and the guidance.

Simon Stevens: Well, I think it is the difference between an expectation and a requirement.

Q45 Mr Burrowes: So can expectations just be ignored?

Simon Stevens: No. Look, as someone who came into this fresh, I think a perfectly good process has been undergone, which was to ask local areas, “What is it you want to do? What is it you can produce with this, which everybody sees as strategically the right direction of travel?” There is bound to be more pooling of health and social care funding, given that, from the point of view of individual patients and individual users of social care, in many respects it is increasingly a distinction without a difference.

So the judgment was made at the time, I think correctly, to allow local areas to come up with their plans to show what they might produce. They did that. However, what it also showed was that the degree of cashable savings, if you like, that would then be available to offset the £1.9 billion implied budget transfer from CCGs was not as high as might have been expected when those expectations were tested for reality. So on the basis of that, I think a good decision was made to firm up the expectations of £1 billion of value being realised to offset what would otherwise have been a very substantial gap opening up in the finances of the National Health Service from next April.

Q46 Mr Burrowes: Before you got there, was anyone else responsible at all for delivering the assumed savings? Anyone else at the table? We have heard who is responsible for signing the difference cheques. Who is responsible for cashing in the savings?

Jon Rouse: First of all, there was a general assumption that this would make savings right from the outset.

Q47 Chair: Where you there? You have probably just arrived, have you? How long have you been at it?

Jon Rouse: I was there, yes. I arrived in—

Q48 Chair: You were there. So you signed off on the things that said it was going to save whatever it was: £350 million. You signed off on that, did you?

Jon Rouse: Can I step back just for a moment? So if we go back to the time of the SR, there was no requirement around a particular figure in terms of savings. **Chair:** But there was an expectation.

Jon Rouse: First of all, there was a general ambition that there would be savings and that was reflected through the metrics and the conditions. Now, clearly, as DH and NHS England—thinking ahead to April 2015—we started to think about what would this potentially provide us in terms of value to the NHS. But we were looking at many aspects of our planning for 2015-16 at that time; we were still 18 months out. But what we had not done at that time was firmed up on any figure that it would have been right to make a requirement in terms of the planning process.

Q49 Chair: I'm really sorry. I'm getting really cross down this end. What the report tells me is, when those plans first came in—actually, correct me if I'm wrong—local areas estimated the fund benefits would total just over £700 million. The expectation was £700 million, signed off by everybody at the table, except for Simon Stevens.

Ashley McDougall: On the expectation, what we have and what the report says is that at the time of the SR—that is, summer 2013—the Department of Health and NHS England had a shared planning assumption that there would be £1 billion of savings at that time.

Chair: Right. But when the plans came in—

Ashley McDougall: When the plans came in, there were two elements. The plans promised £731 million and NHS England, as requested by Mr Stevens, tested the plans and found that they were going to give £55 million of cashable savings.

Chair: No, no. Before the £55 million. So when they assessed them and signed them off in whenever it was—April—

Jon Rouse: They were not signed off.

Ashley McDougall: Health and Wellbeing Boards signed off their plans for submission, and that was £731 million—what they expected the plans would save.

Q50 Chair: When the first set of plans came in, there was a process that took place. Yes? They were examined by Carolyn Downs, Bob Kerslake or Helen Edwards and you, Mr Rouse, because you say you were around. You three guys were responsible. At that time, before Simon Stevens arrived, you expected a saving of—and before Andrew Ridley was anywhere near it—

Carolyn Downs: There was no specific figure that we were working to for savings. There was an expectation that the Better Care Fund would deliver savings and other benefits to the NHS, and that was the basis on which we were working.

Q51 Stephen Phillips: Hold on. It goes further than that. The expectation, as you all agree, was that it would make a saving of £1 billion.

Carolyn Downs: No, it was not £1 billion. We were never party to that; that's why the guidance sent out in December did not include the requirement to achieve £1 billion worth of savings. My understanding of the plans when they were received in February was that the savings that were identified ranged between £350 million and £750 million. That was the assessment that we had undertaken. NHS England then undertook a separate assessment that came to the £55 million figure.

Q52 Stephen Phillips: I am very confused. I want to know who at that end of that table, at what stage, expected a saving of £1 billion to be generated by the Better Care Fund.

Jon Rouse: From a DOH and NHS England perspective, we had discussions at the time of the SR about what we thought the potential might be. That began to firm up through the autumn, in

terms of what we might reasonably expect—not in terms of savings per se, but a combination of savings plus investment in the NHS.

Q53 Stephen Phillips: So the underlying planning assumption on the part of the Department of Health, which was communicated to the Treasury, was that the establishment of the Better Care Fund would result in savings of approximately £1 billion to the NHS budget—yes or no?

Jon Rouse: We did not communicate to the Treasury in those terms, as you have described them. There was no fixed, formal planning assumption at that time.

Q54 Stephen Phillips: How was this £1 billion modelled by DH and NHS England?

Jon Rouse: It was based on reference to the best evidence that was available from previous attempts at integration programmes, plus a working estimate of what we believe local areas might choose to invest in the NHS from the £3.8 billion, but both of those were estimates, which is why it would not have been sensible at that time to turn that into some sort of fixed figure or requirement, nor would we have known on what basis—particularly if it was a savings requirement—to allocate that to individual areas, given that they were all starting from different places.

Q55 Stephen Phillips: My question was how it was modelled. The answer you have just given tends to indicate that it was a guess based on past experience.

Jon Rouse: It was an estimate.

Q56 Mr Burrowes: As far as the Treasury is concerned, was that just an estimate that could easily be ignored?

Marius Gallaher: Yes, that's absolutely right. It is reflected in the fact that there was no mention, as I understand it, of the £1 billion savings in the settlement letter of the SR. If there had been an agreement on such savings, I would be quite confident that the number would have featured in the settlement letter, because Treasury officials like to get numbers like that into settlement letters if they think they are sufficiently robust.

Q57 Mr Burrowes: What amount of savings was the Treasury counting on at the time of the spending round? Was it content with a stab being taken at an estimate?

Marius Gallaher: No, we were looking for significant savings, but I do not think that my colleagues had a quantified target. If they had had one, it would probably have featured in the settlement letter.

Q58 Chair: Why did it become a requirement halfway through the process, Mr Stevens? Everybody around you said, "Well, it might save a bit of money. We don't really care. It is a sort of

aspiration, I would put it, rather than even an expectation.” Suddenly, you jump in and it becomes a requirement.

Mr Burrowes: Ambition is what we heard.

Chair: It turned from an ambition to a requirement. Why?

Una O'Brien: Before Simon answers—

Mr Bacon: Why are you answering the question? I heard the Chair say “Mr Stevens”.

Una O'Brien: I am happy to come in after Simon—either way.

Mr Bacon: Even though you are a long way away, we can see you whispering to each other. The Chair definitely said Mr Stevens—I am close enough to the Chair to hear what she is saying.

Simon Stevens: The question is why the £1 billion became a requirement from spring. The answer is because there was the legitimate bottom-up exercise of asking people around the country, “What is it you think you’re going to be able to produce in the way of first-year savings?”, and when that set of plans was stress-tested, as we have spoken about a moment or two ago, that number was rather a low number. So, in effect, what we are saying is that if you really thought it was £55 million or thereabouts of savings, we would have been taking out just under £1.9 billion of purchasing power from CCG baselines for next April, which, as the NAO rightly pointed out, is equivalent to about 4% of acute hospitals’ cost structures, on top of the efficiency requirement already being made to the national health service.

Q59 Chair: Yes, that was the policy, Mr Stevens. You changed the policy. Why?

Simon Stevens: It is not for me to change policy. I just came at it with fresh eyes, and listening to what people say—

Q60 Mr Bacon: Why did it take you to spot that there was a £1 billion hole that no one else had spotted?

Simon Stevens: I am sure everyone had. It was not a question of me doing it; it was simply a question of the fact that we were still a year out at that point.

Q61 Mr Burrowes: So when you say stress test, was there no stress test before you arrived?

Simon Stevens: Yes, of course, that stress test was going on through the autumn and through the spring. I benefited from the results of that stress test at just the time that I happened to take up post and therefore, with colleagues, was able to reflect on the results of that stress test and bring that to the attention of Ministers.

Q62 Chair: Can you literally just give us an answer on this? I will bring Ashley in, and we will come back to the purpose and I will bring Carolyn Downs in, but why did you change to make that an

absolutely essential requirement of the way this money was used? Was it because it was one of the ways of dealing with the deficit? If you tell me that straight, we at least have a straight answer. I think everything else is waffle. Was it just to deal with the deficit?

Simon Stevens: It wasn't dealing with it; it was to prevent creating a further gap, so actually a very pragmatic solution was arrived at. That of course does not suit everybody, and no doubt there are legitimate and huge pressures in local government due to social care, so the concerns of local government are entirely understood. Equally, hospitals were saying—legitimately, too—that, given that patients were still going to be turning up requiring services, a £1.9 billion cost takeout from their baselines from next April, which in effect is what it would have been, was going to be extremely challenging as well.

Q63 Chair: I have allowed you a long answer. The truth is that it is there to help NHS England's finances.

Simon Stevens: Well, a pragmatic decision was made that £1 billion of the £1.9 billion, which is not new money, would continue to be available either to reduce emergency admissions or to support spending on out of hospital services in the NHS, and £900 million of the £1.9 billion would be available particularly for local authorities to support the pressures in social care. Now, of course, that in a way under-tells the story, because the reality is that we are getting far more than the sum of our parts here. We have £5.3 billion pooled, and it is the synergies that are going to create the value.

Q64 Austin Mitchell: There was a planning assumption, or perhaps just wishful thinking, that was formulated by the health side of the equation for a combination of services between health and social services. That is admirable in principle, but it was known at the time that this was formulated—the £1 billion in savings—that social services were under considerable pressure and in considerable financial difficulties. I want to know this—perhaps Carolyn Downs from the Local Government Association can tell us. Your press release on the National Audit Office Report says: “The failure to set out the £1 billion savings target to councils...has made carrying out these plans more difficult and left many councils with significantly less time to implement the changes before the April 2015 deadline.” Were the councils told? What did the councils do? How were you told to make the savings?

Chair: Austin, I will bring that in, because that is the next phase of this sitting, but let us just bottom this issue out. I promise that I will move back to it, but first, Stephen and then Ashley.

Q65 Stephen Phillips: I do not really care who answers this, but does it really come down to this? There was an ambition at the beginning that the Better Care Fund would result in significant savings, which were estimated to be about £1 billion. The plans that came into NHS England were assessed and seen to deliver a much lower saving of as little as £55 million. As a result, there was naturally going to be a deficit position as regards the saving that was expected. You therefore had to do something, and what you did was push back the date by which it was going to be brought in. Is that right, Mr Stevens?

Simon Stevens: No. The date was always going to be April 2015, so that has not changed.

Q66 Chair: Can I just go to Helen Edwards? Why did you shake your head when Stephen Phillips was speaking?

Helen Edwards: It was always clear that there were expected to be significant financial savings, but the £1 billion figure, as we have heard from the Treasury, was never part of the formal SR settlement. We planned and designed the fund on the back of the settlement, as you would, because that is the formal position to set up the fund.

Q67 Stephen Phillips: That doesn't explain why what was anticipated to be a significant saving subsequently was not delivering something that was not in the settlement and, therefore, why Mr Stevens took the decisions that he did.

Sir Bob Kerslake: There were two issues at the time that needed to be addressed. One was the question of how much saving or benefit was going to come from the fund. The second was how confident we were about the actions delivering the level of savings. That is why we went back round the loop again—

Q68 Stephen Phillips: Which of those led you to go back round the loop again?

Sir Bob Kerslake: Both, in fact, were important. The first one—

Q69 Stephen Phillips: No, answer the question, Sir Bob. You can either say both or say one or the other.

Sir Bob Kerslake: I think I said both, actually.

Q70 Stephen Phillips: No, you said both were important. I want to know the causative question.

Sir Bob Kerslake: Let me be more precise, then. Both were factors in going back.

Chair: Let me go to Ashley.

Ashley McDougall: To clarify, the true stress-testing of the money that was coming out of the plans, because there was no target against which to stress-test, was £731 million. Paragraph 11 says that the assessment "did not include achieving £1 billion" of savings. So up until April, no one was looking to see whether the funds were going to achieve £1 billion.

Q71 Mr Burrowes: But Simon Stevens said that you beat the stress tests prior to him arriving.

Simon Stevens: Yes, that's right, and they were looking at what the savings would be. Whether you set a figure of £1 billion or whatever, nevertheless they got to the answer that it was £55 million versus £730 million-odd.

Q72 Chair: Why did you not identify £55 million before Mr Stevens arrived?

Simon Stevens: Well, that was the process that was going on and the good work that was being done. The plans were due in from late autumn through to the spring.

Q73 Chair: I do not think that you were doing the work. You started the work when you came. I do not think that—

Simon Stevens: No, I benefited from the work that had been going on.

Carolyn Downs: The work was being undertaken; the plans were being assessed; the level of savings were being looked at—what they were put in at—and it was the analytics of NHS England which came out with £55 million being the figure that it felt was cashable savings as opposed to wider benefits to the NHS.

Sir Bob Kerslake: I think the key point is not that we did not expect there to be savings, but that the plans did not demonstrate adequately how the actions would deliver the savings.

Q74 Chair: When did you arrive, Mr Stevens?

Simon Stevens: 1 April.

Q75 Chair: It tells me here that 90% of the plans were ready to be approved in April, so they were already there.

Jon Rouse: Can I help on this? The plans were due in, from memory, on 4 April, so three days after Simon arrived. That was the time to do the deep stress test. There had been a very early version of the plans submitted in February, but at that stage they did not contain sufficient data to do a full stress test. Secondly, just to build on the point that Sir Bob made, which was crucial, this was not just about the level of savings identified—

Q76 Chair: I am sorry to stop you, Mr Rouse, but if you look at page 18, para 1.18, it says, “In April 2014...they”—I assume that is a mixture of LGA, DCLG and you, without Mr Ridley and his five months in the job—“determined that 90% of the plans—136 of 151 plans—were ready for sign off”. So it was not that you started the work to assess them in April 2014; you were ready to sign them off.

Jon Rouse: Can we just be clear about who was ready to sign them off? That figure relates to the work that the regional assurance teams had done: that was the local area directs of NHS England and the local authority chief executives who were doing a representative role within their regions. What had not been completed at that stage was the national assurance and the national moderation, which was the point at which Simon came in and we undertook the national stress-testing.

Q77 Chair: So your NHS area teams are completely different from you.

Simon Stevens: No, no. We are a unitary organisation, united in purpose.

Q78 Chair: They signed them off, but you dissociated yourself from them.

Simon Stevens: No. They were engaged in an exercise to look at—

Chair: They signed them off.

Q79 Mr Bacon: It actually says very clearly, Mr Stevens, in paragraph 2.5 that they were engaged in a different exercise. It says, “The goals of the scheme, it now appeared—

Simon Stevens: Sorry, which paragraph?

Mr Bacon: Page 23, paragraph 2.5: “NHS England told us that this was because the local teams were not asked by the departments to review plans against a £1 billion expectation since no formal target existed. The goals of the scheme, it now appeared, had not been those that local planners were working towards.” That includes the NHS England area teams.

Simon Stevens: Yes, I think that is exactly consistent with the chronology that we have described.

Q80 Mr Bacon: So they were actually working on something different from what it turned out was required in the end.

Simon Stevens: What they were doing was looking at the plans that the local authorities and the local health service had produced to give a sense of what sort of savings they thought they could manage within the parameters of the Better Care Fund. That was a piece of data that this exercise revealed.

Sir Amyas Morse: Can I ask a question, just thinking about the situation that you found yourself with, Mr Stevens, as an incoming chief executive? I am thinking about what incoming chief executives in the private sector do. They have a very good look around at what unresolved and unquantified risks might be about to land on their plate. I rather suspect that is just what you did. You had a jolly good look round and said, “This sounds very fuzzy. Let’s insist on getting it clarified, so that we don’t find it landing on our head without having any idea where the savings might come from in future.” You took a strong stand and insisted on getting that done. I offer that up as a possible translation for what you might have done, because that is what most chief executives with your business experience would probably have thought about. They would have done an inventory when they walked in, had a very good look around at what they were taking ownership of and tried to bottom out the risks. No?

Simon Stevens: I was pushing at an open door.

Sir Amyas Morse: Is that yes? Are you saying yes?

Simon Stevens: I certainly did exactly what you describe, in terms of taking a hard look at the financial position of the NHS both this year and next and found a strong degree of alignment across Whitehall, between Ministers, about the importance of getting that right. So, when this conversation was had with Ministers, a very good pragmatic judgment was reached.

Sir Amyas Morse: Excellent. Thank you.

Q81 Chris Heaton-Harris: I am not confused; I can understand how it has happened, but there seems to be a disconnect between what you were trying to achieve and the information that you were gathering or being given at the top. Last week, we had the pleasure of Sir Bob before us and we talked briefly about the Better Care Fund. I will quote Sir Bob directly: “That is why we put a huge amount of effort in the last spending round”—a time, I think, slightly before you arrived, Mr Stevens—“into the work we did with the Department of Health on creating the Better Care Fund. We could see that unless you could find ways of transforming the way service was delivered, it was going to become challenging for those authorities.” It is about joint departmental working.

I have got a horrible feeling that, if you don’t give a target written in blood to Government Departments, there tends to be a bit of faffing around and you get to £55 million when it is stress-tested. This is to you, Sir Bob. You know how much how much pressure your councils that operate are under financially. Una, you know exactly how much the CCGs and your primary care budgets are under stress. Merging two together, or part of two together, was surely going to cause extra problems, wasn’t it? I can understand the policy and why it was going to happen, but you were never going to achieve a £1 billion-worth of savings. So that is why it ended up at £55 million, isn’t it?

Sir Bob Kerslake: I will make a few points on this. The first is that the savings were one part of the conversation on the Better Care Fund, not the only one that happened. There were some really important national conditions that were being put in place here. For example, one of the key conditions was the protection of social care services as part of the deal. Similarly, there were a whole set of tests of success that were put in place as well. Those were the things that were really very important to make sure that the plans covered, as well the issue of savings. It wasn’t just a question of the savings figure; it was, crucially, a question of whether the partnerships were working effectively and delivering the national conditions, particularly protection of care. That is the way to look at it. They were not fuzzy—

Q82 Chris Heaton-Harris: I really do understand that bit, and I think it’s going to be an exciting success when we go forward. However, if it was delivering only £55 million of savings, was that an issue?

Sir Bob Kerslake: No, I think it’s really important to say that what the analysis, the stress-testing, showed was that essentially the quality of the plans was such that it didn’t give you confidence about the saving against the action. That wasn’t to say that the action would not save the money, and in fact when we did the more thorough, more robust exercise, through Andrew’s leadership, we came out with a saving of £532 million, which is pretty much in the middle of the range that Carolyn talked about. Our issue at the centre was that we did not have plans of sufficient confidence to be sure what the saving was. I think it was perfectly sensible to go out and improve the quality of the plans at that point.

Q83 Chris Heaton-Harris: So the quality of the plans in delivering adult social care was good enough, but the quality of the financial structure of the plan and any perceived savings was not strong enough.

Sir Bob Kerslake: It is exactly that. We had very good partnership on the whole. We had very good proposals, many of which have stayed in the final plans; they haven't changed. The thing that was not as strong as it needed to be in those plans was the link between the actions and the outcomes. The evidence of the connection between those two just wasn't strong enough in the plans. That is why we went round the loop again, and we also dealt with the issue, as Simon has said, about the quantified benefits for the NHS.

Q84 Chair: Can we go to Carolyn Downs? The purpose has shifted. Figure 3 gives us the original conditions and purposes of the fund: "Plans jointly agreed... Protect existing social care services. Seven-day working in health and social care. Better data sharing... An accountable professional... Agree the impact". Then you have your PIs underneath. That was the purpose; the purpose now is to save £1 billion, isn't it?

Carolyn Downs: That was the change. Once the £1 billion was brought in as a requirement, that really pushed the focus towards the performance indicators and particularly the reduction in emergency admissions. With that being a primary requirement, I have to say, from the local government perspective, we very, very strongly pushed as well the protection of adult social care. So those two performance indicators became the primary requirements, as opposed to the wider conditions that were originally conceived.

Q85 Chair: I'm right in saying, aren't I—I am depending on the ADASS survey—that, till 2014, we had a 12% reduction in social care and that the 2014-15 budgets give us another 2%, so there has been a 14% reduction in social care?

Carolyn Downs: Absolutely.

Q86 Chair: With demand going up.

Carolyn Downs: With demand increasing at the same level, we would say, as the NHS demand.

Q87 Chair: And a further 10% cut in local authority budgets for '15 and '16 will lead to a further cut in social care budgets. Is that right?

Carolyn Downs: Unless councils themselves choose to protect those budgets, but ordinarily, yes.

Q88 Chair: And it is right—is it not?—that 90% of councils now offer care only for substantial and critical needs.

Carolyn Downs: That is absolutely correct.

Q89 Chair: Do you accept Age UK's analysis that 870,000 people between the ages of 65 and 90 have unmet needs, which include struggling to take medication, struggling to bathe, struggling to eat on their own, struggling to get dressed, struggling to go to the loo and struggling to get out of bed?

Carolyn Downs: We would agree with that, yes.

Chair: I just said to Richard that if I were a local authority leader and money had been taken away to support the health service and reduce A and E admissions, I would walk away. What would keep me there? I would walk away, because all the risk is—

Chris Heaton-Harris: Particularly in the context of Northamptonshire, because—

Chair: We had this discussion before.

Chris Heaton-Harris: Not in relation to the money. Northamptonshire's plan has not been signed off by the Department for almost exactly that reason, I think.

Jon Rouse: Can I help on this?

Chair: Can I get an answer from the local government perspective? I'd walk away and say, "Get on with it. I'm not playing this game. This isn't a fair sharing of resources, burdens and risks."

Carolyn Downs: That was definitely a discussion that took place in local government—about whether, in terms of the eventual prize and the principle we all signed up to and very strongly agree with, the conditions were changing to an extent that one would wish to walk away. However, every area but one has put in their plans. Sir Bob and Simon Stevens were involved in the discussions, and what was critically important to us were the words saying that if the savings could not be made, the spend should be through NHS-commissioned services, and that includes those services that are undertaken through a section 75 agreement—that is integrated services. If that wording had not been agreed, local government might have walked away. However, we didn't; in fact, we have worked with colleagues in government non-stop to try to make sure that local areas can bring forward plans. That is particularly because we so strongly support the principle of the Better Care Fund, and of health and social care integration.

Q90 Chair: But social care is going to be cut. What I was reading out to you was the cuts to date. Looking forward to 2015-16, when the Government are committed to a 10% further cut in local government grant, what are you going to be able to deliver? That is why, if I were a local authority leader, I would think, "God, signing up means all the risk is coming my way. I don't have any of the money, because it's been taken back into the NHS to deal with their crisis. What am I signing up to?"

Simon Stevens: Social care is getting £2.1 billion of the £5.3 billion in the Better Care Fund, and the NHS will be making a net transfer, viewed in very narrow terms, which is not the right way of thinking about it. But, of the £1.9 billion, £900 million is shifting from NHS spending to be local authority-directed under the health and wellbeing boards. So, yes, it is a pragmatic response to a set of dual pressures on both sides of the fence, but to say that local authorities have been cut—it is just

that they have not gained as much as would otherwise have been the case, in order to offset the pressures on the other side of the ledger.

Q91 Chair: Have you removed the double counting? We had this argument yonks ago, Sir Bob—I can't remember when we looked at it—when you counted spending as local authority spending and they counted it as NHS spending. What have you done now on local authority spending?

Sir Bob Kerslake: I think you are referring to the spending calculations, and, obviously, that question will come up when we come to the financial settlement later in the year.

Q92 Chair: You will cut it. It was always unfair that it appeared in both budgets. It came out of last year's financial settlement that the money appeared as an NHS expenditure and a local authority income—it appeared twice in the same round. Now that they have taken £1 billion back, and you have £1 billion less, I would expect that to be reflected in a more honest, open and transparent way.

Simon Stevens: It's not quite like that, because there is the £900 million and the £253 million or thereabouts under the pay for performance arrangement that is available to support the work of local authorities. Even that is actually £1.25 billion—

Q93 Chair: We'll come to whether that will ever be realised or whether that is another thing that needs stress-testing.

Sir Bob Kerslake: Can I just come back to this question about local government losing £1 billion, because it is not actually as you have described it? I think either Andrew or Jon organised a survey of local government to find out the consequence of the revised plans and the revised approach.

Jon Rouse: I have the figures here. Because we were concerned, we changed the scheme. What is the impact on local government? We surveyed every local authority, and they all responded—this was in September. In terms of impact on budgets, 74% said there would be no change, 8% said there would be an increase—second time round—and 19% said there would be a decrease.

Q94 Chair: Which budget were you looking at—the 2015-16 budget?

Jon Rouse: This is a projection for the 2015-16 budget.

Q95 Chair: They haven't set their 2015 budget. My authority is just in the middle of doing the rounds, so you don't know. They are just arguing about what to put in their 2015-16 budget.

Sir Bob Kerslake: The question you asked was: did the change that was made in July result in local government losing money? I think our survey shows pretty compellingly that, for the vast bulk of local authorities, it didn't.

Chair: I do not know what other colleagues' authorities are doing, but mine is literally in the middle of its budget—I am talking to them about it now—so the idea that this won't have an impact on what it spends is nonsense. It might not impact on 2014-15, but—

Q96 John Pugh: Are you saying, Sir Bob, that, in terms of discharging statutory services—adult social care—when a chief executive looks at their current budget, they are looking, in general, at more money, rather than less money than they had previously?

Sir Bob Kerslake: No. There are two different questions here. There is the wider question of local government finance, which we covered last week—

Q97 John Pugh: Yes, and it is related.

Sir Bob Kerslake: And there is the related but separate question of what was the consequence of the changes we made around the Better Care Fund in terms of its impact on local authorities. I am dealing with the second question, not the first. I fully accept—

Q98 John Pugh: Okay, I understand. That is a rather more modest claim. The way I see it is that from the local authority's point of view, they have to put forward schemes that engineer some savings across the piece, and they have to develop integrated services, often of a novel and new kind. I think that the bottom line is that they must, during the process, show that they are not reducing existing social services. Am I right in thinking that?

Sir Bob Kerslake: They have to commit to protect the services.

Q99 John Pugh: They have to commit to the services, but not necessarily to the level of funding.

Sir Bob Kerslake: That is right.

Q100 John Pugh: Has anyone worked out whether those three parameters can actually be met, especially in those local authorities such as the metropolitan boroughs that have principal social services responsibilities and face a declining budget? That links to what we did last week.

Sir Bob Kerslake: There is no doubt, as Carolyn has said, that these are very tough times for local government, but in signing off the better care plans—this was in the original version as well as the revised one—the local authorities, which are signatories to the plans, have to indicate that they will maintain the overall level of service, albeit while making efficiency savings.

Q101 John Pugh: And you are confident, having looked at them, that they can do that.

Sir Bob Kerslake: That was tested through the process.

Jon Rouse: This is obviously really important, because there is a group of authorities that either have not been approved, or have been conditioned for the very reason that NHS England does not judge that they have met the condition to protect social care services. They now have to undergo remedial action or provide extra information to demonstrate to us that that condition is met.

Q102 John Pugh: Against the background of local authority cuts, the temptation must be to take the extra money and then devise a scheme that enables them to backfill statutory services and support them.

Sir Bob Kerslake: They cannot do that. One of the questions that the Chair asked—quite reasonably, given the changes—was, “Why are people not walking away?” As I said last week, the answer is simply that transforming how the services work to drive efficiencies and improve the quality of care is one of the only games in town for the future, so a lot is at stake here.

Q103 Chair: But you have approved only six.

Jon Rouse: There are 91 with support and 49 with conditions. Five have not yet been approved.

Q104 Chair: Yes, but you have approved only six; all the others have a risk that the money you promised them will not come to them because they will be cutting adult services. Is that not right, Carolyn Downs?

Carolyn Downs: No, I don’t think it is right. Effectively, the areas with support—six have been fully approved, as you say—do not have concerns around adult social care. I think there are 21 that have a condition attached to them and have serious concerns, and 14 need to show that they are going to meet the national condition to protect social care. There are then, of course, the five that are not yet approved.

Q105 Austin Mitchell: For a change, North East Lincolnshire has had a bit more experience in this, because we were a Care Trust Plus and began the integration of the two services earlier. I wonder whether it poses a risk for local authorities generally—not including North East Lincolnshire, of course—in the sense that all the strains fall on the local authority because social care is in some difficulties given the financial stringency. The benefits, in so far as payments for performance are linked only to emergency admissions, go to the health service. Is that not a problem?

Carolyn Downs: No, because we have insisted on the protection of social care. As I say, there are only 14 plans at the moment where the protection of social care is an outstanding issue. Local areas are working, through NHS England and local government colleagues, and specific support has been put into those areas. There is now a team of better care advisers working with local areas and health and wellbeing boards with the means to get those 14 plans with concerns—indeed all plans—through the process, hopefully before Christmas.

Q106 Austin Mitchell: What makes the health service sure that you can achieve a fall in emergency admissions—I think that 3.5% was mentioned in the Report—when the general trend is up, and remorselessly up?

Simon Stevens: It is. So the question is, to what extent should we, having looked at the individual plans, which vary—3.07% is an average, with some thinking that they can do more than that and some less. Obviously there is a process that Andrew and Carolyn’s team, with support from local government, have been going through to take a look at those, but the beauty of the pay for performance scheme that has been arrived at for the £1 billion value that is going to continue to support what would otherwise have been health service spending is that, if the 3.07% turns out to be 2.5% or 4%, in one sense it does not really matter for the stability of the local health service. If it is lower, there is a payment stream there to support the extra emergencies that will still be going into hospital. If it is more, that is more savings that local government can use through the health and wellbeing boards, jointly, to boost community services. The beauty of the pay for performance scheme is that we do not have to second guess, to the extent that would otherwise have been the case, the degree of ambition that local councils and the local NHS are themselves coming up with.

Q107 Chair: So how much of the £1 billion can be spent on the acute trusts keeping up the A and E?

Simon Stevens: The £253 million is the net efficiency offset from the emergency admissions reductions that Mr Mitchell was talking about—the 3.07%—and then £747 million, as Carolyn said, is available to be commissioned by CCGs in out-of-hospital services, including joint—

Q108 Chair: Sorry, can you just answer the question? How much of the £1 billion that has been taken back could be spent shoring up A and E departments in acute trusts?

Simon Stevens: The £250 million is the piece of it that is supposed to be saved from emergency admissions going down. If emergency admissions do not go down, that £250 million, or some share of it, is available to pay for those emergency admissions.

Q109 Chair: So £250 million could be used to shore up A and E departments.

Simon Stevens: Not shore up. To coin a phrase, the money would follow the patient.

Q110 Stephen Phillips: Is that £253 million available only to the extent that emergency admissions are not reducing?

Simon Stevens: No, it is part of the fund that will then be available through health and wellbeing boards for the jointly commissioned wider services. The £253 million gets spent only with emergency admissions if that is what actually transpires—if the plans do not crystallise in the way that local people want.

Q111 Chair: Let us go back to the original purpose, Mr Stevens. The purpose was not to use this fund of £3.8 billion or whatever in any way to shore up—in my terms; to follow the patient, in your terms—A and E departments.

Simon Stevens: Well, you say that, but the reality is that this is not new money. The incremental £1.9 billion is being—

Chair: I agree. No one is contending that it is new money.

Simon Stevens: It is being taken out of health service budgets supporting current volumes of patient treatment, so I think that a very pragmatic judgment has been made to recognise the pressures in social care and to ensure that for the part of it that is going to continue to sustain NHS services next year, some piece of it will ensure that if CCGs are still having to pay for emergency admissions, the money is there to do that.

Q112 Chair: Will you give us an assurance? You are just trying to hide behind words. In my view, the £250 million and the A and E stats—well, will you tell me what the A and E stats for the first two quarters of this year were? Were they up or down?

Simon Stevens: As I think you are aware, they are up.

Q113 Chair: They are up. Have you stress-tested these figures? Do you think that they can get their 3% or whatever?

Simon Stevens: Yes. The baseline for comparison will be what actually happened this year, so if this year has gone up, then that will be the baseline against which we will be judging—

Q114 Chair: You have stress-tested that, and you are confident that they can do it, are you?

Simon Stevens: The 3.017% in aggregate is the number that is there now. We collectively will use the period between now and March, through the finalisation of the NHS planning process, in the round, to look at that. Then, frankly, because there is no point sugar-coating it, we will have a nuanced judgment to make as to where, in a particular place, they think that they can do better than—

Q115 Chair: Tell me, where are the financial incentives? I am sitting in an NHS trust; it is money that is newly available to me.

Simon Stevens: No, it is actually not.

Q116 Chair: It is.

Simon Stevens: No, it is money that I am getting this year for these very same emergency patients who are showing up. The only interesting question is how many of them will or will not show up next year, so it is not new money at all.

Q117 Chair: If you are in an NHS acute trust it is money you could get in 2015-16. Where is the financial incentive in the way you are using this money to encourage people to reduce A and E admissions?

Simon Stevens: As we discussed last week or the week before in the context of emergency admissions, if the hospitals were sitting here, they would be telling you that they have no financial incentive for more emergency admissions. We have made adjustments, since we were last together, to the emergency tariff for next year to deal with that somewhat. The reality is that the hospitals are under pressure on their emergencies, without a doubt.

Q118 Mr Burrowes: But it is a punt, in terms of this figure of a 5% reduction, because you cannot equate the situation facing my challenged local health service, with its particular reconfigurations and challenges in primary care—we spoke and asked questions about this in previous hearings—with the situation in Stephen or John’s area. They have their own challenges and differences. You have plumped for a reduction of 3%, 4% or 5%, perhaps without knowing any further information.

Simon Stevens: No, we haven’t. That is just an average expectation, with a lot of variation. Local areas have been able to come up with their own number; that just happens to sum to 3.07%. The question that we will have to judge is: where people are expecting to make substantial progress next year, do we back those judgments or do we tell them, “No, actually we want you to dial back the number”? The beauty of the pay-for-performance scheme that has been arrived at is that we do not actually have to interpose our judgment, because the same money will not be spent twice. It will either be spent successfully in keeping people out of hospital or, if patients do end up in hospital, will be there to support their hospital care. That is a good principle.

Q119 Chair: I just want a yes or no to this one: is the £700 million definitely going to be spent outside hospitals?

Simon Stevens: That is the expectation that we have.

Q120 Chair: Yes or no? Is it an expectation or a requirement?

Simon Stevens: The answer is yes, that is what we have required, and obviously we will be able to tell you that as the year proceeds, but that is what we have told the—

Q121 Chair: So is it a yes? Will you come back and account if it goes wrong? You are saying that out of the billion, £250 million could go back into the hospitals to support A and E, but the other £750 million will not be spent on propping up the acute sector in its financial difficulties. Yes or no?

Simon Stevens: Yes, they are the terms that we have set out, but the reason I hesitate is that between now and March we have a final set of decisions to make on whether 3.07% is indeed the overall national position. If that becomes 3.17% or 2.97%, that will make a bit of difference at the margin; but the principle is clear.

Sir Amyas Morse: On the bit that is capped at £250 million, which might or might not be spent on A and E, depending on the level of activity, if the level of activity was higher than you are planning for, and exceeded the £250 million, what then? That just comes out of other NHS funds?

Simon Stevens: That is right.

Q122 John Pugh: Just to drill down on the A and E a little bit, I think we would all accept that the big saving across the piece, and probably in most of the plans you are looking at, is in terms of reducing admissions to A and E. That is a fair assumption, isn't it? There are some people—the Secretary of State, for example—who sometimes go to A and E because they cannot get access to doctors. Availability and access to doctors plays into this as well, but that is not actually controlled by any of these plans, is it? That is directly conditioned from NHS England. How do you factor that in, in order to ensure that you have a plan that is working? It could be derailed by paucity of doctors or poor access to doctors—a range of factors that are completely outwith the plans.

Simon Stevens: Yes. Two separate things here: I think what Jeremy was talking about was going to an A and E for a visit, as against turning up for an emergency admission. Obviously it is emergency admissions that we are talking about here, in terms of the way the Better Care Fund will work. On the underlying point you make, and the second part of the response, you are absolutely right: the availability of out-of-hospital services, including accessible GP services, clearly has an impact on the demand in hospital.

Q123 John Pugh: So a good scheme needs to factor in NHS England's commissioning of the GP service.

Simon Stevens: That is what the health and wellbeing boards, with the CCGs, are doing. It is why one of the benefits of the extra cash that was announced over the weekend—another £250 million that we will be able to put into GP services and out-of-hospital services next year—will be to create more infrastructure there, together with the extra money that has gone in for things like the Prime Minister's Challenge Fund and GP weekend and evening working. All that is clearly part of the equation.

Q124 John Pugh: There are two real reasons why people turn up in A and E. Either they are mismanaging, or there is a crisis in, the chronic disease they have, or they do not know where else to go and A and E departments always have their lights on, even though they are not always the appropriate place. Your modelling of the savings presumably anticipates a substantial reduction in the number of people appearing in A and E who are managing a chronic disease—is that right?

Simon Stevens: When you say the “modelling of the savings”, which modelling do you mean?

Q125 John Pugh: If you expect £1 billion to be saved, you expect it to be mostly on this, don't you?

Simon Stevens: We expect £253 million of offset.

Q126 John Pugh: The paper makes clear that there are two different emergency tariffs for any short-stay or long-stay tariff. There is a huge difference in cost between the two: one is £800 and the other is £3,000. Again, in terms of your projections and your thinking on what can be saved, are you trying to principally work on the higher figure, or do you think you can substantially reduce the lower figure and the type of admissions? What type of admissions do you think are not going to happen in the new order when this all takes off big-style?

Simon Stevens: For the purposes of this exercise, we have used the average cost of £1,490, which bifurcates, as you implied, between £800 or £3,000, based on whether the length of stay is under or over two days. Obviously, we want, and the incentive will be for, people to have the bigger impact, as they can, on the most expensive of the admissions. The point is that length of stay is important there as well. A lot of the things that are being done, not just on the back of the Better Care Fund but, for example, through the extra money that we are putting in this winter, are precisely about helping flow through hospitals to reduce length of stay. That in turn reduces the cost of the emergency admission.

Q127 John Pugh: So you are advising a local authority that, in order to get their plan through, it would be important for them to explain what the local health and wellbeing board will do to reduce the number of high-cost admissions?

Simon Stevens: We have left it that they can, locally, enter which of the figures they want to use for the price of the emergency admissions.

Q128 John Pugh: The temptation would always be to cite the higher figure, wouldn't it? To say, "We will save lots of the high-cost one."

Simon Stevens: You can argue that both ways. As you say, that would improve the overall savings, but they have the flexibility to come up with realistic points of view as to what they can have an impact on. Interestingly, in terms of the out-of-hospital component of this, the Royal College of General Practitioners produced a report last week showing that it believes we can save £447 million by reducing short-term A and E attendances and admissions, and up to £960 million from better out-of-hospital primary care. I think there is a sense that this can be done. Certainly, when I was at the Homerton hospital yesterday morning talking to GPs, nurses and A and E consultants, it was clear that the degree of integration across Hackney is producing superior A and E and emergency performance at that hospital, such that it was the first hospital to be ranked outstanding for its A and E by the Care Quality Commission.

Q129 Austin Mitchell: The whole concept of integrating these two sides is admirable, but it is a pity it has been so messed about. I feel a particular interest; as someone who will fall under the care of the North East Lincolnshire social services when I leave this hospice in March, I have a vital interest in successful social care in the area. I am concerned by paragraph 1.2 of part 1 of the Report. It states that there is an increasing demand for social care, that adults with long-term and multiple health difficulties are living longer, and that the number of adults aged 85 or over—which does not yet include me, but soon will—is increasing.

Yet, there has been a fall in real-terms expenditure on adult social care between 2010-11 and 2012-13 of 8%. That is projected to continue falling further. Can Jon Rouse tell us whether adult social services are going to be sufficiently protected by this new deal?

Jon Rouse: It is a really good question. As we have said, we have put in place this national condition. But if I can paint a bigger picture rather than focusing on the single condition within the Better Care Fund—what we are doing on the Better Care Fund also has to be related across to social care reform. That is another study that the NAO is just getting underway at the present time, and which we will no doubt come back to.

Q130 Austin Mitchell: Will you know whether they are failing or not? Will they be adequately monitored?

Jon Rouse: There are two elements to this: what the Better Care Fund can do and the condition within it. There is also the broader adult social care world and adult social care sector, where the social care reform programme is equally, if not more, important. There are certain changes and protections in that programme or reform process that will help. The first is that there will be a single standard definition of eligibility which will be available to everybody nationally. We will therefore not have any sense of postcode lottery because there will be one eligibility threshold. Secondly, there will be a duty on each local authority to invest in preventive services and also to provide high-quality advice, information and advocacy for those who need it. Thirdly, there will be new rights for carers. They will have parity within the care process; they will have the same right to information, advice and assessment and to see whether they are eligible under the new system. You have to look at the Better Care Fund and the social care reform process together in terms of the protections that we are putting in place.

Q131 Chair: Can I ask about transitional funding? How much is available? Who will answer this one? You haven't said anything, Una. How much is available to support the development of the new facilities?

Una O'Brien: Are you talking about the announcement being made today?

Chair: No, not particularly. It is nonsense to assume that you can have the savings in one year if there is not some up-front money available to provide the alternative facilities. I am seeing both Jon Rouse and Carolyn Downs nodding at that. How much is available?

Jon Rouse: There is an additional transfer from NHS to local government of £200 million.

Q132 Chair: That is just to do with the plans. That is to have the officer time.

Jon Rouse: No. With £200 million, it is for far more than that. It is actually to put in place some of the preparations.

Q133 Chair: Is it? That is not what it says here. Do you know, Carolyn?

Carolyn Downs: No.

Q134 Chair: This is the problem with all this NHS stuff. If you do not have up-front money to prepare your alternative—Mr Ridley, you have not talked very much.

Ashley McDougall: It is paragraph 1.3 on page 12.

Jon Rouse: Actually, the wording here is correct. I think that the NAO has got this absolutely right. It talks about preparing for the “first full year of the Fund”. It is not just about preparing plans; it is about preparations for the first full year.

Q135 Chair: But I know what that is; that is just getting officers in place. Another interesting thing—what is a “local area”? We have 151 local authorities.

Carolyn Downs: Health and wellbeing board areas.

Q136 Chair: We have how many commissioning groups?

Simon Stevens: There are 211.

Q137 Chair: So what is a local area in this context?

Simon Stevens: A local area is—there are 27 of them, shortly to be 14.

Jon Rouse: Or if you mean in terms of health and wellbeing boards—

Chair: No. This Report talks about “local areas”.

Ashley McDougall: There are 151 local authorities.

Q138 Chair: Is it 151 or 211?

Carolyn Downs: It is 151.

Q139 Chair: Just to make it even more difficult. My guess is that the £200 million will be money that you need, Carolyn, within a local area and local wellbeing boards to set them up?

Carolyn Downs: Yes. There is that transitional funding of £200 million. I think you make a more fundamental point, actually, with which we have always agreed: if you really want to see radical transformation, then you do need some double running, which would ease the impact on the acute sector as you undertake change. That is something that we have always said should have sat

alongside the Better Care Fund and that is something that, going forward, if it continues, we would like to see.

Q140 Chair: As a calculation, out of that £200 million that is available, how much is being used up by either consultants or bureaucrats in doing preparation, financial modelling and so on as opposed to services? We will come to consultants in a minute.

Helen Edwards: I do not know the answer to that, sorry. I am afraid that we do not have that information.

Chair: Do you know, Mr Rouse?

Jon Rouse: No.

Chair: Now, Mr Ridley, here is your chance to show that you have been really busy for these last five months. Do you know?

Andrew Ridley: We do not have specific detail about how the £200 million of enabling money has been spent by health and wellbeing boards.

Q141 Stephen Phillips: How did you distribute it? Did you have to bid for it? Was it done on a formula?

Jon Rouse: It was distributed through a mechanism called a section 256 agreement—

Stephen Phillips: Can we have it in English, please?

Jon Rouse: I am sorry; I was going to explain what that meant, but I wanted to reference where it came from. This is an agreement between the NHS and the local authority, where the local authority sets out how it will use that resource, not least in terms of benefiting the health system and, in this context, preparing for 2015-16.

Q142 Stephen Phillips: The local authority has to demonstrate how it will use the money, so does it bid for a specific sum from the £200 million?

Jon Rouse: No, there is a specific allocation formula which determines how much each area gets.

Q143 Stephen Phillips: That formula presumably tells you what the money was being used for, whether officer time or whatever. So you could write to us—in broad terms, at least, given that formula—indicating how that £200 million has been spent.

Jon Rouse: Indeed. We do collect and aggregate data each year on where money has been spent under a 256 agreement—

Stephen Phillips: That is your homework following this session, Mr Rouse, and we look forward to the letter.

Jon Rouse: Okay. Thank you.

Q144 Chair: Can you give us any sense of the information so far?

Jon Rouse: No, I do not have that information.

Chair: Either you let them double run, which you cannot do because you need your £1 billion—or you will take the money out and give it back to the hospitals—or you have some feel. You cannot just say, “Oh, we’ve put £200 million into the system” without knowing how much of that is real to allow a bit of double working, because you will not know. Very disappointing.

Q145 Chris Heaton-Harris: If I may, I want to use this process for a local issue. Northamptonshire is one of the areas where this plan is yet to be approved and, with April approaching relatively rapidly, I wonder what is going on in broad terms in conversations with authorities that feel uncomfortable with where they are at this point in time.

Andrew Ridley: That is something that my team are working on. We have got five areas that are not approved and a further 49 that are approved with conditions, which means that we think there is some material further work to be done on their plan. The other 97 plans that have been approved have already been mentioned to NHS England. Those that are not approved or those with conditions remain the responsibility of the central taskforce, which reports to me.

Every area has been allocated a better care adviser from a team of over 20 people that we have recruited from across the system: experienced health and social care people who have worked on integrated care, often at quite a senior level. Each of those areas has the input of a better care adviser for one or two days a week. They have all agreed an action plan and they will have access to externally commissioned, expert support over the next two months to help them get to a better place.

During the period between now and January, areas can resubmit at a time of their choosing. Last Friday, 10 areas out of the 49 with conditions resubmitted their plans with further evidence around the conditionality and those plans are being assured this week. So we expect a further tranche to be approved during December and we are expecting 20 or so areas to submit again mid-December and the final 20 or so areas to submit by 9 January. So, by the end of January, we expect to have had resubmissions from all the areas that have either been not approved or have got conditions.

Within that is a sub-set of the not approved. Four out of the five are perhaps more problematic. One of them is just a local dispute about Care Act funding and I do not think will be materially difficult to resolve. There are four, including your own area, where we will have to put in significant amounts of support. The person we have allocated to support Northamptonshire, for example, is an extremely experienced person who has worked as a director of social services, a chief executive of a local authority, and an interim chief exec in the NHS. He is spending two days a week with the leaders across that health and social care economy, making sure that they are in a good place to resubmit by 9 January.

Q146 Chris Heaton-Harris: What happens if they do not resubmit by 9 January?

Andrew Ridley: It is our intention, because of the significance of this, particularly to local authority funding, to work intensively. We are spending another £1 million on support during November and December in those areas, in addition to the better care advisers that we have allocated. It is our intention to get everybody to a state of approval by the end of January so that local authorities can go forward and formally set their budget.

In the unlikely event that there are one or two—less than a handful of areas—that we cannot get to an approved category, we will have to discuss with the programme board and with NHS England how we enact the legal powers that are enshrined within the Care Act. It governs this particular fund and will enable NHS England to directly either direct expenditure or direct non-expenditure in relation to the Better Care Fund. We are beginning to work up those options now to cover the eventuality that we may have one or two areas that are not approved in the requisite timetable.

Q147 Chris Heaton-Harris: If I may, Sir Bob, I will go back to the conversation we had last week about local authorities just passporting money through and having very little say, or feeling they have very little say, on direction. They commission local services, but there is very little discretionary spend. If you are in the position of a local authority that looked at this and decided that it is having to commit to a service where there is no limit to the level of spend that might come with adult social care, is it not just easier to allow the emergency measures, as foreseen, to kick in and let the Government get on with this directly?

Sir Bob Kerslake: We are not asking local authorities to commit to open-ended expenditure; we have asked them to protect the service levels in their area. If that local authority has distinct issues that are getting in the way of it doing that in their particular area, clearly they would need to come and talk to us about their own financial issues. But, for the vast bulk of authorities, it makes absolute sense for them to go in with these deals, and that is why 97% have managed to do this. Yours is unfortunately one of only five where we have an issue of this scale—I suspect even less than that in the end. So it is the exception rather than the rule. If there were particular reasons why that local authority could not do it, we would be happy to join in that conversation.

Q148 Chris Heaton-Harris: Lots of local authorities were comforted, as Mrs Downs said, by the comment that Una made: there will be some logic attached. It will be interesting to see, because this is meant to be a much more localised plan—much more locally commissioned and better value.

Sir Bob Kerslake: It is worth saying that I have done quite a lot of visits to better care teams over the last three to six months, and it genuinely feels locally owned and locally led. Yes, they have had this recent period in which they have had to redo some of the plans, and that has been frustrating sometimes. Most of them say it has improved the quality of the plans as a consequence of that, and most of them are just getting on with the delivery of what they have locally agreed, so I would not want you to go away from here saying they were all down in the dumps about what they were doing. Most of them have just got on with it and they are now implementing it.

Andrew Ridley: Can I just add to that? It is probably worth reflecting that, over the summer, we put in a very intensive programme of plan improvement support for local areas. The key purpose

was to help local areas get to a much more robust sense of specificity of what they were going to do—a good analytical understanding of their population, an understanding of their relative performance to other areas, how they could improve services, what the evidence base might say, how they should select interventions, how they could model the benefit, and then how they could financially plan for it and plan delivery. The 97 that have been approved have got very robust plans and our task is to get the other 50 areas into that degree of specificity as well.

In addition to that, within each area there is a requirement that financial risk-sharing arrangements are put in place between the NHS and social care, so nobody is really signing a blank cheque. They are very specific financial plans and the degree to which there is any risk is understood and shared and captured in a risk-share agreement between partners.

It is also helpful to reflect that 64% of local areas voluntarily chose to pool more than the minimum requirement, so the pool is at £5.3 billion rather than £3.8 billion. That is indicative that there remains considerable support in local areas. Of the additional £1.5 billion that areas chose to pool, half comes from local authorities and half from the NHS. That shows a kind of mutual enthusiasm, notwithstanding the fact that there are a handful of areas—complex counties, on the whole—where we have got very complex problems. That is partly, in Northamptonshire's case, because of the underlying financial situation of all parties, which is extremely tough. I was talking to the local authority chief executive about this matter last week. It is also a reflection of some of the complexity of the planning footprints of the bigger counties where they have got many more CCGs and acute trusts and it is just more complex to agree the specificity that we require to approve the plan.

Q149 Chris Heaton-Harris: I have one further question to Mr Stevens. When you did your stress testing to start with, you only found your £55 million worth—let's call it bubble or bounce excitement. Then, a few months later, with a stiffer letter of direction, you have managed to get £500 million worth of savings. Is it not rather easy to find half a billion pounds worth of savings in these things?

Simon Stevens: No, because you are not comparing like with like. The £55 million was just looking at savings in emergency usage in the NHS. The £532 million is including delayed transfers, rehabilitation and admissions to care homes, so savings that will also show up for social care and local authorities. Those are highly useful savings to have, but the two are not a like for like comparison.

Ashley McDougall: The Report says £314 million is the minimum for NHS saving, so that is the comparator to the £55 million and the second savings.

Q150 Chris Heaton-Harris: I am really interested in why there was only the £55 million at the start. Were you only looking at emergency admissions before your initial stress test?

Una O'Brien: It is the rigour of the challenge that we brought to bear the first time round. That was a very tight test that was put on the plans in April and that is why we sent them back and said we wanted a much greater line of sight between the action and the impact that it was going to have. The work was there and, if you look at the plans now, the actions are broadly the same, but we have tied down the specificity of the relationship between the planned action and the impact that it will have.

Q151 Chris Heaton-Harris: So you have been able to quantify other actions in the adult social care system and put a financial value on it?

Una O'Brien: Yes. They are much more detailed, robust and rigorously challenged, so our level of confidence in the plans that we have now is necessarily higher. If I might just say, it is a strength of the process that we were able to bring that degree of rigorous challenge to the plans. I think it was a much better process to be able to do that rather than to just have waved them through and then hope on a wing and a prayer that it would be okay. It was the right thing to do to pause that process there and send the plans back so that it could be more thoroughly structured.

Simon Stevens: Which is, indeed, what the National Audit Office found in its Report. These initiatives “are all likely to improve the quality of plans,” it rightly finds, and it says, “Pausing and redesigning the scheme...was the right thing to do.” I think both Una and I agree with that.

Q152 Chair: Can I just be a bit more sceptical on this? Chris talked about these savings of £532 million. Part of it assumes A and E admissions go down and we have already said that in the first two quarters of this year they are up. The other part is transfers. Can whoever this is relevant to just remind us what has happened to delays in transfer in the past year? Have they gone up or down? Has the figure got worse or better?

Simon Stevens: They’ve gone up—

Chair: It’s got worse?

Simon Stevens: Which of course highlights the benefit of the kind of process that the Better Care Fund will bring.

Q153 Chair: But you are completely confident you can get that more than £500 million savings, wherever it comes from, are you? All I am doing is trying to do some stress testing of it, Mr Stevens.

Simon Stevens: Yes, obviously that phrase didn’t warm the cockles of your hearts. I will try to find a better one. How about “reality check”? Support to enhance the granularity of the actions that were being intended—

Chair: I don’t mind the words; it’s the same thing. I just don’t believe it.

Simon Stevens: You don’t believe that £532 million savings were—

Q154 Chair: You have done that on an assumption that A and E admissions will go down, but they are now up. You have done it on an assumption that delays in transfers of care will be less, but there was a 7% increase in the last year that those were measured to September 2014-15. I can’t see any evidence staring me in the face that leads me to believe that, when you stress test this, you have any confidence in your figures.

Simon Stevens: The key point here again is because of the simplicity of the pay-for-performance element that has been derived. For the emergency admissions, which we have already discussed, clearly, we are either seeking to have a reduction or pay for the hospital emergency admissions that occur, for the other pieces—

Chair: We are on a different point now; we are on a point about savings.

Simon Stevens: Yes, absolutely. For the other pieces—

Q155 Chair: Jeremy Hunt got up and said, “these plans will mean savings ...of £500m in the first year alone” to the NHS. All I am trying to do is test that.

Simon Stevens: Well, it is £532 million across the system. Some of those savings will occur for local authorities—

Chair: Jeremy Hunt said £500 million to the NHS alone, actually—on 30 October.

Simon Stevens: And I certainly believe that, relative to the counter-factual—relative to what would have happened otherwise—doing more of the sorts of things that are going to be funded by the Better Care Fund will improve patient experience, will improve quality of care, and will produce some of the sorts of line items of savings that we have got here. Now, there will be demand pressures next year—of course there will—but will this improve matters versus not doing it? I think it will improve matters.

Q156 Chair: I think that everybody believes this is a good thing. What we are testing you on is whether it will save money. I repeat that Jeremy Hunt, on 30 October, which is not that long ago, said: “these plans will mean savings”—to the NHS—“of £500m in the first year alone. More importantly in terms of patient care, they will mean 163,000 fewer hospital stays or 447 fewer hospital admissions every single day; and 100,000 fewer unnecessary days spent in hospital in total through organising better delayed discharges.” What did he base those figures on?

Simon Stevens: I think those are based on the figures produced from the assurance process, with perhaps the caveat that I think the savings—the £500 million savings—are to both the NHS and to local authorities.

Q157 Chair: On what the Report says, I shall just give a little bit of history. I was around when we did community care and closed the long-stay mental hospitals. The argument at that time was always, “You do that and you’ll save masses and masses of money.” The reality, when it came to implementation, was that it actually doubled the cost. It doesn’t mean that the quality was not better and we have not ended up with a better form of care, but the idea that it would save money proved in practice to be false.

The evidence here—page 9, paragraph 16—says there is limited evidence that integration saves money and reduces A and E. It also goes on to say, actually, that the fixed costs of acute providers mean that they are very difficult to shift, that large-scale changes need to be decommissioned, and that the savings that you are proposing here for the NHS are probably not achievable. Do you want to comment on that?

Simon Stevens: Yes. I think I'd like to challenge both the premises in that statement. First of all—if I take them in reverse order—on the fixed cost point, since emergency admissions are going up, year over year, I think you can argue that the fixed costs, in the sense of the physical infrastructure—the boiler house and so on—are already, for the most part, covered in the baseline payments to hospitals. Take the projection that we have done in the context of the tariff: we have adjusted the marginal rate of increase to better reflect the extra costs of each extra emergency admission, but the truth is you don't have to build a new A and E department for each new patient who shows up. Some of those fixed costs are already being covered by the baseline level of spending that is flowing into emergencies. That is the first point. I will come on to the second point, but you are looking equivocal on that one. Do you want to come back on that before I go on to the second point?

Q158 Chair: Maybe I have misunderstood you. The fixed costs are there because A and E admissions are up; is that what you are saying?

Simon Stevens: Yes. If this year—or at some point—we have paid for the fixed costs of the hospital, then if you have another 2% or 3% of emergency admissions next year, you do not have to rebuild or pay for the boiler house next year. That has already been paid for in the baseline spending.

Q159 Chair: I understand that. If you have 2% to 3% more admissions to A and E, they don't get their money for the Better Care Fund; the only way they get that is by reducing A and E admissions. Am I being daft? Am I missing something?

Simon Stevens: I do not think that relates to the fixed-cost point, though.

Q160 Chair: You said that it does not take time to get rid of the fixed costs as we are using those fixed costs anyway, because A and E is going up.

Simon Stevens: If it were a zero-sum situation, yes. If we were at 100 and were taking substantial cost out, then yes, that would be the case. If you look out over the next three to five years, however, the Nuffield Trust has calculated that if we do not get integration right, we will need another 17,000 more in-patient hospital beds, which is equivalent to building 34 new DGHs across this country. That is additional fixed cost that we will avoid, as against net fixed cost that we have to take out.

Q161 Chair: I do understand that, but what is the point of the 3% reduction in A and E? It won't happen. You are saying that you will slow down the increase of A and E admissions.

Simon Stevens: No. For next year, the plans that have been produced by local health services and councils working together aggregate to 3.07%. That is absolutely true, and you would expect that. Nobody thinks that will be the end of emergency admissions in perpetuity, but we would expect to see an impact in the year in which you make these extra out-of-hospital investments.

Una O'Brien: The bottom line is that one in five unscheduled emergency admissions, when the analysis is done, could have been cared for better outside of hospital. We are facing a strategic choice: carry on building ever more acute hospitals in a three, five, or 10-year time frame to meet that pattern that Simon has described, or, even in adversity and under this pressure, start this journey. We have to start this journey because we know scientifically, clinically and with regard to all that is needed around compassionate and dignified care that we can do a better job for people outside hospital, and it is what people want.

Q162 Mr Bacon: Where does the one in five number come from?

Simon Stevens: I believe that was an NAO number.

Una O'Brien: Yes, from your own Report.

Ashley McDougall: I think it was about admissions.

Q163 Chair: Am I being stupid? What I am now being told is that if you do nothing, A and E will carry on going up. Right? If you do this, there will be a reduction, or there will be a reduction in the rate of growth.

Simon Stevens: The plans that the local councils and the local health service have come back with show that, relative to this year's out-turn, they would expect to see a reduction as a result of the substantial—

Q164 Chair: A reduction in the rate of growth?

Simon Stevens: No, a reduction of 3.07%.

Sir Amyas Morse: But is it not true that that is because they were given direct planning instructions to put that in?

Simon Stevens: No.

Sir Amyas Morse: I'm sorry; I thought it was.

Andrew Ridley: It is a planning assumption of 3.5%

Carolyn Downs: That was an ambition, not a diktat.

Sir Amyas Morse: I accept it was not a diktat. I am not trying to say that.

Q165 Chair: Right, okay. We are lost on this one. I am not going to proceed with it. I want to cover one final area. How many bureaucrats and consultants have we employed on this lot? How much have we spent on consultancy?

Simon Stevens: Andrew, do you know what the spend has been?

Andrew Ridley: I can speak from 7 July onwards.

Q166 Chair: 7 July is far too late. You are accountable even for what happened before. A lot of these plans were in by April.

Andrew Ridley: I think the Departments will want to comment on pre-7 July. I am not sure there was any cost.

Q167 Chair: You are the accounting officer.

Jon Rouse: Pre-7 July there was virtually no spend centrally on consultancy. Clearly, I do not know how much was spent at a locality level by individual local authorities and CCGs; I do not have those data.

Sir Bob Kerslake: I think that there was funding to the LGA.

Jon Rouse: For 2014-15, there has been an injection of some £400,000 to the LGA. We also put in some money to ADASS in January to February 2014 to support them in terms of peer mechanisms, but that is not really consultancy of the kind that you are talking about.

Andrew Ridley: Since we changed the approach to the programme and it became more centralised, there is myself and a small team of about 20, which comprises secondees from the Department of Health, the Department for Communities and Local Government, the LGA and NHS England. In addition to that, we have employed part-time 20 better care advisers, who either work in health and social care already or have recently retired.

Q168 Chair: Oh my God, don't tell me these are people who have been made redundant and have come back in. I bet it is.

Simon Stevens: On that point, it is worth getting this on the record: we are changing precisely to avoid that. We, NHS England, are changing the NHS standard contract from 1 April so that anyone who is re-employed by an NHS provider while in receipt of an NHS redundancy payment cannot be paid twice.

Q169 Chair: But they can, in this programme.

Andrew Ridley: They are mostly people who work in the system whom we are seconding.

Mr Bacon: It is always the system that looks after its own, Mr Ridley; that is the problem. There are some people on five or six rounds of redundancy now, because of all the turmoil in the NHS.

Q170 Stephen Phillips: How much have you spent on consultancy since 7 July, Mr Ridley?

Andrew Ridley: I was coming to that. The main item of expenditure on consultancy was £2 million. We put in place a national support programme that ran for eight weeks from 25 July until

about the third week in September. That produced a number of resources that are now available on the Better Care Fund website, and resulted in 136 of the 151 areas accessing that support, which was mainly delivered through regional clinics, with experts to help people improve specific aspects of their plan. That was the main consultancy spend. In addition to that, we have just let another contract for £800,000 plus VAT, focused on the 50 most problematic areas. That will run from now until the end of January.

Q171 Stephen Phillips: So £2.8 million overall—is that right?

Andrew Ridley: That is correct.

Q172 Stephen Phillips: Who has it gone to? How many firms has it gone to?

Andrew Ridley: Both contracts actually went to a consortium, led by PA Consulting, of mostly small firms that specialise in working on integrated care.

Q173 Chair: You do not include those advisers in that figure. They are consultants, aren't they? They are on short-term contracts.

Andrew Ridley: They are.

Q174 Chair: They may not have come through PA Consulting, but they are short-term contracts.

Andrew Ridley: Yes. We actually employ them through the LGA, but they are on day rates.

Q175 Chair: And how much do they cost?

Andrew Ridley: We budgeted £300,000 for them.

Q176 Mr Bacon: How much do they each cost per day?

Carolyn Downs: We usually cap it at about £800.

Q177 Chair: What is this contract with the North and East London commissioning support unit?

Andrew Ridley: The North and East London commissioning support unit is an NHS organisation. They were given the contract by NHS England to put in place a nationally consistent assurance review. When their plans were resubmitted, we had a more consistent and robust analysis than we had previously, which generated the approvals category that we now have. The contract with them ran to a value of about £1.1 million. Some of that was subcontracted out to four other

NHS commissioning support units and to some audit firms that did the desktop review of the plans that were resubmitted in September.

Q178 Chair: And how much did these health and wellbeing boards spend on consultants?

Jon Rouse: I do not have the answer to that.

Q179 Stephen Phillips: There was a fund of £400,000—is that right?

Jon Rouse: We have routed, for this year, £400,000 via the LGA to provide support to local areas.

Q180 Chair: Can we just ask the NAO to do a quick survey so that we can incorporate those figures in our report?

Simon Stevens: The NAO has already looked at this and concluded that “Programme management since the redesign is much improved”. What Andrew has just been describing is an essential part of that improved programme management.

Chair: Okay. Thank you very much.